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Violence during Pregnancy among Young Married Women in Nepal

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Violence during Pregnancy among Young Married Women in Nepal

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Introduction:

The purpose of this thesis is to study violence during pregnancy among young married women in Nepal. The data collected for this project comes from young married women from four different districts in Nepal who were surveyed by a research institution based in Nepal. Intimate partner violence which mainly occurs during pregnancy has received very little attention in Nepal. Hence, in my thesis, I will address the issue of violence against women by their intimate partners especially during pregnancy. I will explore the antecedents of pregnancy violence and the subsequent health consequences. I will present the literature review on various studies conducted globally as well as nationally in Nepal, followed by a background of Nepal. I will then present the methods and measures used to conduct the survey analysis followed by presentation of my results. In the end I will discuss the issues surrounding violence against women based on both the literature review as well as my results followed by recommended interventions. I will present the various sections of this thesis keeping in mind the specific aims of the study which include:

1). Estimating the prevalence of violence against young married women during pregnancy.

2). Assessing the factors that place young married women at increased risk of violence during pregnancy.

3). Documenting the impact/consequences due to violence during pregnancy.

4). Analyzing evidence regarding status of pregnant women who have experienced violence and suggest interventions for positive change.

Chapter 1. Literature Review:

Violence against women (VAW) is a serious public health issue as well as a pervasive human rights violation. There are various forms of violence against women including rape, trafficking, kidnapping, abduction, and also violence from extended family. VAW in situations of armed conflict is another aspect of violence that has been largely disregarded until recently. Similarly, rape in armed conflict has been used as a strategy to destabilize populations, facilitate ethnic cleansing, express animosity towards the enemy, or supply soldiers with sexual services. Family violence is another factor in VAW and it refers to all forms of abuse within the family regardless of the age or sex of the victim or the perpetrator. In addition, VAW can also occur in the extended family, especially by in-laws due to conflicts within the family and problems due to the practice of dowry mostly in Asian countries (Coomaraswamy, 2005; Ellsberg & Heise, 2005).

Not only does violence cause injury, it increases women's long-term risk of many health problems including physical disability, drug and alcohol abuse, chronic pain, and depression (Nasir & Hyder, 2003). Women who are victims of violence may often choose to remain silent about their experiences mainly due to lack of protection by powerful institutions, the legal system and the social customs in their society. Violence against women affects all spheres of a women's life including her autonomy, her capacity to protect herself and her children and eventually her overall health status and quality of life (Zaman, 2003). Violence can also occur during pregnancy.

Defining 'Violence':

Violence can be described as the deliberate use of force to harm a human being. It can lead to fatal and non-fatal injury, which may be physical, sexual and psychological (Eng et al., 2010). According to the United Nations definition, the term "violence against women" means any act of gender based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life (Ellsberg & Heise, 2005). Intimate partner violence (IPV) has been defined by the National Violence Against Women (NVAW) Survey as including rape, physical assault, and stalking perpetrated by current and former dates, spouses, and cohabiting partners and also includes same-sex and opposite-sex cohabitants (Tjaden & Thoennes, 2000). In the context of violence during pregnancy, the CDC defines domestic violence during pregnancy as "Physical, sexual, or psychological/emotional violence, or threats of physical or sexual violence that are inflicted on a pregnant woman" (Pan American Health Organization, 2000).

Prevalence of Violence:

The World Health Organization's (WHO) Multi Country study on women's health and domestic violence against women has reported that violence committed by male partners directed against women is the most common as opposed to violence committed by other institutions and persons. There are different forms of intimate partner violence including physical, sexual and psychological violence against women. In Brazil, research that was conducted nationally among women aged 15

and older, 43% reported being subject to violence by their partner, a third reported some form of physical violence, 13% sexual and 27% psychological (Ludermir, Schraiber, D'Oliveira, Franca-Junior, & Jansen, 2008). Similarly, research findings from two sites in Brazil, Sau Paulo and Zona da Mata, documented a large proportion of women experiencing violence (50.7%) with frequent forms of violence being psychological violence alone (18.8%) or accompanied by physical violence (16.0%) (Ludermir et al., 2008).

In the United States, approximately 1.5 million women annually are raped, or/and physically assaulted by an intimate partner; one in four women is at lifetime risk of physical assault (Cronholm, Fogarty, Ambuel, & Harrison, 2011). In Mexico several regional studies have documented the prevalence of violence against women in general from 20% to 40% and this violence causes serious health effects for women (Castro, Peek-Asa, & Ruiz, 2003). According to Nasir, K & Hyder, A.A. (2003), an estimated 28% of all women report at least one episode of physical violence in the developed world whereas studies indicate a prevalence of 18-67% in the developing countries (Nasir & Hyder, 2003).

The Demographic and Health Surveys (DHS, Macro International) document the prevalence of violence against women in various developing countries. For instance, DHS results show South Africa as one of the countries with the highest prevalence of IPV in the world (Ntaganira et al., 2008). In Nigeria, 81% of married women reported being verbally or physically abused by their husbands (Ezechi et al., 2004). Similarly, findings from a study done in Rwanda indicate that more than one in two participants have experienced at least one form of IPV from their male partners (Ntaganira, Muula, Siziya, Stoskopf, & Rudatsikira,

2009). IPV is a significant problem in Sub-Saharan Africa as well. A survey reported that 46% of Ugandan women, 60% of Tanzanian women, 42% of Kenyan women, and 40% of Zambian women face physical abuse.

A study, conducted with married Arab women in Israel revealed that 30% of the women reported one or more recent episodes of physical abuse or sexual coercion. Similarly, in urban Thailand 20% of husbands reported subjecting their wives to physical abuse. Thirty-eight percent of women reported having been beaten by their husbands within the previous year in a study in Korea, with 12% of women undergoing intense battering. Moreover, 21% of a nationally representative sample of partnered women in Columbia reported lifetime physical abuse and in Nicaragua 52% of women reported ever being abused by their partners (Koenig, Ahmed, Hossain, & Khorshed Alam Mozumder, 2003). In India, a community-based survey found that 41% of the women reported having ever been beaten by their husbands, with slightly higher rates of reported violence in the northern state of Uttar Pradesh than in the southern state of Tamil Nadu (Jejeebhoy, 1998; Koenig et al., 2003).

Intimate partner violence (IPV) is a significant cause of morbidity and mortality and can result in negative mental, physical, sexual and reproductive health outcomes. It is also linked with risk factors for poor health such as alcohol and drug use, smoking and unsafe sex (Garcia-Moreno & Watts, 2011; Janssen et al., 2003). IPV can also have an indirect effect on family members left traumatized because of the violence they have witnessed in their homes. Moreover, in a dominated society, women are more likely to face violence from men who feel they have the right to exercise control.

Structural Factors:

There are several structural barriers that serve to perpetuate intimate partner violence. These include cultural factors that serve to perpetuate intimate partner violence such as definitions given to narrowly defined sex roles, expectations of roles within relationships and social, legal, and cultural contexts that give men rights over women. Economic factors, such as women's economic dependence on men, discriminatory laws regarding inheritance, property rights and limited access to employment, education and training for women may perpetuate gender-based violence. There are also legal factors such as women having less legal status, low levels of legal literacy, laws that do not criminalize domestic violence and police forces not adequately trained to deal with violence which facilitate IPV. Lastly, political factors including under-representation of women in power, limited participation of women in the organized political system and a permissive climate related to domestic violence all may increase prevalence of IPV (Heise, Raikes, Watts, & Zwi, 1994).

Consequences:

IPV is a serious issue and leads to many serious consequences including death, physical injury and disability, depression, post-traumatic stress syndrome, suicidal ideation, high blood pressure, unwanted pregnancy, miscarriage, low birth weight babies and sexually transmissible infections (Ntaganira et al., 2009). A study done in Bangladesh presented evidence that perpetrators of IPV are more likely to engage in risky sexual risk behaviors and have recently contracted sexually transmitted infections compared with men not committing IPV. Results in the same

study among women who are physically abused by their male partners also show female partners having limited sexual negotiation power (for example, capacity to refuse sexual activity or to insist on condom use or other protection), which also increases their risk of infection (Silverman, Decker, Kapur, Gupta, & Raj, 2007).

Women who face partner violence may be less likely to adopt contraception and may be more likely to experience an unwanted pregnancy (Stephenson, Koenig, Acharya, & Roy, 2008). Findings from studies done in Australia and New Zealand have found a link between partner abuse and pregnancy termination. A study done with women aged 18-27 years in Australia found that women who had terminated their pregnancy were more than three times more likely to have faced partner abuse than women who did not (Taft & Watson, 2007). Similarly, a study done in New Zealand consisting of ever pregnant women attending an abortion clinic discovered 50% of women reporting having experienced some sort of physical or sexual violence in their lifetime as compared to the general population (36%). Women who went to the abortion clinics and had faced some sort of partner abuse were also more likely to be having relationship problems and cited them as a driving factor for pregnancy termination (Whitehead & Fanslow, 2005).

Intimate partner violence has been linked to women's mental health problems including stress, fear, anxiety, fatigue, sleeping and eating disturbances, post-traumatic stress disorder (PTSD), and suicidal thoughts (Campbell, 2002; Ludermir et al., 2008). For example, 70% of women who have faced abuse in developing countries report having mental health problems especially emotional distress in Nicaragua due to IPV, and depression and anxiety reported in abused

women in Pakistan (Campbell, 2002). Similarly, a population-based study of mental health conducted in Brazil found an association between intimate partner violence and mental health problems (Ludermir et al., 2008).

Violence during Pregnancy:

The prevalence of intimate partner violence is gaining recognition in the developing world and there is also interest to some extent, in understanding the association between violence and pregnancy outcomes (Ntaganira et al., 2009). The male partner often feels a sense of stress and anxiety over the upcoming birth, which leads to the potential for increased risk of violence during pregnancy. The stress manifests itself into irritation, which gets directed back at the pregnant woman and her unborn child. Domestic violence during pregnancy puts not just one, but two lives at risk (Pan American Health Organization, 2000; Silva, Ludermir, de Araujo, & Valongueiro, 2011).

Pregnancy is an extremely vulnerable stage for women physically and mentally, so it is vital to recognize that pregnant women are more likely to be abused in a relationship. Two out of every five pregnant women report violence during pregnancy in United States and other developed countries (Burch, Rebecca L.Gallup Jr.,Gordon G., 2004). In some cases the abuse is actually initiated during pregnancy rather than just continuing into pregnancy. IPV before pregnancy can be a risk factor for pregnancy violence and violence during the postpartum period. Similarly, pregnancy violence can continue through the postpartum period. During the postpartum period having a child may be characterized by sleepless nights and changes in family dynamics, which may lead to fights between couples especially

about their sexual relationship. Factors such as financial responsibility, woman's physical and hormonal changes and playing the role of father and mother are factors that exacerbate the occurrence of violence in homes (Silva et al., 2011).

Women may believe that pregnancy is a protective factor against violence and that their partners will be more sympathetic towards them. However, pregnancy may give rise to insecurities in men who are often jealous and may see pregnancy as not an outcome of his own doing but rather an indication of his worst fears coming true (Burch, Rebecca L.Gallup Jr.,Gordon G., 2004). Pregnancy is a time of increased risk for violence for some women. According to Jasinski, J.L. (2004), violence is known to occur mostly among couples where the male partner identifies pregnancy of his female partner occurring sooner than intended or when he is jealous, drunk, or not getting enough sex.

