

Prevalence, Risks, and Health Consequences of Intimate Partner Violence during Pregnancy among Young Women: A Systematic Review

Tipparat Udmuangpia*, Mansoo Yu, Kathryn Laughon, Thoranit Saywat, Tina Bloom

Abstract: Intimate partner violence during pregnancy among young women is globally prevalent, but there is limited information on descriptions of this vulnerable population in low- and middle-income countries. A comprehensive search for primary research studies was conducted using PubMed, Medline (OVID), and CINAHL. Inclusion criteria consisted of research conducted in low- and middle-income countries, addressing intimate partner violence and pregnancy, at least 50% of participants under age 25 years, published in English, between 2009 to 2018. The aim of this systematic review was to describe what is known about the prevalence, risk factors, and health consequences associated with IPV among young pregnant women in these countries.

Results of the 12 articles that met the inclusion criteria showed that intimate partner violence during pregnancy in young women is prevalent in these countries. Across studies the range of prevalence was reported for physical violence (5%-52.8%), sexual violence (2.8%-21%), and psychological violence (17%-67.4%). Negative health consequences to maternal and child health included postpartum depression, low birth weight and unwanted pregnancy. Risk factors associated with higher risk of intimate partner violence during pregnancy included having a husband/partner with a low education level, a low level of family income, and problem drinking among their partners. Protective factors included sex education for girls, youth services, and reducing gender inequality. Most risk factors identified were influenced by culture and were unique to low- and middle-income countries. Without promoting gender equality, the problem of intimate partner violence in this population is likely to continue, and more culturally tailored intervention research addressing this among this population in low- and middle- income countries is needed.

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Introduction

According to a multi-country study, about one third (30%) of women have experienced physical and/or sexual violence by their partners in their lifetime.¹ This result is similar with that of a meta-analysis created from 141 studies in 81 countries, including high-income (HIC) and low- and middle-income countries (LMIC).² In addition, the results showed that

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women from LMICs, especially, those of sub-Saharan, western sub-Saharan, and South Asia, are higher than other regions; 65.6%, 41.8%, and 41.7% respectively.²

There are several factors, such as, financial problems, lack of human resources, cultural barriers, social norms, and policy of government may impact on or increase risks and consequences of IPV during pregnancy of women in LMICs.³ In LMICs, women are more vulnerable than men as they tend not to be employed because of a lack of formal education and social norms,⁴ and are more likely to engage in unhealthy behaviors such as risky sexual conduct resulting in early or unintended pregnancy.⁵⁻⁸ IPV during pregnancy would make this already troublesome situation worse.

Review of Literature

The problems of IPV during pregnancy has been globally well-documented in research,⁹⁻ including in LMICs.¹⁻² Additionally, a study confirmed that the proportion of IPV during pregnancy in LMICs is higher than HICs (27.7% versus 13.3%).¹¹ There is also a higher prevalence of IPV and worse consequences for pregnant women from LMICs⁹⁻¹⁰ IPV during pregnancy is associated with adverse maternal and fetal health outcomes, including abdominal trauma, miscarriage, membrane rupture, placenta damage, premature labor, fetal distress, low birth weight, maternal depression, substance abuse, and maternal and infant mortality.¹²⁻¹⁴ In addition, the rate of IPV during pregnancy, and the risk factors and negative health consequences are more likely in young women (adolescents and young adults).

A pregnant young women is particularly vulnerable to IPV, and the rate for the age group 16 to 24 years is the highest risk group.¹⁵⁻¹⁸ Literature shows that IPV during pregnancy can contribute the risk of homicide in postpartum women who have aged between 15 and 19 years.¹⁹ A younger age of pregnancy also shows that it is one of associated factors of physical violence, with prevalence rates among adolescents 1.5 to 3.0 times greater than those for pregnant adults.^{18, 20-21} There are significant reasons why IPV occurs in young women. Firstly, there are a lot of young women who left their partners due to dating violence, return to their partners when they discover they get pregnant because of being alone and fear to raise a child—it would make

the violence may occur again or getting worse during pregnancy.²² Secondly, young pregnant women are highly violence acceptant and they also confuse between jealousy and love.²³

A cross-sectional study with nine LMICs explored the prevalence of IPV during a 12-month time period with women aged 15 to 24 years.²⁴ The results showed that between 19–66% were considered to have a higher risk of experiencing IPV than women above 24 years with the exception being a rural site in Ethiopia. Young women in LMICs are at greater risk of violence than adult women.²⁴ For example, in South Kivu, Democratic Republic of the Congo (DRC) and Ethiopia, about 50% of young women reported at least one form of violence within 12 months, and more than one fourth have experienced sexual violence.²⁵ Additionally, less education of young women in DRC and young age in Ethiopia are more likely to report violence. Reasons for IPV among young women in LMICs includes that firstly, pregnancy is common in child marriages.²⁶ Child marriage is also highly associated with gender inequality.^{24, 27} Secondly, a further significant reason is that for pregnant young women, LMICs is the social contexts of their native countries, such as inequitable gender-norms, which result in the denying of access to education and justifying wife-beating by fellow women.²⁸⁻²⁹

However, even though IPV during young pregnant women is a significant issue, there are some systematic reviews investigating IPV during pregnancy in this population in HIC and LMIC,³⁰⁻³¹ including women with antenatal and postnatal mental disorder and unintended pregnancy. Therefore, given these available data, it seems reasonable to hypothesize that (a) IPV and young pregnant women is likely a co-occurring problem among young women in LMICs, and (b) these young women face a higher prevalence and risk for negative health consequences.

Research Aim

The aim of this review study therefore was to describe what is known about the prevalence, risk factors,

and health consequences associated with IPV among young pregnant women in LMICs. To our knowledge, this current study is the first study to synthesize the association between IPV and young pregnant from literature in LMICs. The outcomes of this review will be useful for researchers to understand the prevalence, risks, and health consequences of this issue and to design tailored interventions addressing IPV during pregnancy in young women and reducing the negative health consequences of this population as well.

Definition of Terms

For this review, intimate partner violence was defined as physical, sexual, or psychological harm by a current or former partner or spouse.³² The term “young women” refers to women between the ages of 15 and 24. Low- and middle-income countries (LMICs) refers to countries with low, lower-middle, and upper-middle incomes as determined by the World Bank’s 2019 report.³³ The World Bank classifies countries by gross national income per capita as follows: (1) low income: \$1,025 or less; (2) lower middle income: \$1,026 to \$3,995; (3) upper middle income: \$3,996 to \$12,375; and (4) high income: \$12,376 or more.

Theoretical framework

The ecological framework is a well-known framework to describe IPV. This framework offers a comprehensive view by looking through several factors covering in many levels, individual, relationship, community, and society.³⁴ First, individual level that covers biological and personal factors. These factors include age, education, gender, salary, and psychological disorder.³⁴ This level also categorizes risk factors such as substance abuse and depression.³⁵ The relationship level includes partner, friends, situations in workplace. This level can bring to the risk of continuing and accepting violence.³⁴ In addition, risk factors of this level may include IPV and family structure.³⁵ Next, the community level is defined as the places where persons live, build relationships, and interact with their people (friends and colleagues).³⁴ This level also includes factors that increase the number of vulnerable people or violent acts.

High levels of neighborhood crime and family poverty can increase the risk of IPV.³⁵ The final level is society. This relates to the structures, systems, and social norms of the society and culture where the person lives.³⁴ These have an effect on the people’s lives, for example, legislation and political pressure may contribute the risk of IPV for this level.³⁵

Methods

A systematic review was conducted using the PRISMA framework, (see **Figure 1**), which allows to include the diverse of research methodologies, such as experimental and non-experimental research.³⁶

Search Strategy

The search was conducted by the first researcher, who utilized PubMed, Medline (OVID), and CINAHL, using search terms as shown in Figure 1. The search period selected was the 10 years between January 2009 and December 2018, a time span large enough to find sufficient articles and then to reflect on the state of current literature. Next, the titles and abstracts were screen for eligibility, and checked for duplications in the different databases, and duplicates and studies not available in full text were removed. The inclusion criteria for selected studies included: (1) the aim of the study focused on the intersections between IPV during pregnancy and young pregnant women ages, 15 through 24; (2) the majority or at least 50% of participants in the study were young pregnant women; (3) the setting of the study was in a low- and/or middle-income country; (4) the literature was published between January 2009 and May 2018; (5) the literature included primary data and secondary data; and (6) English language was used. Exclusion criteria were: studies conducted in high-income countries, published in languages other than English, and studies that did not focus on IPV. The final step was reading the citations and reviewing the abstracts. In the end, 12 full text articles were reviewed by the researchers and determined eligible for inclusion in the systematic review.