Many of the risk factors identified generally in IPV among women are also found for IPV during pregnancy. In a study done in India, 30% of women reported violence prior to pregnancy as well as during pregnancy (Helton, McFarlane, & Anderson, 1987; McFarlane, Parker, Soeken, & Bullock, 1992). In some societies pregnancy serves as protection against violence whereas in others abuse during pregnancy is pervasive. For instance, results from a British longitudinal study reported that pregnancy represents a period of comparatively low risk for domestic violence (Bowen, Heron, Waylen, Wolke, & ALSPAC Study Team, 2005). On the other hand, a study done among pregnant women in Jos, Nigeria reported that pregnancy is not a protective factor against violence since as many as 11.6% of pregnant women in their study had experienced violence during pregnancy as opposed to 3.8% in-between pregnancies (Gyuse & Ushie, 2009).

Violence during pregnancy poses a severe threat to women's health and in the extreme can even cause the mother and her unborn child's death (Bacchus, Mezey, & Bewley, 2004). Similarly, IPV during pregnancy is associated with adverse pregnancy outcomes such as low birth weight, spontaneous abortion, bleeding during pregnancy, preterm labor, preterm delivery and higher neonatal deaths. In South Africa, women who have been victims of IPV during pregnancy are also more likely to delay seeking prenatal care, have sexually transmitted infections (STI), and vaginal and cervical infections (Hoque, Hoque, & Kader, 2009). Violence against pregnant women may affect them through direct and indirect means. For instance, a blow to a pregnant woman's abdomen may cause unfavorable outcomes such as preterm labor and delivery and fetal injury and death. On the other hand, the indirect mechanisms pertain to the risks of psychological stress or insufficient access to medical care, which could cause poor outcomes (Ezechi et al., 2004). A study done among a national cohort of Australian women reported pregnancy terminations as a result of partner violence (Taft & Watson, 2007). Partner violence has also been known to result in high levels of depressive symptoms or PTSD according to a study done among pregnant Latinas in Los Angeles, California. The pregnant Latinas in this study were positive for IPV and had more than twice the odds of reporting PTSD symptoms and were exposed to trauma, social undermining and stress with less social support (Rodriguez et al., 2008).

Prevalence and Importance of Pregnancy Violence:

The prevalence of violence during pregnancy ranged from 0.9% to 20.1% from a review synthesizing results of 13 studies conducted in various countries globally (Gazmararian et al., 1996; Romero-Gutierrez, Cruz-Arvizu, Regalado-Cedillo, & Ponce-Ponce de Leon, 2011; Shamu, Abrahams, Temmerman, Musekiwa, & Zarowsky, 2011). Prevalence of physical violence against pregnant women ranging between 0.9% and 30% were reported by a second review of 18 studies from which 6 represented developing countries (Shamu et al., 2011; Taillieu & Brownridge, 2010). According to authors, (Oweis, Gharaibeh & Alhourani , 2010), the prevalence of violence against pregnant women ranged from 4 to 29% from studies done in the developing countries, whereas statistics show a figure between 1 to 20% in the developed world. Similarly, authors found on average from 3% to 8.3% abuse during pregnancy in the largest meta-analysis that was done of first generation research (first descendants of immigrants). If this range is correct and the estimation applies to the four million women who deliver live born infants each year in the United States, one would expect roughly 156,000 to 333,000 of these women to experience violence during pregnancy (Tuerkheimer, 2006). Among 340 randomly selected pregnant women, in a rural part of Africa, IPV during pregnancy was highest in the age group 21-25 years and psychological (49%) and physical violence (36%) were reported to be the most common types of violence (Hoque et al., 2009). Additionally, a study done in Jos, Nigeria found full-time pregnant house wives and the self-employed were the ones at high risk of abuse (35.3% and 43.3% respectively) (Gyuse & Ushie, 2009).

Risk Factors for Intimate Partner Violence (IPV):

1. Socio-demographic Factors:

There are numerous socio-demographic factors identified by the National Violence Against Women survey (NVAW) as putting a woman at risk of IPV. These include lower income, less educated women, couples with income, education, or occupational status disparities and person with a disability. The NVAW is a national phone survey consisting of telephone interviews of a sample of 8000 women and men in the US (Koenig et al., 2003). Another study done among low-income African American women documented the same factors predicting IPV with additional considerations such as being young, African American, and living in urban areas as a greater risk for domestic violence as well as HIV infection (Silverman, Decker, Saggurti, Balaiah, & Raj, 2008).

2. More Dominant Husband:

Having a more dominant husband serves as a negative component and may lead to violence in a marital relationship. A study done in Cambodia defines "husband control" as the exercise of power or control by the husbands over the wives' social activities, such as meeting with female friends, and through the husbands' accusations of wives' unfaithfulness. Husband control is also a factor leading to violence in marital relationships. Men are expected to be controlling in their relationships in Cambodia, as it is a male dominated society. Cambodian women themselves are known to support dominant roles for males (Eng et al., 2010).

Husband control is a significant factor in a relationship because power is concentrated in the hands of the husband where he makes most of the decisions

and controls his wife (Tjaden & Thoennes, 2000). Women's lack of power in relationships and in society is a factor in marital relationships leading to violence directed to them by their intimate partners. Most men in marital relationships expect their partners to be submissive as well as sexually available to them at all times. Men also think it is their right and requirement to use violence against their partners if they are perceived to misbehave (Hoque et al., 2009). Women whose partners are more likely to be jealous, controlling and verbally abusive are more likely to report being raped and physically assaulted by their intimate partners (Tjaden & Thoennes, 2000). Gender-based power may be unbalanced in many relationships and factors such as the type of relationship (for example casual, marriage, cohabitation, commercial) and communication between partners may have an effect on gender power dynamics. There is a clear causal link between power relations and violence within sexual relationships which may in turn affect women's health (Blanc, 2001).

3. Problems in Spousal Communication:

Spousal communication is another major predictor of IPV (Eng et al., 2010). Better and frequent spousal communication is commonly known to decrease the risk of violence (Naved & Persson, 2005). However, in some cultures such as Japanese and other Asian cultures, communication between spouses may have no effect with the rate of violence. Moreover, spouses in Japanese culture have reported communication between them as unilateral with the husband initiating and dominating the conversation most of the time. Japanese women have identified the patriarchal system in their culture as directly influencing IPV (Nagae & Dancy,

2010). In contrast, frequency of spousal communication positively predicted emotional violence in Cambodian couples but with the idea that more spousal communication would lead to more violence. The reason behind the positive correlation is that according to Cambodian norms, husbands hold patriarchal beliefs that a wife should be quiet and submissive. Hence, wives' frequent communication with husbands would be interpreted by them as a violation of Cambodian norms (Eng et al., 2010). It is clear that gender-based power inequities may be a factor contributing to a lack of communication in marital relationships (Blanc, 2001).

4. Substance Abuse and Husband EMS (extra marital sexual relationship): Substance abuse in intimate partner relationships is another risk factor that may lead to intimate partner violence (Eng et al., 2010; Stephenson et al., 2008; Varma, Chandra, Thomas, & Carey, 2007). Consuming alcohol leads to fighting with other men, being unfaithful and committing physical violence according to a cohort of Indonesian women (Hayati, Hogberg, Hakimi, Ellsberg, & Emmelin, 2011). Similarly, a Polish study documented that male perpetrators who drank alcohol were more likely to be physically violent than those who did not drink alcohol. A study done in Rwanda also documented having multiple sexual partners, having HIV positive status, low education and socioeconomic status, being pregnant, and being in a short-duration relationship as risk factors for IPV (Ntaganira et al., 2009; Schensul et al., 2006).

5. Social Support:

Two studies conducted among African American women showed social support as a mediating factor between experiences of child maltreatment and intimate partner violence. If there is social support from family or loved ones before or after the first experience of violence among women, there will be less chances of revictimization (Bender, Cook, & Kaslow, 2003; Bradley, Schwartz, & Kaslow, 2005). Women often seek help from formal and informal sources in response to intimate partner violence and this was reported in a study conducted among battered Korean women in intimate relationships. Formal sources include police, medical, legal and shelter. Informal sources include family or neighbors (Kim & Lee, 2011). Life cycle factors and familial factors can contribute to violence against women. Parental support is one such familial factor that is a determinant of domestic violence. For example, the presence of members of the wife's family was associated with lower rates of reported domestic violence in South India and Cambodia (Koenig et al., 2003).

6. Female Gender Attitudes:

Female gender attitudes are attitudes of females about the justification of men's treatment towards their wives or intimate partners, which may include wife beating and refusing to have sex. Female gender attitudes are formed through gender inequality and inequity and leads to gender based violence and discrimination (Adinma & Adinma, 2011). Survey respondents consisting of 24% to 36% of a sample comprising of 507 Chinese, Korean, Vietnamese and Cambodian adults living in the U.S agreed that violence against a woman could be justified in certain

situations. These situations included wife's sexual infidelity, her nagging and her refusal to cook or clean. It was discovered from this study that Southeast Asian respondents were more supportive of attitudes of male privilege and use of violence in certain situations in comparison to the East Asian respondents (Yoshioka, Dinoia, & Ullah, 2001). Indonesian women on the other hand expressed attitudes and norms, which verifies that unequal gender relationships are more common among women living in the highlands and being married to poorly educated men. Around 59%, which is slightly more than half of the Indonesian women considered it justifiable to refuse coercive sex. Financially independent women (71%) were more likely to adopt this kind of attitude and also had a higher risk of exposure to sexual violence (Hayati et al., 2011).

Risk Factors for Violence during Pregnancy:

1. Socio-demographic Factors:

Studies have documented that being young or adolescent, single, separated or divorced during pregnancy, belonging to an ethnic minority and having a low education status were some of the socio-demographic risk factors reported by authors. Other risk factors included increased substance and drug use and intoxication that may facilitate violence against intimate partners. Male controlling behavior/women's lack of power and having economic power were also included as vital characteristics of perpetrators associated with IPV during pregnancy. Similarly, low levels of social support and high levels of stress were also seen as factors that increased the risk of IPV during pregnancy (Bowen et al., 2005; Hoque et al., 2009; Shamu et al., 2011).

2. Paternal Uncertainty:

A study that was done in New York among men documented paternal uncertainty as a significant factor in predicting violence during pregnancy. For instance, a man who is sexually jealous and often blames his partner for unfaithfulness would be more likely to question the paternity of the child which may in turn increase abusive behaviors toward his partner (Burch, Gallup, & Gordon, 2004; Silva et al., 2011). The same male partner may be more likely to abandon the child once it is born. He would also more likely check up on his partner, reproach her of spending time with others and stop her from engaging in activities with others (Burch, Gallup, & Gordon, 2004).

3. Alcohol Use and Husband EMS:

Alcohol use by partners has also been reported to be associated with having multiple sexual partners by a study done in Rwanda among 600 randomly selected pregnant women. Men use alcohol as an excuse to engage in antisocial behaviors such as violence against their partners. Similarly, women reporting male partners of having other sexual partners were more likely to report exposure to IPV (Ntaganira et al., 2008).

Violence against Women in South Asia:

The violence committed against women is more severe in South Asia than in Europe or America mainly because of the particular cultural and religious practices that exacerbate the problem of violence against women (Coomaraswamy, 2005). South Asia is mainly comprised of patriarchal societies where men play a dominant

role and control decisions. If women question or deviate from this framework of males playing the dominant role, it may result in greater violence. In addition, when a community embraces the use of violence in order to resolve conflict then it may only lead to an increase in violence in homes (Coomaraswamy, 2005). Female economic inequality is also known to be one of the strongest factors facilitated by male control in the family to be determinants of violence in general as well as during pregnancy (Heise et al., 1994).