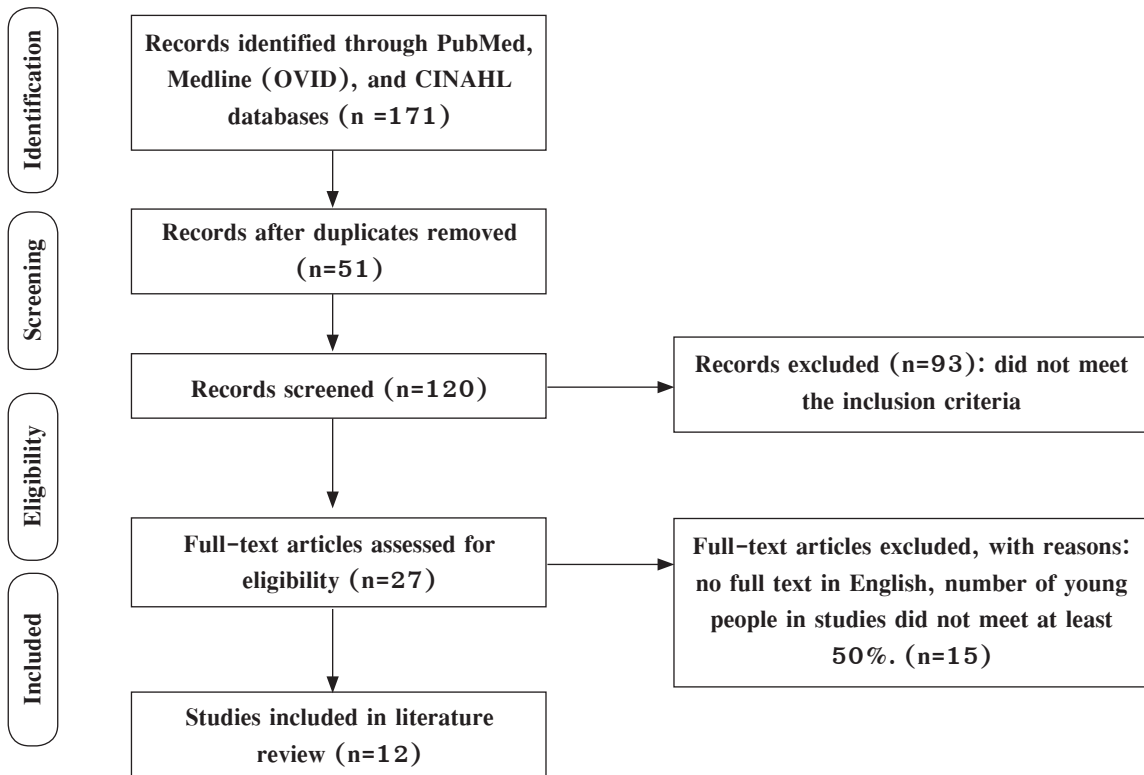


Figure 1. PRISMA chart of searching and screening strategy.

Data Extraction

Relevant data were extracted, with cross-checking performed by two researchers with experience with systematic reviews of IPV research. Two tables were used to summarize data. **Table 1** included critical findings: author and year of publication; study design; type of income country; the number of young pregnant women; setting and country where the studies were implemented; measurement; type of violence and percentage in each type; and study results. **Table 2** included the prevalence and type of IPV. The first researcher extracted the data and took notes for each article during the first reading. After that, all articles were further to review by two researchers once results were entered.

Results

Study Selection Process

The study selection process is shown in the PRISMA diagram (see **Figure 1**). A total of 171 articles were retrieved through databases: PubMed (54), Medline (OVID) (111), and CINAHL (6). After the removal of duplicates (51), 120 were identified for screening. Ninety-three (93) records were excluded because they did not meet inclusion criteria. In all, 27 articles were considered eligible for full-text screening; of that number, 15 studies were excluded because the full text was not in English or at least 50% of the participants were not young women. Twelve (12) articles met the inclusion criteria and were reviewed.