IPV was more common among families that were of Hindu faith, younger age, higher household income and when alcohol abuse was present in the male partner. This finding was reported in a study that was conducted in India among pregnant women. It was also documented that in order to maintain family harmony and peace and honor, women who faced violence believed that domestic violence should be kept secret and treated as a private matter (Varma et al., 2007). Similarly, another study done in rural India reported that women who experience violence from husbands were less likely to have control over sexual activity or be able to make decisions about the timing of childbearing. Hence, women who reported in this study as having greater decision-making power in their marital relationships were less likely to experience unwanted pregnancies. Hence, the importance of female autonomy and the role that gender equity plays in molding a woman's capability to manage her fertility intentions are clearly demonstrated (Stephenson et al., 2008).

Marriages are often reflected in a negative light due to the various customary practices associated with it in South Asia. For instance, in Pakistan Watta Satta marriage is another form of marriage that violates the rights of women.

Women in Watta Satta marriage are part of barter between men which means a woman is given in marriage to a man in exchange for another woman. Moreover, many South Asian societies traditionally prefer sons over daughters which contributes to violence against women. As such, women are treated with less respect and subsequently have lower status in the family than men. Women's lack of independence and empowerment, lack of economic security, inheritance laws and practices, patriarchal rules, the lack of access to land, the lack of education, denial of mobility and violent models of masculinity are other risk factors that has a great deal to do with the high levels of violence in South Asian societies (Coomaraswamy, 2005).

Researchers have identified various risk factors associated with violence during pregnancy. This is clear in a study that was done in Bangladesh, which has reported social and demographic factors such as low socioeconomic status, type of residence and level of education to be predictors of violence during pregnancy. The same study also reported poor spousal communication to be positively associated with violence during pregnancy (Naved & Persson, 2008).

Violence during pregnancy is often underreported in developing countries, especially parts of Asia. The reason behind this is that Asia has been classified as the worst region in terms of indicators of violence against women. According to a review from six studies on violence during pregnancy from India, China, Pakistan and Ethiopia, the prevalence of physical violence ranged from 4% to 28% (Naved & Persson, 2008). In addition, a study that was conducted in India reported physical violence during pregnancy to be 13%. There have also been area-specific small studies in India that reported 16% of all deaths during

pregnancy as a result of partner violence in Pune (Mahapatro, Gupta, Gupta, & Kundu, 2011). Violence in South Asian societies is viewed as normal or part of society and this prevents men and women from seeing the violence as offensive.

Chapter 2. Nepal and Intimate Partner Violence:

Background of Nepal:

Nepal is a small landlocked country in the foothills of the Himalayas and situated between two populous countries, China to the north and India to the south. The majority of Nepalese are Hindu (81%), 11% are Buddhist, 4% are Muslim and 4% are Kirant (Family Health Division, Ministry of Health (Nepal)., New ERA., & ORC Macro., 2007; Regmi, Simkhada, & Van Teijlingen, 2008). The majority of people in Nepal (85%) live in rural areas with limited or no access to health care services or basic infrastructure. Subsistence farming and livestock raising comprise some of the major economic activities for Nepalese people in the rural areas (Family Health Division, Ministry of Health (Nepal). et al., 2007; Paudel, 2007; M. Puri, Tamang, & Shah, 2011). Agriculture is a major source of economy in Nepal, providing livelihood for three-fourths of the population and accounting for over 38% of the Gross Domestic Product. Nepal is a traditional and patriarchal society. According to the census that was done in 2001, which identified 100 ethnic and caste groups, Nepal is also a multi-cultural and multi-ethnic society. Because Nepal has a predominantly patriarchal family structure, women have little or no say about whom and when to marry, sex within marriage, and child bearing (M. Puri et al., 2011).

Early Age at Marriage:

Early age at marriage is common in Nepalese as well as other South Asian societies (Regmi et al., 2008). Traditionally, parents arrange marriages in Nepal given considerations of caste, religion, ethnicity, economic status and ties between the families. The bride and the groom frequently have little input in the selection of

the partner (M. Puri et al., 2011). Girls and boys in Nepal are married at an early age leading to a low age for first birth (M. Puri, Shah, & Tamang, 2010). The girls in 40% of the marriages in Nepal are under the age of 15. Early marriage for both girls and boys when they both barely know each other before marriage often leads to lack of communication about the relationship and each other's rights. Although the legal age of marriage is 18 years for both men and women with the consent of guardians or 20 years without approval of guardians in Nepal, teenage marriage is the standard in many ethnic groups. Half of all women and 25% of men aged 20-24 years have reported being married by the age of 18 years. Among women aged 20-49, the median age at first marriage is 17.2 years (Family Health Division, Ministry of Health (Nepal). et al., 2007; M. Puri et al., 2011; World Health Organization, 2009). Child marriage, which is a customary practice in South Asia, is a major risk factor that contributes to violence against women (M. Puri et al., 2011). The low status of Nepalese women, which disempowers them in comparison to men, is also another factor that leads to violence committed against them.

Gender Roles for Nepalese Women:

Once married, a junior (young) woman in a Nepali family has to defer to other members of the family whether male or female in terms of social, economic and personal decisions as well as mobility. The oldest male in the family serves as the head of the household followed by the younger males, then the mother-in-law and other in-laws. The mother in law usually holds power and authority; in most households the junior wife has to obey her in-laws. The social system in Nepal is

based on patriarchal Hindu philosophy that empowers men and subordinates women. Women are seen as weak and dependent on men and derive their social status (access to property, inheritance right) from male members of her family (Luitel, 2001). Wife-beating is another factor which represents violence against Nepalese women and is considered to be acceptable if the wife is unfaithful to her husband, rude to her in-laws, if husband suspects wife of being unfaithful and if she disobeys her husband's orders or fails to perform her duties such as cooking and cleaning (Paudel, 2007).

A survey that was conducted in two small districts of Nepal by Women's Rehabilitation Center (WOREC) with 205 adolescents and youths in 2005 revealed that more than four-fifths (81%) had heard about violence and more than one-third of the girls (35%) had themselves experienced some kind of violence at home and in the community (M. Puri et al., 2011).

There is also significant correlation between the educational level of women and the incidence of gender-based violence (GBV) which was reported from a study done in five different rural districts of Nepal that also found more than one-third (35%) of women who were interviewed had experienced GBV in their homes (Ministry of Health and Population, New ERA, & ICF Macro., 2011; Paudel, 2007). The types of violence experienced by women in these rural areas were recorded as psychological, physical, economic and sexual. In the same study, physical violence was defined as the intentional use of physical force to demoralize and harass women, potentially causing injury, damage or even death. The major forms of physical violence experienced by Nepalese women were kicking and slapping, beating with sticks or brooms, scratching, poking, pulling hair, punching,

burning, forced expulsion from home and throwing boiling water or other food items. On the other hand, depriving women of economic resources was a way of committing economical violence. Psychological violence comprised mostly of scolding and mental torture. Sexual violence consisted of sexual abuse and forced sex committed by men against their wives. The reasons that the women from the five rural districts gave for being victims of violence included not having their own source of income or control over resources, low family income, alcoholism of their partner, low level of education of intimate partner and not bringing home a large dowry or bearing a son (Ministry of Health and Population et al., 2011; Paudel, 2007).

Similarly, the Nepal Demographic and Health Survey conducted in 2011 found that one in three (34%) women aged 15-49 years have ever experienced physical violence since age 15 years and 9% of these women reported facing physical violence within the past 12 months. The percentage of women who have ever experienced physical violence is highest among women with no education (51%). However, women with higher levels of education reported less chances of violence (15%) (Ministry of Health and Population et al., 2011; Paudel, 2007).

Domestic violence against women is underreported in Nepal due to a variety of reasons including to save family prestige and privacy, fear of husband and mother-in-law, love and affection with husband and family members, fear of breaking family relation, fear of socio-cultural values, fear of further beating, marginalization, uncertainty of justice and lack of faith in justice and support from others (Joshi, 2009). Very few studies have been done in Nepal to assess the prevalence of violence in different settings and populations, especially of pregnant

women. As in many developing countries it is known that violence against women exists in Nepal but it has never been scientifically studied and has received little attention from researchers and policymakers. This study aims to shed light on the proportion of young married women facing violence during pregnancy in Nepal through the analysis of a survey dataset.

Chapter 3. Methods:

This research is a part of a larger survey conducted by the Center for Research on Environmental and Population Activities (CREHPA) in Kathmandu, Nepal. CREHPA is a non-governmental research organization established in July 1994 and has expertise in undertaking research, quantitative surveys, quality of care evaluation, feasibility studies, participatory research and training in many public health issues. It is registered under Society's Act 2034, HMG as a non-governmental organization and with the Social Welfare Council (SWC), Nepal. CREHPA's fields of specialization include family planning, sexual and reproductive health, preventing unsafe abortions, women's empowerment and reducing gender-based violence, child welfare, environment sanitation and other public health issues. I was an intern at CREHPA during the months of July and August 2011. As part of the internship I was involved in the analysis of a large survey dataset on violence within marriage. With CREHPA's permission I used data from this survey to examine the subset of women who were ever pregnant and their experience with violence.

Qualitative Interviews:

Ten in-depth qualitative interviews were conducted in the Lalitpur district of Nepal with married women aged 15-24 years who were potential victims to violence. The interviews were conducted while I was an intern in CREHPA using a snowball sampling technique.

Survey Sample:

The survey was conducted in 2009 and is cross-sectional in nature. It included 1296 married women aged 15-24 years and was carried out in four districts of Nepal including Dolkha, Sindhupalchowk, Dang and Kapilvastu. The selection of these districts represented the four major ethnic groups in Nepal namely the two groups from the hilly regions (Tamang and Brahmin/Chettri) and the two from the Terai/plains (Tharu and Muslim). These ethnic groups were chosen based on factors such as geographic variation, different levels of socio-economic development and cultural diversity of the country.

Sampling Approach:

Interviews were conducted for the sample of 1296 married women using a two-staged systematic random sampling technique. In the first stage, by use of a population proportionate to size, 48 clusters in the selected districts were chosen. In the second stage, for each cluster 27 households were selected after creating an updated list of the households with the assistance of community leaders. A short screening questionnaire was administered to the heads of the households right after selecting a house. The heads of the households were given the questionnaire only because they are considered to be generally the ones making the decisions in household matters in Nepal. The questionnaire aimed at seeking basic information on all family members including age, sex and marital status. Eligible respondents (i.e. married women ages 15-24 years) were identified based on the screening questionnaire and selected using a systematic random sampling. If persons identified themselves as unavailable, interviews were terminated after completing

the screening questionnaire. If the households had more than one eligible participant, one woman was selected randomly for interview. Interviews were conducted individually in a location where the respondent found it comfortable; mostly outside homes. Twelve Nepali female research assistants who were well trained conducted all interviews and collected the data. In total there were 5080 households that were visited in order to select eligible participants. Among all eligible women (1811) who were identified from visiting the households, 1296 were interviewed as the desired sample based on the cutoffs.

Questionnaire:

The individual questionnaire that was administered to the women were mostly adapted from the 2005 WHO multi-country study on women's health and domestic violence against women which had been adjusted to suit the local context. The questionnaire was first available in English and then later translated into Nepali (National language of Nepal). The areas covered by the questionnaire included:

1. Demographic and socio-economic background of the woman
2. Fertility and contraceptive use
3. Husband's background
4. Attitude towards sexual relationship
5. Spousal communication and negotiation on sexual matters
6. Respondent and her spouse
7. Non-consensual sex
8. Coping strategies
9. Consequences

10. Decision-making

The Research Model

This thesis will examine the relationship between violence during pregnancy, which is my dependent variable, and independent variables including socio-demographics, marital relationship, gender and social support. Violence during pregnancy results in physical, maternal and child health and mental health consequences. The relationship between the dependent variable of violence during pregnancy, its impact and the independent variables is presented below through the research model. The independent variables, which are positioned closer to the dependent variable, are expected to have a closer relationship than variables that are placed distal to the dependent variable. The model itself has many pathways that will be illustrated below through five hypotheses and a diagram:

Hypothesis 1: The poor quality of sexual relationship will be associated with higher violence during pregnancy.

Hypothesis 2: Having a more dominant husband will be predictive of higher violence during pregnancy.

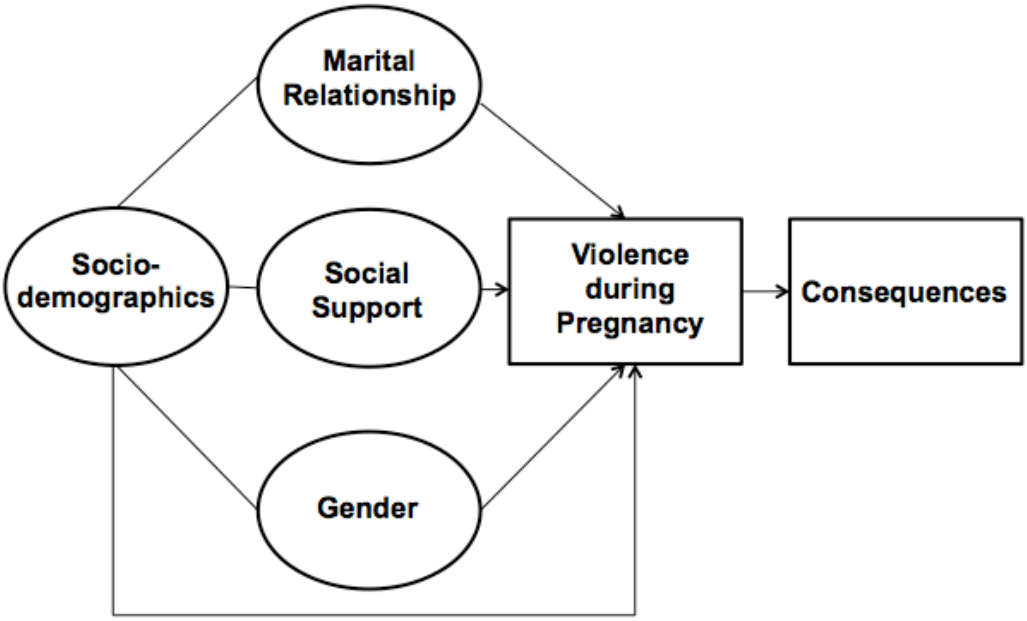
Hypothesis 3: Higher social support from husband, family members and social organizations will be predictive of lower violence during pregnancy.

Hypothesis 4: Female gender attitudes with males being superior to females will be predictive of higher violence during pregnancy.

Hypothesis 5: Higher empowerment in women will be predictive of lower violence during pregnancy.

Hypothesis 6: Higher violence during pregnancy will be predictive of more negative health consequences.

Figure 1: Diagram of Model



Key Variables:

I. Independent Variables:

1. Socio-demographic Variables:

Socio-demographic variables were also analyzed from the dataset and their association with violence during pregnancy. The independent variables that were analyzed for both men and women were age, level of education and occupation. Other independent variables that were analyzed for association with the dependent

variable were district, caste, age at marriage, type of marriage, husband living with wife and type of material goods.

a). A material goods scale was constructed and has 10 items that measures the type of material goods available in the house (range= 10, mean=2.87, standard deviation=1.87, alpha=.63) and serves as a form of wealth index. The questions contained in this scale counted the yes to any material goods found in the house including electricity, radio, television, telephone, a gas stove, a kerosene stove, private tub well/tap, bicycle, motorbike and a tractor.

2. Marital Relationship:

Marital relationship is organized into a series of factors that are described below:

i). Husband's Risky Behavior:

It is characterized by husband's extra marital sex and consumption of alcohol.

ii). More Dominant Husband:

It is defined as 'control by husbands' over wife's activities ranging from social to cultural issues mostly dominant in societies. It also takes into account women's knowledge about sex, her ability to say no to sex and her decision-making and mobility.

a). A more dominant husband scale was constructed with 12 items which asked about situations that are true for many women (range=13, mean=2.87, standard deviation=3.38, alpha=.78) . Thinking about their husband, the women were asked in the survey to answer yes or no to the following questions:

a. Tries to keep you from seeing his friends.

b. Tries to restrict contact with your maternal family

c. Does not listen to your views

d. Insists on knowing where you are at all times

e. Ignores you and treats you indifferently

f. Does not show affection to you

g. Gets angry if you speak with another man

h. If often suspicious that you are unfaithful

i. Does not do things to please you

j. Does not help with housework or children

k. Expects you to ask his permission before seeking health care for yourself

l. Does not go to cinema/mela with you

m. Sexual act without your consent

b). Saying no to sex scale was constructed and contains items regarding ways women try to avoid sex when they are forced to have sex with their husbands. The items are dichotomous in nature (yes/no) and are the following:

a. Tried to convince him

b. Screamed

c. Fought back

d. Tell him that I have my menses

e. Make body tight

f. Turn the other side

g. Sleep in separate bed

h. Sleep in separate room

i. Wake the children

j. Carry the child and keep him near me

k. Sleep early

The distribution of responses was relatively normal (range= 10, mean= 1.71, standard deviation= 2.30, alpha= .58) indicating greater levels of ways women try to avoid sex from their husbands according to women's reports from the survey.

c). A decision-making and mobility scale was constructed and contains 5 items (range=5, mean=1.85, standard deviation=1.76, alpha=.78) which measures women's decision making skills and is rated as yes or no. The questions included in this scale are:

1. Are you able to visit friends or relatives without permission of your husband or other family members?
2. Are you able to visit health center or hospital without permission of your husband or other family members?
3. Are you able to hold any group member in the community without permission of your husband or other family members?
4. Are you able to spend money without permission of your husband or other family members?

iii). Spousal Communication:

A spousal communication scale was constructed containing 5 questions regarding frequency of communication with spouse on various matters. The measures of spousal communication included questions on matters such as frequency of communication on money matters, daily activities, things that worry the wife, her feelings and love and how easy she felt sharing her feelings with her spouse. The items were responded to on a 4-point Likert scale, 1=often, 2=occasionally, 3=rarely

and 4=never. The distribution of responses was normal (range= 15, mean=10.83, standard deviation=3.38, alpha=.76) indicating greater levels of spousal communication reported among women in the sample.

2. Social Support:

It is defined as assistance emotionally as well as financially that will be potentially available or used from family (natal/maternal), friends, community-based organizations, community institutions such as schools and social service agencies.

3. Gender:

A scale was constructed called female gender attitudes and was rated as agree or disagree and measured female gender attitudes about sexual relationship between husband and wife especially about empowerment, wife beating, men's entitlement and refusal of sex (range=18, mean=12.99, standard deviation=3.05, alpha=.66). The questions contained in this scale include:

a. A woman should be able to choose her own friends even if her husband disapproves
b. A good wife does not always obey her husband even if she disagrees
c. Having sex would not be a way for me to show my love to husband
d. It is not alright for a man to demand sex from wife any time
e. A man wants sex, his wife should say 'no' if she disagrees
f. If a wife does not feel like having sex then it is her right to refuse sex
g. Men and women have same level of sexual desire
h. Men can control their sexual desire

i. It is not women's inappropriate behavior that provokes physical aggression by their husbands

j. If a man mistreats his wife others outside of the family should intervene

There are additional questions about wife beating which are part of the female gender attitudes scale. In the question, women were asked their thoughts about whether a man does/does not have good reason to hit his wife and again the scale is measured as agree or disagree.

a. She does not complete her household work to his satisfaction
b. She disobeys him
c. She refuses to have sexual relations with him
d. She asks him whether he has other girlfriends
e. He suspects that she is unfaithful
f. He finds out that she has been unfaithful

Refusal of sex questions that are part of the same scale are as follows:

In your opinion, can a married woman refuse to have sex with her husband, if:

a. She does not want to
b. He is drunk
c. She is sick
d. He mistreats her

II. Dependent Variable:

Violence during Pregnancy:

Defined as any experience of physical, sexual, verbal and psychological violence committed by an intimate partner against his wife during pregnancy.

III. Outcomes

Health Consequences:

Questions that were specific to asking questions about health impact or consequences due to violence were analyzed separately. Violence in this case leads to health consequences. These variables included physical health consequences, maternal and child health consequences and mental health consequences.

a). A health consequences scale was constructed which includes 6 items that measures health consequences including physical health consequences and mental health consequences (range=6, mean=1.17 standard deviation=1.29, alpha=. 59). The questions about physical health consequences were rated as either yes or no and asked whether the woman had experienced any of the following:

1) Pain during urination
2) Painful ulcers/sores in genital area
3) Non painful ulcers/sores in genital area
4) Smelly discharge from vagina

Mental Health questions were as follows: (yes or no)

1) Have you ever experienced any psychological problems?
2) Have you ever tried to take your life?

Violence outside of Pregnancy:

a). Sexual Violence Scale:

This is a 4 items scale that measures sexual violence experienced by women outside of pregnancy (range=4, mean=.95, standard deviation=1.22, alpha=.75). The questions about sexual violence were rated as either yes or no and asked the following:

1. Did your last husband ever physically force you to have sexual intercourse with him even when you did not want to?
2. Was there ever a time when you were afraid to say 'no' for sex with your husband?
3. Did your husband ever threaten you that if you didn't have sex with him he would leave you or go to another woman?
4. Did your husband ever force you to do something sexual that you found degrading or humiliating?

b). Physical Violence Scale:

This scale contains 6 items that measures the physical violence experienced by women outside of pregnancy (range=6, mean=.53, standard deviation=1.07, alpha=.79). The questions about physical violence were rated as either yes or no and asked the following- Has he ever:

1) Slapped you or thrown something at you that could hurt you?
2) Pushed you or shoved you or pulled your hair?
3) Hit you with his fist or with something else that could hurt you?
4) Kicked you, dragged you or beaten you up?
5) Choked or burnt you on purpose?

6) Threatened to use or actually used a gun, knife or other weapon against you?

Analytic Approach:

Qualitative Measures:

The 10 in-depth interviews were analyzed to check for patterns and themes in regards to the correlation between pregnancy and experience with violence. Important quotes from these women have been noted in the thesis itself to illustrate the important link between violence during pregnancy and the various factors that affect the quality of a marital relationship. The questionnaire that was used to interview these women is available in Appendix A.

Quantitative Measures:

Software:

Statistical Package for the Social Sciences (SPSS) was used for analysis of the survey data (SPSS, 2011).

Descriptive Statistics:

Initially, descriptive statistics were run for all the variables and then examined for outliers and was followed by a check on the normality for all variables. For all measures that were of a continuous nature, descriptive statistics including sample size, mean, standard deviation, range and skewness were produced. For measures that were dichotomous in nature, descriptive statistics such as sample size and sample percent were produced. For measures that were continuous in nature but skewed, the variable was recoded into a dichotomy or into a variable with multiple

categories. The dependent variable ‘violence during pregnancy’ was created based on if the respondent answered ‘yes’ to the question, ‘Has your husband ever forced you to have sex when you were pregnant?’ Since this thesis is concentrating on ‘women who have ever been pregnant’ as the sample, the rest of the women in the survey who answered as ‘never been pregnant’ were filtered out of the dataset.