Key Features of Included Studies

The included studies were published between 2011 and 2017, and the majority (six) were published in 2017 (**Table 1**). With respect to research design, nine studies collected cross-sectional quantitative data, one collected qualitative data, and two collected data through mixed-methods. Geographically, studies were conducted in nine LMICs: Bangladesh, Colombia, Ethiopia, Kenya, India, Iran, Nepal, Rwanda, and Uganda. In terms of research settings, six studies collected data from communities; three studies collected data from hospitals as antenatal clinics and postpartum ward; one study used the current Demographic and Health Surveys (DHS); and two studies used the DHS as secondary

data. The studies used the following measurements to determine IPV: six studies used a domestic violence module from the DHS; two studies used the Conflict Tactics Scale (CTS); one study used the Abuse Assessment Screen; one study used self-reporting of IPV; and two studies used an interview guide. There were 11 studies collected from young pregnant women who experienced IPV within the last 12 months or during pregnancy, and only one study collected data on experiences of IPV within the last five years.

Findings from this review indicate a high prevalence of IPV in young women during pregnancy, and that culture plays a part in the IPV risk for young women living in LMICs. See **Table 1**.

Table 1. Studies included in review

Author	Country	Study design	Sample/Setting	Results
Anand E, Unisa S, & Singh J. (2016). (1)	South Asia (Bangladesh, India, and Nepal) (<i>Lower-Middle Income Country</i>), Nepal (<i>Low-Middle Income Country</i>)	Cross-sectional study	N= 9788 who ever-married responded, ages 15–24 and had given birth to at least one child in the last five years in Bangladesh, India, and Nepal. Age: 15–24 y/o (N=9788) Setting: Demographic and Health Survey from Bangladesh, India, and Nepal. Measured: P, S, PS Measurement: Conflict Tactic Scale (CTS) (experienced) Period: five years	38% of the respondents in India, 52% in Bangladesh and 28% in Nepal reported having experienced physical or sexual IPV. - Physical or sexual IPV had higher odds of unintended pregnancy (1.36 in India and 1.99 in Bangladesh). - IPV is a risk factor for unintended pregnancy among adolescent and young adult married women.
Deuba K, Mainali A, Alesson HM, & Karki D. (2016). (2)	Nepal (<i>Low-Middle Income Country</i>)	Qualitative study	N= 20 Women who have IPV during pregnancy Age: 15–24 y/o (N=20) Setting: 13 slums in the Kathmandu. Measure: Semi-structure interview guide. Measured: Interview guide Measurement: interviewing (During)	- Identification of fetal gender increased the experience of physical violence at the prenatal stage. - Women faced severe physical violence during pregnancy such as having their hair pulled and being slapped, battered, push to the floor, pushed downstairs, and kicked in the abdomen. - Reasons for physical violence were argument with their husband about his family members, denied a request to have sex, visited neighbor's home to gossip, husband came home intoxicated, and only gave birth to daughters. - Psychological violence was from scolding and abusive language as a sex worker.

Table 1. Studies included in review (Cont.)