Bivariate Analysis:

Firstly bivariate analysis was conducted through chi square analysis to check fit between observed and expected values of variables. A chi square analysis was run if both the dependent variable (violence during pregnancy) and the independent variables (refer-diagram of model) were dichotomous. On the other hand, if the dependent variable was continuous and the independent variable was dichotomous or continuous, a One-way Anova test was conducted. Both chi-square as well as One-Way Anova tests were conducted to check for significance between the dependent and the independent variables.

Multivariate Analysis:

Due to the dichotomous nature of the dependent variable, binary logistic regression was employed. Using binary logistic regression was also the better alternative for skewness-reducing transformation of all the variables. This way the inherent power of the continuous metric will be preserved. Hence logistic regressions were run for all the independent variables against the one dependent variable to check for significance as well as to estimate odds ratio (OR).

Chapter 4. Results:

Presentation of Results:

The chapter will present quantitative followed by qualitative results. Under quantitative results, the descriptives of demographic variables will be presented first followed by results from bivariate analysis of violence before and during pregnancy. The correlation of various antecedents to pregnancy violence will be presented with tables displaying results for each. Multivariate analysis, which was conducted through logistic regression of significant variables, will be presented along with a table of results. The outcomes of pregnancy violence data will be displayed right after showing correlation as well as logistic regression results. Finally, under qualitative section predictors of violence results will be presented and supported through quotes from the ten women who were interviewed followed by a conclusion.

Demographic Variables:

Age:

The average age of ever-pregnant women among 1082 was 21.75 and the average age at marriage was 17.04. The average age of their husbands was 25.

District:

The women were equally represented from four different districts of Nepal such as Sindhupalchowk (26.1%), Dolakha (25%), Dang (26.5%) and Kapilvastu (22.4%). The district of Sindhupalchowk and Dolakha are hilly areas and Sindhupalchowk in particular is located near the capital of Nepal, which is Kathmandu. On the other

hand, the districts of Dang and Kapilvastu are located in the Terai (plains) areas of Nepal.

Caste:

Women were also equally categorized into four different castes such as Brahmin/Chhetri (25%), Tamang (26.1%), Tharu (26.5%) and Muslim (22.4%). The Chhetris mean Kshatriya (warrior) in Sanskrit and they are from the hills of Nepal and mostly Hindus. Brahmin means Brahmana in Sanskrit and was the name traditionally given to persons who had attained the highest spiritual knowledge and they are also mostly Hindus. The Tamangs on the other hand are native inhabitants of the Himalayan regions of Tibet, Nepal and India and mostly follow Buddhism. They occupy the mountainous regions of Nepal. The Tharu people are native inhabitants to the Terai (foothills of the Himalayas in Nepal and India) and follow Hinduism. A majority of the Muslim people in Nepal live in the Terai region (plains) and follow the Islamic religion.

Education:

Fifty-three percent of women were literate or had some formal education. The husband's education ranged from primary (25.4%), secondary (33.4%), higher secondary and above education (23.3%) to being illiterate (13.7%) or having a non-formal education (4.3%).

Occupation and Type of Marriage:

Three-fourth (76.7%) of the women had no job. The majority of the husbands were mostly involved in agriculture (26.6%) and daily wages (20.9%). There were only 6.7% of husbands who did business and 6.3% did private job. Similarly only half (55.8%) of the husbands lived with their wives the reason being 20.7% of the husbands did foreign employment and 2.6% were in the army. The majority of the women had arranged marriages (69.4%), which is more common in Nepal.

Sex of Child:

Similarly, 37.9% of women had at least one son but no daughter, 36.3% had one daughter but no sons and 25.7% had at least one daughter and son.

Violence before and during Pregnancy:

Among the 1082 ever-pregnant women, 59.2% reported having ever experienced some type of violence from their husbands. 22.8% of these women have faced verbal or emotional violence and 36.4% have faced sexual violence outside of pregnancy. 53.1% of the 1082 ever-pregnant women have faced violence outside of pregnancy but not during pregnancy. The nature of the sexual violence outside of pregnancy included being forced to have sex by husband (45.7%), afraid to say 'no' to him for sex (26%), threatened by husband that if wife did not have sex he would leave to go with another woman (10.4%) and forced to do something sexually degrading or humiliating (13.1%). In addition, 17.7% (191) of ever-pregnant women had experienced 1 out of these 4 sexual experiences from their husbands outside of pregnancy. There were other women who had experienced 2(14.6%), 3(10.2%) and

4(4.4%) sexual experiences from their husbands outside of pregnancy and 53.1% (575) of women reported no sexual violence outside of pregnancy.

Table 1: Correlation of Violence Outside of Pregnancy to Pregnancy Violence

Antecedents	P	F
Sexual violence	<.001	690.05
Physical violence	<.001	141.40

Similarly, the physical violence scale contained questions which included slapping or throwing something at wife (16.2%), pushing, shoving or pulling her hair (17%), hitting her with fist or with something else (6.5%), kicking, dragging or beating her (11.9%), choking or burning her on purpose (0.8%) and threatening to use or actually used a gun, knife, or other weapon (1%). Among women who were ever pregnant, the numbers of different physical violence experiences were 1(13%), 2(7.6%), 3(3.3%), 4(2.2%), 5(0.8%) and 6(0.4%) from their husbands outside of pregnancy. In addition, 72.6%(786) of women experienced no physical violence outside of pregnancy. In addition, 214 (19.8%) faced violence during pregnancy. Out of the 214, 90.2% of them stated that the violence happened during their last pregnancy. There was statistical significance between pregnancy violence and non-pregnancy violence from Table 1.

Antecedents to Pregnancy Violence:

There are many antecedents to pregnancy violence that are shown below:

1) Socio-demographics:

Table 2: Correlation of Demographic Variables to Pregnancy Violence:

Antecedents	P	Chi Square	F
Age at marriage	<.001		6.08
Women's education level	<.001		15.78
Husband's education level	<.001		13.07
District	<.001	53.89	
Caste/Ethnicity	<.001	53.89	
Women's age	.010		6.08
Husband living with you	.017		5.70
Husband's age	.20		1.58
Type of marriage	.32	1.15	
Sex of child	.20	3.24	
Material goods	.54		0.38

In Table 2 above, women's age at marriage, their current age, women as well as their husband's education level were significant to pregnancy violence. This means that an older woman with higher education and who got married at an older age with a husband who has a higher level of education was likely to face less violence from her husband. District is shown significant to pregnancy violence and the districts are located in various geographical regions (hills or plains) of Nepal where women from Kapilvastu (34.7%), Dang (20.2%), Sindhupalchowk (16.3%) and Dolakha (9.6%) have reported to experience different levels of violence during pregnancy. These violence rates in the different districts indicate that women from the plains (Kapilvastu and Dang) were more likely to face violence during pregnancy from their husbands than women from the hilly areas (Sindhupalchowk and Dolakha).

In addition, caste/ethnicity was significant to pregnancy violence and women from Muslim (34.75), Tharu (24.2%), Tamang (16.3%) and Brahmin/Chhetri (9.6%) caste groups reported different rates of violence during pregnancy. These violence rates indicate that the Muslims were more likely to face pregnancy violence compared to the rest of the caste groups. On the other hand from Table 2, husbands living with wife was significant with pregnancy violence suggesting that women were more likely to face violence when their husbands were living with them as opposed to when they were away (foreign employment or in the army).

2). Marital Relationship:

i). Husband's Risky Behavior:

Table 3: Correlation of Husband's Risky Behavior to Pregnancy Violence:

Antecedents	P	Chi Square
Alcohol consumption by husband	.70	0.19
Husband EMS	.010	6.79

Forty-four percent of husbands consumed alcohol and 7.9% of husbands had other wives or relationships while being married. Women whose husbands had extra marital affairs/sex (7.9%) were more likely to report violence during pregnancy from Table 3.

ii). More Dominant Husband:

Table 4: Correlation of More Dominant Husband to Pregnancy Violence:

Antecedents	P	Chi Square	F
More dominant husband	<.001		369.06
Saying no to sex	<.001		518.85
Knowledge about sex	.49	0.48	

Twenty-four percent of husbands controlled their wives on at least one matter whereas 23.6% controlled for two matters. Husbands also controlled for 3 (14.5%), 4 (9.1%), 5 (5.0%) and >5 but <13(13.0%) matters. But, 10.8% of women in the sample reported no husband control on any matter. From Table 4, the higher the husband control, the more likely women are to experience violence by their husbands during pregnancy. The scale for saying no to sex (Table 4) had high correlation with pregnancy violence as well. The scale comprises of different ways that women try to avoid sex with their husbands such as try to convince him (90.9%), scream (9.5%), fight back (28.8%), tell him that I have menses (41.2%), make body tight (26%), turn the other side (40.2%), sleep in separate bed (32.9%), sleep in separate room (22.5%), wake the children (18.7%), carry the child (37.1%) and keep child near me and sleep early (18.1%). Women tried 0 (54.25), 1(7.7%), 2 (6.8%), 3 (7.2%), 4 (7.7%), 5 (6.9%) and >5 but <10 (9.5%) different ways to avoid sex with their husbands. From Table 4, women who tried more ways to avoid sex were more likely to report violence during pregnancy. In addition, 52.6% of women had knowledge about sex that takes place with spouse before marriage.

iii). Spousal Communication:

Table 5: Correlation of Spousal Communication to Pregnancy Violence

Antecedents	P	F
Spousal communication	<.001	65.90

The frequency of communication between the spouses were on 5 (2.3%), 6 (7.1%), 7 (7.0%), 8 (9.1%), 9 (11.6%), 10 (15.2%) and >10 but <20 (47.7%) different matters with 5 indicating less frequency of communication between the spouses and >10 but <20 indicating more frequency of communication. The different matters for communication between the spouses included money matters, daily activities, things that worry the husband or the wife and their feelings and love for each other. The spousal communication scale (Table 5) was significant with pregnancy violence. The lower the spousal communication, the more likely women are to experience violence by their husbands during pregnancy.

2. Gender:

i). Female Gender Attitudes & Empowerment:

Table 6: Correlation of Female Gender Attitudes to Pregnancy Violence:

Antecedents	P	F
Female gender attitudes	<.001	28.30

Among 1082 ever-pregnant women, there was some participation in groups, organizations or associations such as civic/political (1.2%), social work (5%), women's organization (12.8%), mother's group (12.8%), agricultural group (1.5%) and other groups (1.2%). However, intimate partners (14.3%), parents (0.8%), in-laws (20.3%) and others (1.1%) prevented these women from attending a meeting or participating in an organization. From the female gender attitudes & empowerment scale, women from the sample thought that it is not justified for men to misbehave against their wives on 2 to 5 (2.0%), 6 to 10 (17.1%), 11 to 15

(59.9%) and 16 to 20 (21.2%) different matters. From Table 6, the more women think that it is not justified for men to beat their wives, be entitled for sex and for wives to give in to sex, the less likely women are to experience violence during pregnancy.

ii). Decision Making and Mobility:

Table 7: Correlation of Decision-making and Mobility to Pregnancy Violence:

Antecedents	P	Chi Square	F
Decision-making and mobility	<.001		52.32
Contraceptive use	.030	4.81	
Prevention from contraceptive use	<.001	69.56	
Authority figure who makes money decisions	.001	9.84	

In terms of decision-making, the husband or the in-laws made decisions about how the money the women earned will be used 80.2% of the time. From the decision making and mobility scale, women from the sample reported being able to make decisions and move around on 0 (34.8%), 1 (15.1%), 2 (13.9%), 3 (13.8%), 4 (11.8%) and 5 (10.7%) different matters with 0 indicating less freedom in terms of making decisions and moving around and 5 indicating more freedom on decision-making and mobility. The different matters for decision-making and mobility included being able to visit friends or relatives, visiting health centers without permission from husband among many others. From Table 7, the more women are able to make decisions and have the freedom to visit people, the less likely they are to experience violence during pregnancy from their husbands. In addition, 57.1% of women in the sample reported using or trying ways to delay or avoid getting pregnant and 26.2% of husbands refused to use a method or tried to stop wives

from using a method to avoid getting pregnant. The antecedents such as contraceptive use, interference with wife's contraceptive use and less involvement in household decisions were statistically significant with pregnancy violence.

3. Social Support:

Table 8: Correlation of Social Support to Pregnancy Violence:

Antecedents	P	Chi Square
Reliance on maternal family	.001	12.97
Travelling distance to maternal family	.64	0.27
Frequency of communication with maternal family	.003	9.12
Reliance on friends	<.001	25.08

In terms of social support, 13.5%(146) of ever-pregnant women relied on their maternal family. 30%(324) of them communicated with their maternal family at least once a week or never as opposed to 70%(756) who communicated with their maternal family once a month or once a year. Similarly, 66.4%(718) ever-pregnant women relied on their friends if they needed help. The women reported seeking the most help from their friends (43.92%), followed by relatives/family (14.86%), then non-governmental organizations (2.7%) and others (8.1%) being women's group, mother, maternal family and neighbor. 18.5% also reported sharing their forced sexual experiences with others. From Table 8, the more women rely on members of their maternal family for support, the less likely they are to face violence during pregnancy (p=.001). Similarly, women who communicate more often with their maternal family are less likely to experience pregnancy violence (p=.003). In addition, women who rely on their friends in case they need help or have a problem are less likely to experience violence during pregnancy (p<.001).

Multivariate Analysis:

A regression analysis is used to help us understand how the value of the dependent variable changes when any one of the independent variables is wide-ranging, while the other independent variables are held fixed. So, a logistic regression was performed to assess the antecedents that were shown to be significant in the bivariate analysis and this is shown in Table 9 below.

Table 9: Logistic Regression Antecedents for Pregnancy Violence

Antecedents	B	P	OR (95% CI)
Saying no to sex	.47	<.001	1.60 (1.32-1.95)
More dominant husband	.28	.012	1.32 (1.06-1.64)
Interference with wife's contraceptive use	1.37	.019	3.94 (1.26-12.33)
Less involvement in household decisions	1.80	.050	6.07 (1.00-36.77)
Female gender attitudes and empowerment	-.03	.790	1.03 (.84-1.25)
Spousal communication	-.04	.661	1.04 (.88-1.21)
Frequency of communication with maternal family	-.07	.909	1.07 (.34-3.40)
Reliance on maternal family	-.16	.827	1.17 (.29-4.74)
Reliance on friends	-.03	.959	1.03 (.29-3.64)
Decision-making and mobility	-.13	.444	1.13 (.82-1.57)
Women's age	-.04	.811	1.04 (.76-1.42)
Women's education level	.00	.645	1.00 (.99-1.02)
Age at marriage	.16	.207	1.17 (.91-1.50)
Contraceptive use	-.09	.888	1.10 (.30-3.94)
Husband's age	.01	.885	1.01 (.84-1.23)
Husband's education level	.00	.926	1.00 (.98-1.02)
Husband living with wife	.03	.956	1.03 (.35-3.05)

From Table 9, it is clear that there are four major predictors that are significant to pregnancy violence such as saying no to sex, having a more dominant husband, interference with wife's contraceptive use and less involvement in household decisions while controlling for other factors in Table 9. For every unit increase in a woman able to say no to sex, there is a 1.60 odds of increase in violence during pregnancy. Similarly, for every unit increase in a more dominant husband, there is a 1.32 odds of increase in pregnancy violence. On the other hand, for every unit increase in interference with wife's contraceptive use, there is a 3.94 odds of

increase in pregnancy violence. In addition, having in-laws be involved in making household decisions shows 6.07 odds of increase in pregnancy violence as opposed to wives making the decisions.

Health Consequences:

Bivariate Analysis:

Table 10: Chi Square Analysis of Pregnancy Violence Outcomes

Outcomes	P	Chi Square
Unwanted pregnancy	<.001	75.88
Pregnancy as a result of sexual violence	<.001	176.24
Health problems/injuries as a result of sexual violence	<.001	337.94
Suicide attempt	<.001	74.26
Psychological problems	<.001	148.76
Pain during urination	<.001	85.14
Painful & non-painful ulcers and sores in genital areas	.74	0.024
Smelly discharge from vagina	<.001	23.30

Physical Health Consequences:

Among 1082 women in the sample, 75.8% have ever experienced any health problems or injuries after undesired sexual relationship outside of pregnancy. From Table 10, women who experienced pregnancy violence are more likely to face health problems or injuries after unnecessary sexual relationship. Similarly, women who faced pregnancy violence are more likely to get pregnant as a result of sexual violence from their husbands. In addition, women who experienced pregnancy violence faced physical health consequences such as pain during urination (61.2%), painful and non-painful ulcers and sores (1.4%) and smelly discharge from vagina (39.3%). From these physical health consequences, pain during urination and smelly discharge from vagina are significant to pregnancy violence but having

painful and non-painful ulcers and sores are not significant. These physical health consequences are also part of the health consequences scale so they have not been analyzed separately for logistic regression.

Mental Health Consequences:

Women faced depression (22.4%), fear (16.6%), tension (7.2%)and suicidal feelings (3.9%) outside of pregnancy as a result of violence. But 68.2% of women who have faced violence during pregnancy have ever experienced any psychological problems. From Table 10, women facing pregnancy violence are more likely to experience psychological problems Similarly, women who have faced violence during pregnancy are more likely to attempt suicide.

Maternal and Child Health Consequences:

39.9% of women who have faced pregnancy violence experience an unwanted pregnancy. This finding means that women who have experienced violence during pregnancy are more likely to have an unwanted pregnancy (Table 10).

Health Consequences Scale:

From analyzing the health consequences scale, it was found that women have reported violence to have caused 0 (40.9%), 1 (26.2%), 2 (15.8%), 3 (11.1%), 4 (4.3%), 5 (1.8%) and 6 (0.1%) different types of health consequences with 0 being no health impact to 6 being more number of health consequences. In addition, from Table 10, the health consequences scale, which comprised of physical and mental health consequences, was significant with pregnancy violence. Hence, women who

experienced violence during pregnancy are more likely to experience physical and mental health consequences.

Multivariate Analysis:

A logistic regression was performed on outcomes that were significant in the bivariate analysis section and are shown below in Table 11.

Table 11: Logistic Regression Outcomes of Pregnancy Violence

Outcomes	B	P	OR (95% CI)
Health consequences	.31	<.001	1.36 (1.16-1.58)
Pregnancy due to sexual violence	1.30	<.001	3.86 (1.85-8.01)
Health problems/injuries due to sexual violence	2.23	<.001	9.30 (6.15-14.07)
Unwanted pregnancy	.13	.650	1.14 (.64-2.03)

In Table 11, health outcomes that are shown significant to pregnancy violence are health consequences (mental and physical health outcomes) scale, pregnancy due to sexual violence and health problems/injuries due to sexual violence. So, for every unit increase in pregnancy violence, there is a 1.36 times odds of increase in health consequences. Women who have faced violence during pregnancy are 3.86 times more likely to have pregnancy as a result of sexual violence and 9.30 times likely to have health problems/injuries due to sexual violence. It is clear from Table 11 that having an unwanted pregnancy is not significant to pregnancy violence. But, women who have faced pregnancy violence are 1.14 times more likely to have an unwanted pregnancy than those who have not.

Qualitative Analysis:

The qualitative data draws from 10 women in-depth interviews conducted in the rural area of Lalitpur district. The age range of the 10 women interviewed was 20-24 with a mean age of 23 years. 3 out of 10 women had received education till 2nd grade, 5th grade and high school respectively. The occupation of the 10 women ranged from agriculture and construction work to being a maidservant and caretaker in schools and orphanages. 9 out of 10 women were Hindus and 1 woman was Christian. The 10 women belonged to different caste systems such as 6 were Chettri, 2 Brahmin, 1 Magar and 1 Sherpa. 3 out of 10 women had love marriages and their age at marriage was 18 years. 7 women had arranged marriages that were arranged by parents or cousins and their age range at marriage was from 13 to 19 years. All 10 women had ever been pregnant in their lifetime. There were 6 women who had at least 1 child, 3 women who had 3 children and 2 women who had 2 children. Five women had at least one male child and 8 women had at least 1 female child. All 10 women experienced violence from their husbands, but 3 out of 10 women experienced violence during pregnancy as well. 5 out of 10 women had also witnessed violence during their childhood.

Predictors of Violence:

More Dominant Husband:

Having a more dominant husband was one of the major predictors of violence against wives as reported by the 10 women who were interviewed**.** All the ten women reported their husbands as being controlling in their daily activities. According to the wives, the husbands controlled their social activities, which

included meeting with their friends and family or even seeking for help. The husbands also demanded their wives to cook for them, look after the children, do grocery shopping and all other household chores on time. Similarly, 3 out of 10 women had husbands who were jobless and were depending on their wives for money. If the wives did not give the husbands money, they would threaten to leave or beat them.

24 year old Hindu woman, Chettri, 2 children:

It is better to tolerate their beatings since they are all dominant and powerful.

23 year old Hindu woman, Brahmin, 2 children:

My husband used to be a driver but he has no job now. I cannot feed my two children well. I have to give some money to my husband. I also bring cigarettes for him. My husband only knows how to collect wives and does not take care of the children. If I do not fulfill my responsibility as a loyal and faithful wife then he will beat me.

23 year old Hindu woman, Chettri, 2 children:

Even if I talked to a stranger my husband would get mad at me. If I did a small mistake or did not take care of my children well, he would get mad at me.

Sex of Child:

The sex of the child was of great importance to a few husbands. 2 out of 10 women reported having a female child as a predictor of violence from their husbands.

24 year old Hindu woman, Chettri, 3 children:

He threatened me that if I did not give birth to a son then he would bring another wife which he eventually did.

22 year old Hindu woman, Chettri, 1 child:

When my husband found out that I gave birth to a girl he was very upset and started scolding me saying that a girl will not be able to do anything and having a son would have been far better.

Alcohol Consumption:

7 out of 10 women experienced violence from their husbands due to alcohol consumption from their spouse. The women who were interviewed explained the correlation between alcohol consumption and violence against them by their husbands.

24 year old Hindu woman, Chettri, 3 children:

Normally the abuse starts when he is drinking. He becomes very aggressive and even destroys things at home. He broke our television the other day. One time he came home after drinking and hit me with a log. It was very painful but I felt helpless. There are also another time when he hit me with a pressure cooker on my head and I started bleeding.

21 year old Hindu woman, Chettri, 1 child:

His drinking habits were so bad and that is why it led to violence in our home. He used to sell the rice that I bought and purchase alcohol for himself. He did not give me any money and instead took my money to buy alcohol.