Author	Country	Study design	Sample/Setting	Results
			Period: not mentioned	- Sexual intercourse during pregnancy is perceived to increase the chances of conceiving a boy child. - Short and long-term actions to reduce intimate partner violence such as female education, economic independence of young women, banning identification of fetal gender during pregnancy and establishing separate institutions within their community to handle violence against young pregnant women.
Farrokh-Eslamlou H, Oshnouei S, & Haghighi N. (2014). (3)	Iran (Upper-Middle Income Country)	Cross-sectional study	N= 313 women during their first two days' postpartum period. Age: <19 y/o (15), 20-29 y/o (183) (N=198) Setting: Urmia district, central city of the West Azerbaijan province. Measured: P, S, PS Measurement: Abuse Assessment Screening (During) Period: 12 months	- IPV during pregnancy was associated with lower education of the husbands, unemployment of the husbands, marriage duration, and gravidity of two. - No significant associations between IPV during pregnancy and women's age, educational level, and employment status.
Ferdos J & Rahman MM. (2017). (4)	Bangladesh	Cross-sectional study	N=400 pregnant women Age: < 25 y/o (N=249) 62.25% Setting: postnatal wards of Rajshahi Medical College Hospital, Rajshahi Measured: P, S Measurement: Conflict Tactics Scale (CTS) (Before and During) Period: not mentioned	29.2% infants were born with LBW. - Physical IPV was associated with an increased risk of having a child with LBW. - The risk of infants born with LBW increased with women's lifetime experience of sexual IPV and both physical and sexual IPV.
Gebrezgi BH, Badi MB, Cherkose EA, & Weldehaweria NB. (2017) (5)	Ethiopia	Mixed method, Cross-sectional study and qualitative study	N=420 pregnant women Age: < 25 y/o (N=356) Setting: Antenatal care in Shire Endaselassie town, Tigray, northern Ethiopia Measured: P Measurement: WHO (During) Period: 12 months	- Women with no formal education were 3.4 times more likely to have IPPV during pregnancy than those with high school education or greater. - Pregnant women from rural areas were 2.63 times more likely to experience IPV - Partners with no formal education were 2.78 times more likely to physically assault their wives. - Pregnant women, whose intimate partner consumed alcohol, were 3.80 times more likely to experience IPV.

Table 1. Studies included in review (Cont.)

Author	Country	Study design	Sample/Setting	Results
Gomez AM. (2011). (6)	Colombia (Upper-Middle Income Country)	Cross-sectional study	N= 4,913 women who had been pregnant in the past 5 years or pregnant at time of study Age: 1324- y/o (N=4,913) Setting: Demographic and Health Survey, Colombian country. Measured: S Measurement: DHS (During) Period: 12 months	- Female youth who experienced sexual violence reported significantly higher levels of unintended pregnancy and unmet need for contraception and lower levels of current modern contraceptive use, compared to those who have not experienced sexual violence. - Having completed secondary or higher education is significantly protective against sexual violence.
Islam MJ, Broidy L, Baird K, & Mazerolle (2017) (7)	Bangladesh	Cross-sectional design	N=426 women who were in the first six months postpartum Age: < 25 y/o (N=293) Setting: Chandpur District of Bangladesh Measured: P, S, PS Measurement: WHO (During) Period: 12 months	- The prevalence of physical IPV was highest compared with that during pregnancy and after childbirth - The prevalence of psychological IPV before pregnancy was highest - Physical, sexual, and psychological IPV both during pregnancy and after childbirth were significantly associated with PPD among the women. - Women who experience physical IPV during the first 6 months following childbirth are 4.01 times more likely to experience PPD than women who do not experience such violence. - Experiencing sexual and psychological IPV after childbirth does not significantly influence the odds of PPD in the full model.
Islam MJ, Mazerolle P, Broidy L, Baird K. (2017) (8)	Bangladesh	Cross-sectional study	N=426 women who were in the first six months postpartum Age: < 25 y/o (N=293) Setting: Chandpur District of Bangladesh Measured: P, S, PS Measurement: WHO (During) Period: 12 months	- Physical, sexual, and psychological IPV during pregnancy are significantly associated with late entry into prenatal care. - Women who experienced physical IPV during pregnancy were 2.61 times more likely to enter into prenatal care later than women who had not experienced such violence.

Table 1. Studies included in review (Cont.)