22 year old Hindu woman, Chettri, 1 child:

He used to drink and come home and beat me up. If I did not listen to him or if things did not happen his way, he would beat me up. There was a time when I even became unconscious due to his beating. Another time, while I was cooking he came home drunk and as soon as he saw me grabbed my hair and tried to push my head over hot oil.

Husband EMS:

5 out of 10 women reported husband's extra marital affairs as contributing to violence during and outside pregnancy. According to the women, they were

sometimes aware about their husband's affair but most of the time they were not and in some cases the husband had another wife.

23 year old Hindu woman, Chettri, 3 children:

My husband had an affair with another girl and without letting me know he flew to Malaysia with her. He called me after 5 months to inform about where he was. I was not aware that he was with that girl for a year and also gave her money.

24 year old Hindu woman, Chettri, 3 children:

My husband is in the army but lives in another apartment in another city. He only comes home during festivals. He married another woman and already had a kid with her. I found out about her when my son was 6 months old.

23 year old Hindu woman, Brahmin, 2 children:

The violence started because of my husband's extra marital affairs. He is a driver so he goes around having affairs with many girls. When I question him about it, he threatens to leave me or beats me.

22 year old Hindu woman, Chettri, 1 child:

My husband lives his life according to his will and never listens to me. When my husband was involved with another woman, it had already been a year without me knowing about it. After having an affair, my husband became violent towards me. We also stopped having sexual relationship after I told him to pick between the two of us.

Types of Violence:

The types of violence faced by these women included, physical, sexual, psychological and even pregnancy violence.

i). Physical Violence: The physical violence experienced by all the women included slapping, kicking and dragging, choking, punching, pulling hair, using weapons such as log of wood, pressure cooker, or knife and burning.

24 year old Hindu woman, Chettri, 1 child:

My husband has slapped me, kicked and pushed me, hit me with his fists and pulled my hair.

22 year old Hindu woman, Brahmin, 2 children:

My husband used to roam around the house with a knife for three years. I was really scared. One time he beat me with his fists and also kicked me. I just tolerated it. But then he started to choke me, I was starting to bleed from my mouth but he still did not let me go. I finally mustered all the courage I had, thought about how awful my life is and lifted my leg and gave him a hard kick. We both were on the floor wrestling like two insane people.

ii). Sexual Violence: 5 out of 10 women reported experiencing sexual violence from their husbands which included husbands trying to force their wives to have sex with them against their wish.

24 year old Hindu woman, Chettri, 1 child:

My husband forces me to have sex with him. If I do not oblige then he threatens me that he will go with another woman. When I did not agree to have sex, he used to tell me that I probably had affair with another man which is why I am refusing it.

21 year old Hindu woman, Magar, 1 child:

My husband has forced me to have sex many times. But I never relented. I used to run away to my neighbor or friend's house.

iii). Psychological Violence: 4 out of 10 women reported having experienced psychological violence from their husbands which mostly comprised of verbal abuse such as a threatening.

23 year old Hindu woman, Chettri, 3 children:

My husband was really scary. One time he threatened me saying that he would put kerosene on me and set me on fire. He also said things like he wants to take my eyes out.

24 year old Hindu woman, Chettri, 3 children:

My husband has abused me verbally by threatening to use a weapon on me if I did not obey his words.

iv). Pregnancy Violence: 3 out of 10 women expressed that they had experienced violence during pregnancy from their husbands**.** The violence experienced during this sensitive period included physical, sexual and psychological violence.

24 year old Hindu woman, Chettri, 3 children:

I experienced violence during pregnancy from my husband. There was one time during my 10 months pregnancy that he hit me on my stomach with his belt. In the hospital the doctor told me that I had lost my baby. I felt devastated and knew that the beating contributed to the loss of my baby.

24 year old Hindu woman, Chettri, 1 child:

My husband hit me even during the time that I was pregnant with his child. He used to hit me on my head and back and would tell me to go away and that the child is not his but belongs to someone else.

22 year old Hindu woman, Chettri, 1 child:

My husband was violent towards me before, during and also after pregnancy. He is drunk all the time. During my pregnancy, he hit me on the back with his fist as well as kicked me with his legs. He also forced me to work when I was pregnant and threatened to leave me for another woman.

Coping Strategies:

8 out of 10 women mentioned that they did try to avoid or minimize negative experiences from their husbands. These 8 women reported just staying silent and tolerating the beatings from their husbands. The reasons the women gave for tolerating their husbands were responsibility of taking care of their children, felt it was mostly their own mistakes, fear that husband would leave the house or go with

some other woman and also saving their family name. 1 out of 10 women mentioned running away to her friend or neighbor's house as a mechanism of avoiding sexual violence from her spouse.

Empowerment:

1 woman reported screaming back or reacting aggressively with her husband as a way of avoiding violence. 1 out of 10 women reported going to church and confessing. 1 out of 10 women mentioned asking church members to talk to her husband and counsel him as a way of minimizing violence. Additionally, 2 out of 10 women called the police on their husbands as an empowering way of dealing with violence perpetrated by their husbands.

Spousal Communication:

2 out of 10 women stated that communicating with their partner about their children's future or any other matter helped in minimizing or avoiding violence from their husbands.

Reducing the Problem:

2 out of 10 women reported that the best way to reduce or prevent violence within marriage is to remain silent and tolerate it. 2 out of 10 women felt that having other people in the village counsel husbands would be a better way to prevent violence within marriage. 3 out of 10 women felt that victims of violence within a marital relationship should communicate with their partners about everything that happens in their life in order to reduce or prevent violence. 3 out of 10 women reported that

having some sort of social support whether from friends, family, neighbors, or non-governmental organizations (NGOs) would be a great way of relieving tension in a marital relationship. However, 1 woman out of 10 expressed dislike in seeking help from an NGO and 2 women have not heard or do not know about an NGO.

The qualitative interviews affirmed the survey data that a more dominant husband, preference for sons, alcohol consumption and husband EMS were the main predictors of violence according to reports from the 10 women who were interviewed. The women experienced physical, sexual, psychological and pregnancy violence. Pregnancy violence was present in 3 out of 10 women, which is an important finding. The majority of women (8 out of 10) did not do anything to avoid or minimize facing negative experiences from their husbands. Few women chose their coping mechanisms as screaming, calling for police, talking to a religious member or seeking help from NGO's. These women do however express wanting some form of social support to help cope with their negative experiences. They also expressed wanting better communication with their husbands on social, financial and personal matters if their husbands were willing to listen to them. The 10 interviews help bring insight to the burden that Nepalese women face with violence at different phases of their lives. Being able to create key messages in society that target these problems expressed by these 10 women would serve as a starting point in the community for intervention and risk reduction.

Chapter 5. Discussion:

The literature on violence against women shows that the greatest majority of violent acts are committed by husbands or intimate partners. These acts can be in the form of physical, sexual and/or psychological violence. Power in social relations places women in a subordinate position giving them fewer rights, not just within their family but also in the community and society. Many women who are victims of intimate partner violence choose to remain silent based on gender beliefs, societal norms and a lack of supportive services. Violence against women has remained invisible to many people in Nepal as well as other developing countries because of a lack of adequate documentation and reporting. Male dominated patriarchal societies compel women to hide the violations perpetrated by intimate partners. Because women are submissive in such societies and hide such violations, the problems never surface and receive little or no attention from government bodies. Violence initiated or continued in the pregnancy period represents a double problem since it presents risks for the health of both the pregnant woman and the fetus. Since women are at a vulnerable stage during pregnancy, it becomes even more significant to protect women from violence during this period.

Frequency of Violence:

In this study, 59.2% of the 1082 ever-pregnant women reported having ever experienced some type of violence from their husbands, which is consistent with the prevalence rate in studies done in other developing countries. The literature review described in chapter 2 shows slightly more than 30% as being the prevalence rate for violence against women in developed countries.

In the survey sample, 214 (19.8%) of the 1082 ever-pregnant women studied have faced violence during pregnancy. This finding is consistent with the prevalence rate of violence against women during pregnancy reported by studies in various countries globally as identified in the literature review. Women's explanations for tolerating such violence as reflected in the 10 qualitative interviews focused on how being a mother puts them in a position where they have to be responsible for taking care of their children and their inability to say no to sex. Moreover, the women tolerated the violence because they felt helpless and were emotionally attached to their husbands.

Socio-demographic Factors:

Results from the bivariate analysis showed that women who had lower education status had higher chances of experiencing violence during pregnancy. This finding is consistent with studies done in developing countries especially in Africa and Nepal in the literature review. Women's age, age at marriage, caste/ethnicity and district were also significantly related to pregnancy violence in the bivariate analysis. This finding is consistent with the literature review on Nepal in the sense that young women who get married at an early age are more likely to face violence during pregnancy. Caste, district and economic status are important factors in determining marriages in Nepal, which are mostly arranged by parents.

Education is an important protective factor because it gives women greater autonomy and control of resources. Women who have more education have more opportunities, are more independent and have greater decision-making skills and economic capacity. Additionally, both the survey and qualitative interviews

suggest that women who belong to a higher caste or are from the hilly areas of Nepal have greater autonomy in their relationships compared to women from lower caste groups and people from the plains in Nepal.

Antecedents of Violence during Pregnancy:

Multivariate analysis identified four risk factors that had significant associations with violence during pregnancy. These four risk factors and their interaction with pregnancy violence are described in more detail below:

Saying No to Sex:

The more ways women tried to avoid sex with their husbands, the more likely they were to face violence during pregnancy in the survey analysis. This finding was consistent with what was found in the literature review about studies done in different parts of Asia; generally, if women tried to question or deviate from men's framework of women being submissive and sexually available to them and try to avoid sex, they were likely to face greater violence. Women avoiding sex with their husbands were also reflected in the qualitative interviews where women reported trying to run away to a neighbor's house or their maternal home. Being able to say no to sex signifies women's response to abuse, which is often limited because of the options that are available to her. It becomes even more difficult for a woman to find ways to avoid sex during pregnancy, as she is at one of her most vulnerable and powerless stages in her life when all she wants to do is to get some rest and look after her body and health.

More Dominant Husband:

The findings of this study confirm that having husbands who dominate or exercise power over their wives on social, economic and other personal matters facilitate violence against women during pregnancy in the multivariate analysis. This was consistent with the literature review that highlighted the fact that power imbalances in relationships could lead to many negative outcomes. These negative outcomes include less communication between the spouses, poor decision-making and more dominant husbands who exercise power on their wives' social activities such as meeting with friends and neighbors that could lead to violence. The qualitative interviews also revealed the role of dominant husbands since the women who were interviewed reported their husbands to be controlling in their daily activities that facilitated violence in their intimate partner relationships. Having a more dominant husband is a significant risk factor to pregnancy violence because it is a symptom of men's patriarchal rule over women and their need to control women through violence. Violence could occur at any stage of a woman's life.

Less Involvement in Household Decisions:

The literature review reports a study done in Nepal that emphasized how a young Nepali woman once married in a Nepali family has to defer to other members of the family. The in-laws hold power in most households and the wife has to defer to her in-laws most of the time. This finding is consistent with the results from the multivariate analysis, which showed an association between in-laws being involved in making household decisions as opposed to the wives resulting in violence during pregnancy. Therefore, when members of the paternal family made decisions

regarding how the money that a wife earned was spent, rather than giving her the option to make those decisions, the wife was more likely to face violence by her husband during pregnancy. This finding is reflected in the qualitative interviews as well since women reported some husbands as being reliant on them for money while trying to gain control over financial decision-making along with her in-laws at home. Financial decision-making authority signifies power and status in the home as well as in the community. When the in-laws deprive the wife of this authority, she will be less empowered and at a greater likelihood of facing violence from her husband and in-laws.

Interference with the Wife's Contraceptive Use:

In this study, when the husbands refused to use contraceptives such as condoms, they were more likely to experience violence by their husbands during pregnancy. Being prevented from using contraceptives denies women control over their fertility, and limits their ability to protect themselves from STI's. Less control over their body in turn affects their health and well being. Studies in the literature review have shown evidence that verbal communication between partners about reproductive health is low in many developing countries and this is mainly due to male dominance, which in turn will increase violence in intimate partner relationships.

The four risk factors illustrate how few options many women have since they lack control over when and if they have sex or use contraceptives. Moreover, because these women lack economic independence or even behavioral independence when they have a highly controlling husband, they are placed in a difficult position where they are more likely to face violence from their husbands.

Consequences of Violence during Pregnancy

The violence committed against women by their husbands during pregnancy was found to lead to significant health consequences that are described below:

Health Consequences:

The consequences resulting from violence outside as well as during pregnancy were consistent for the survey as well as the literature review where women experienced physical, mental and maternal and child related health consequences. When women face violence during pregnancy, it will lead to long-term negative health consequences for victims as well as the infants even after the abuse has ended. Poor health consequences due to violence contribute to poor health status, poor quality of life and high use of health services.

Pregnancy due to Sexual Violence:

Forced sex by husbands was shown in this study in the survey analysis to be a risk factor leading to unwanted pregnancy. This significant finding is consistent with evidence from the literature which mentioned women having unwanted pregnancies due to their inability to say no to their husbands for sex. This has also been reflected in the qualitative interviews where women have expressed how living in a male dominant society compels them to meet the demands of their husbands even if it means tolerating sexual violence. Pregnancy due to sexual violence indicates that women have no control over their sexual activity and lack decision-making power. In such a gender-stratified setting, women are likely to be victims of violence.

Health Problems/Injuries due to Sexual Violence:

Health problems or injuries due to sexual violence were reported by ever-pregnant women as outcomes in the survey analysis that was consistent with the literature review. Because women are particularly vulnerable during pregnancy, experiencing sexual or any other form of violence during this period puts them at a greater risk for health injuries or other complications. In addition, when a husband forces his wife to have sex, it can result in an unplanned pregnancy, leaving a woman unable to care for herself and her other children. In addition, having an unplanned pregnancy could lead to stress, anxiety and other mental problems, which could affect a woman's overall quality of life. The health consequences could be far-reaching and end up in poorer outcomes.

Discrepancy between Literature Review and the Nepal Survey Data:

Having preference for sons, the husband's alcohol consumption and extra marital sexual relationships were positively correlated with pregnancy violence in the literature review as well as in the qualitative interviews but were not significant in the survey analysis. This finding could have been a result of women underreporting their husband's alcohol consumption and extra marital sexual relationships in the survey. In addition, results from the bivariate as well as the multivariate analysis between pregnancy violence and female gender attitudes with males being superior to females did not show an association. However, the literature review about Nepal identified that wife beating is acceptable if women have been unfaithful to their husbands or fail to perform their duties as wives (cooking and cleaning) according to Nepalese women.

Moreover, social support is a risk factor that has been shown to decrease violence in intimate partner relationships in the literature review but it had no correlation with violence outside as well as during pregnancy in the bivariate and multivariate analysis. In the 10 interviews that were conducted, the women did not turn to institutions, families, or friends for advice and support. The women had neither sought help from organizations or any health providers as they considered it shameful to share their personal problems with others. However, the women still expressed the desire for some social support, which could help decrease violence in their intimate partner relationships or serve as a coping strategy to deal with any experiences of violence.

Limitations:

Violence during pregnancy is a sensitive topic that is difficult to research. Pregnancy violence has been underreported in Nepal due to the stigma and trauma that women experience in the family and in society as a result of the violence perpetrated by their husbands. The literature review about Nepal has focused on the fact that women in Nepal fear their husbands and mother-in-laws and choose not to speak up. They would rather save their family prestige and honor and just be responsible for looking after their children. Hence, women in the survey dataset may have underreported the prevalence of violence outside as well as during pregnancy out of fear and insecurity and they may have felt uncomfortable sharing their personal problems outside of the household.

Recommended Interventions:

Women experiencing violence during pregnancy is a significant group to target for assessment as well as intervention efforts. Violence that occurs any time in a woman's life is predictive of future risks that may be associated with medical and psychosocial morbidity (Coker et al., 2002; Rivara et al., 2007; Sutherland, Bybee, & Sullivan, 1998). In order to confront these health problems that women face due to violence from their husbands, attitudinal alteration of men toward their wives is required to bring a substantial change in society. But we all know that changing behavior or attitudes of people is not an easy undertaking and requires interventions that are effective and sustainable and that may also not be enough. The legal system, years of activism and police systems in the field of violence against women have not shown progressive development. What we need are policies and legal reforms that contribute to changing institutional culture and practices (Mahapatro et al., 2011).

The government of Nepal along with NGO's and INGO's have started making efforts to empower and mobilize women especially in rural areas of Nepal through formation of Mothers' Groups (MG) at a local level. These Mothers' groups are called Aama Samuha in Nepali and are located in different VDC's (Village Development Committee) of various districts in Nepal. Members of the MG are mostly married women who interact with outreach health workers and volunteers at their monthly meetings and discuss social problems of the village. These women's groups are actively involved in social mobilization of women at the grassroots level (Lingden, 2008). Another intervention method suggested by a study done in India involved the government and local institutions providing funding for immediate use

that could financially help the victims of domestic violence (Mahapatro et al., 2011). Additionally, health care providers in Nepal are known to be a first contact between a woman facing domestic violence or any other health problem and the healthcare system and could be used for intervention efforts (Joshi, 2009).

Below are six interventions that could be developed in Nepal especially in the Lalitpur district where the 10 women who were interviewed have expressed their need for support.

1) Women's lack of representation in legal or political field is associated with lower women's status. The Mothers' Groups (MG) in the villages should pick individuals from their group as leaders to encourage more women's participation in clubs and anti-violence organizations from different homes which can lead to women having a support system in the case of violence. This will also lead women to be more independent and be able to make household decisions on their own instead of the in-laws which in turn will help increase their status in the house as well as in the community leading to reduced violence.

2) MG members who serve as advisors by reaching out to women who have been victims of violence from their husbands by threatening or counseling husbands should be supported so that husbands are no longer controlling and are compelled to treat their wives better.

3) With the help from MG members, create life skills education classes for young women in collaboration with other NGO's/INGO's. These life skills education classes could be taught by female teachers in different schools in the villages as evening classes and incorporate messages to address gender stereotypes and

attitudes that reinforce male entitlement and women's submissiveness. These life skills classes could support women's empowerment and help them to find more effective ways to avoid violence within intimate partner relationships.

4) Some women lack power in terms of their own sexual and reproductive health decision-making. There are also women who lack verbal communication skills with their partners about their reproductive health. Therefore, problems regarding inability of women to manage their fertility intentions should be addressed in the monthly MG meetings in order to provide help to those women who do not have access to appropriate information and use of services because of difficulties created by cultural norms regarding sexual and reproductive health.

5) The members of MG have health camps that they schedule every year where health providers, outreach workers and other volunteers listen to women's health problems on a variety of issues including sexual and reproductive health. More funds should be allocated by government, local institutions and other NGO's for the training of health providers at these health camps so that they are able to identify women who have been victims of domestic violence and refer them to a social worker/organization.

6) Micro-credit programs should be supported in the Mothers' Group in all villages so that women victims of violence could be actively involved in activities such as vegetable production, tailoring and other small businesses that increase their economic capacity and help increase their status at home as well as in the community.

7) Using opportunities available at "Men Engage Alliance Nepal Country Group Network" (an awareness raising initiative in Nepal), men from different

communities could be reached and educated towards eliminating or reducing violence against women. Members who are part of this men's group comprise of rights activists, government officials, UN agencies, academic institutions, research organizations, interfaith leaders, media and NGO's/INGO's. Since this group works particularly on advocacy, they could help develop common messages addressing violence against women that could be disseminated in various districts in Nepal.

Conclusion:

This is one of the first studies done in Nepal that explored the nature, correlates and reasons for violence in intimate partner relationships during pregnancy and its health consequences. This study hopes to contribute to the limited research that has been done on pregnancy violence in Nepal. This discussion makes it clear that most women who are at a lower status than their husbands are constantly in denial and fear of social stigma preventing them from reaching out for help. Most abused women remain passive victims to violence.

This study has also established that violence in Nepal is a health problem especially for pregnant women. Violence leads to the overall burden of disease as a predictor for other serious health problems. Not only is violence against women a breach of human rights, it also has implied costs in terms of high health expenditure and human distress. This study highlights the urgent need to tackle IPV in health sector policies and programs nationally in Nepal as well as other countries globally.

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Appendix A: In-depth interviews with young married women
Informed Consent:

Introduction:
"Namaste"! My name is Prakrity and I am an intern from CREHPA, a non-for-profit research organization based at Kathmandu.

Purpose of the study:
I am here to conduct a study among young married women in order to examine women's health and life experiences. I will be talking to 10 women.

Procedure:
I am a student and am currently doing my Masters in Public Health. This study is done mostly to contribute to my thesis for my college and add to my knowledge about the status of married women in Nepal.

Confidentiality:
The information that I will collect for this study will be kept strictly confidential and won't have your name on it but a number assigned to it instead.

Right to refuse or withdraw:
You are completely free to take part in this study or to refuse to do so. The choice is completely yours.

Section 1: Demographic information
District:
Sex:
Age:
Number of children:
Level of education:

Section 2: Background

1. Could you tell me about yourself?
   Probes:
   - Family
   - Children
   - Studies
   - Work-both husband and wife
2. Could you tell me about your life before marriage?
   Probes:
   - Where you lived
   - How you got married
3. What good and bad things happened to you during your married life?
   Probes:
   - Difficulties and problems faced

- Satisfaction with married life

Section 3: Nature and types of violence

Now I would like to ask you a few questions about some important aspects of a woman's life. Some of these questions can be a little personal but your answers will be important in helping us to understand the condition of married women in Nepal. Again let me remind you that your answers will be kept completely confidential.

4. Have you heard about gender-based violence? How would you define it?
5. Have you witnessed or experienced any type of violence during your childhood? Could you explain more about it?
6. Have you experienced any type of violence from your husband? If yes, could you explain more? (If no, thank them for their valuable time and move to next person)

   Probes:

   Slapped, pushed, hit you with fist
   Kicked and dragged you
   Choked you, burnt you
   Threatened to leave if you did not oblige for sex
   Physically force you to have sex
   Threatened to use gun, knife, or other weapon
7. What happened when you experienced violence? How did it all start? What did you do? How did you feel? How did you cope?
8. Did you also experience violence during pregnancy by your husband? Can you elaborate?

Section 4: Consequences

9. Can you share with me what happened as a result of violence by husband during pregnancy?

   Probes:

   - What about health and mental problems?
   - Social and family problems?

Coping strategies:

10. When you experience violence from your husband, how do you avoid or minimize the negative experiences? What do you do?

Reducing the problem:

11. How can the problem of violence within marriage by husbands be prevented or reduced? What about during pregnancy? What do you think victims of violence should do?

Probes: what about services for both husbands and wives?

Thank you so much for giving me your valuable time and talking with me about your personal matters. Do you have any questions for me or would like to give any suggestions?