Author	Country	Study design	Sample/Setting	Results
Makayoto LA, Omolo J, Kamweya AM, Harder VS, & Mutai J, 2013 (9)	Kenya (<i>Lower-Middle Income Country</i>)	Cross-sectional study	N= 300 pregnant antenatal care patients. Age: mean 23.7 y/o Setting: Kisumu District Hospital, Kenya Measured: P, S, PS Measurement: Self-reported IPV (during) Period: 12 months	• IPV is common among women seeking antenatal care. • Healthcare providers should be alerted to the possibility of IPV during pregnancy for those who witnessed maternal abuse in childhood, are multiparous, polygamous, have a partner who drinks alcohol or has low level education.
Raj A, & McDougal L. (2015) (10)	South Asia (Bangladesh, India, and Nepal) Bangladesh and India (<i>Lower-Middle Income Country</i>), Nepal (<i>Low-Middle Income Country</i>)	Cross sectional study	N= 4,738 currently pregnant women living in Bangladesh, India, and Nepal. Age: 15-24 y/o (N=2,608) Setting: Demographic and Health Survey from Bangladesh, India, and Nepal. Measured: P, S Measurement: DHS (during) Period: 12 months	- Sexual IPV was associated with pre-pregnancy modern contraceptive use; sexual plus physical IPV was associated with pre-pregnancy traditional contraceptive use. - Sexual IPV was associated with modern contraceptive use. - Sexual and physical IPV was associated with traditional contraceptive use. - Sexual IPV had higher prevalence of contraceptive failure.
Rurangirwa AA, Mogren I, Ntaganira L, & Krantz, G. (2017) (11)	Rwanda (<i>Low Income Country</i>)	Cross-sectional study	N= 921 women who gave birth within the past 13 months. Age: 15-30 y/o (N=632) 68.62% Setting: Northern Province and in Kigali city. Measured: P, S, PS Measurement: the World's Health and Life Experiences Questionnaire. Period: 13 months before and during pregnancy	- Usage of antenatal care services were less common among women who reported controlling behavior. - No statistically significant associations between physical, psychological and sexual violence and antenatal care usage was found. - Low socioeconomic status was associated with physical violence exposure. - Young age, living in urban areas and poor social support were statistically significant in their associations with violence exposure during pregnancy.

Table 1. Studies included in review (Cont.)

Author	Country	Study design	Sample/Setting	Results
Tusiime S, Musinguzi, G, Tinkitina, B, Mwebaza, N, Kisa R, Anguzu R, & Kiwanuka, N. (2015). (12)	Uganda (<i>Low-Middle Income Country</i>)	Mixed-method study	N= 416 pregnant women who attending antenatal clinics, and 8 women who had history of both sexual coercion and unwanted pregnancy. Age: 15–24 y/o (N=416). Setting: Lubaga division, Kampala district, Uganda's capital city. Assessed: sexual coercion Measured: S Measurement: Modified by Wagman et al (2009) Period: 12 months	- History of sexual coercion and non-consensual sexual debut were associated with unwanted pregnancy. - Prevalence proportion rate of unintended pregnancy was higher among the sexually coerced and young women who experiences non-consensual sexual debut. - Financial challenges were partly explained; the price that the husband paid for the partner in exchange for sex which resulted in unwanted pregnancies. - Men used alcohol consumption to coerce young women into sex. - Health education, youth friendly services, imprisonment of perpetrators, and community services for the youth were discussed for preventing sexual violence.

IPV: intimate partner violence; PPD: postpartum depressive; S: sexual violence; P: physical violence; PS: psychological violence

Prevalence and Type of Violence

The prevalence of IPV among young women, aged between 15 and 24 years, in LMICs during their lifetime ranges from 9.2% to 55.9%. Broken down by type of violence, the range of physical violence was 5% through 52.8%; of psychological violence was 17% through 67.4%; and of sexual violence was 2.8% through 21.1%. See Table 2. Six studies measured IPV as physical, psychological, and sexual violence;^{12, 37–41} three studies

measured IPV as physical and sexual violence;^{42–44} one study measured only physical violence,⁴⁵ and two studies measured only sexual violence.^{46–47} For several of these studies, the time that the women were studied varied across the 12 studies. Seven studies measured IPV during pregnancy only;^{42, 37–40, 44–45} one study measured IPV before and during pregnancy;⁴⁷ one study measured before, during, and after pregnancy;³⁸ and two studies measured their subjects' entire lifetime.^{42, 48} See **Table 2.**

Table 2. Prevalence and type of IPV among young pregnant women in LMICs.

Author	Measure	Type	Period	Physical	Psychological	sexual
Anand E, Unisa S, & Singh J. (2016). (1)	Conflict Tactic Scale (CTS)	P, S	5 years	34.3%--India 47.1%--Bangladesh 22%--Nepal		11.6%--India 19.1%--Bangladesh 13.4%--Nepal
Deuba K, Mainali A, Alesson HM, & Karki D. (2016). (2)	Interviewed (During)	P, S, PS	Not mentioned	–	–	–
Farrokh-Eslamlou H, Oshnouei S, & Haghighi N. (2014). (3)	Abuse Assessment Screening (during)	P, S, PS	12 months	10.2%	43.5%	17.3%
Ferdos J & Rahman MM. (2017). (4)	Conflict Tactic Scale (CTS)	P, S	Before and During	43%	35.5%	

Table 2. Prevalence and type of IPV among young pregnant women in LMICs. (Cont.)

Author	Measure	Type	Period	Physical	Psychological	sexual
Gebrezgi BH, Badi MB, Cherkose EA, & Weldehaweria NB. (2017) (5)	WHO's demographic Health Survey (during) and Life Experiences	P	12 months	20.6%	-	-
Gomez AM. (2011). (6)	WHO's demographic Health Survey (during)	S	12 months	-	-	13%
Islam MJ, Broidy L, Baird K, & Mazerolle (2017) (7)	WHO's demographic Health Survey (before, during, and after)	P, S, PS	12 months	52.8% (before) 35.2% during 32.2% postpartum	67.4% before 65% during 60.8% post	21.1% before 18.5% during 15.5% post
Islam MJ, Mazerolle P, Broidy L, Baird K. (2017) (8)	WHO's demographic Health Survey (during)	P, S, PS	12 months	35.2%	65%	18.5%
Makayoto LA, Omolo J, Kamweya AM, Harder VS, & Mutai J, 2013 (9)	Self-report of IPV (during)	P, S, PS	12 months	10%	29%	12%
Raj A, & McDougal L. (2015) (10)	WHO's demographic Health Survey (during)	P, S	12 months	24.6%	-	2.8%
Rurangirwa AA, Mogren I, Ntaganira L, & Krantz, G. (2017) (11)	World's Health and Life Experiences Questionnaire (13 months before and during pregnancy)	P, S, PS	13 months	10.2%	17.0%	9.7%
Tusiime S, Musinguzi, G, Tinkitina, B, Mwebaza, N, Kisa R, Anguzu R, & Kiwanuka, N. (2015). (12)	Modified from Qualitative study by Wagman et al (2009)	S	12 months	-	-	24%

WHO: world health organization; DHS: demographic health survey; S: sexual violence; P: physical violence; PS: psychological violence; During: during pregnancy; After: after pregnancy; IPV: intimate partner violence; Before: before pregnancy.

The Demographic Information of Husbands Contributes to IPV

Demographic characteristics of the husbands were associated with the chance of IPV (particularly physical violence). Low education, employment during pregnancy, and low income were correlated with higher physical violence.^{37, 45} Women with partners who did not have formal education were 2.78 (95%CI=1.10, 7.08) times more likely to be physically assaulted than those women with partners who did have education.⁴⁵ Two studies found that IPV was more likely when husbands had been drinking alcohol.^{45, 47}

Reasons for IPV

Only one study examined possible reasons husbands committed IPV on their young pregnant wives.¹² In a qualitative study in Nepal, the participants reported that reasons for physical violence were arguing with their husbands about his family members, denying a request to have sex, visiting a neighbor's home to gossip, husbands coming home intoxicated, and giving birth only to daughters.¹²

IPV with Unwanted Pregnancy

IPV during pregnancy was connected with unwanted or mistimed pregnancies in four studies.

Studies conducted in Colombia and Uganda found that young women who had experienced sexual violence and sexual coercion reported a high number of unintended pregnancies.⁴⁶⁻⁴⁷ In addition, a cross-sectional study in South Asian countries (Bangladesh, India, and Nepal) reported that young women who had experienced physical or sexual violence had higher odds of unintended pregnancy compared with those women who had not.⁴²

Characteristics of and Risk Factors Associated with IPV During Pregnancy

A qualitative study conducted in Nepal described that pregnant women survivors experienced severe forms of physical violence such as hair pulled, slapped, battered, pushed to the floor and downstairs, and kicked in the abdomen.¹² Moreover, in the same study, the victims experienced psychological violence such as scolding and abusive language as perpetrators treated victims as sex workers.¹²

Low socioeconomic status was correlated with IPV during pregnancy in LMICs in multiple studies. Women with lower levels of education and lower incomes had significantly higher experiences of violence,⁴⁵⁻⁴⁶ while women and their partners having completed secondary or higher education seemed to have a significant protective factor against sexual violence.^{40,46} Moreover, being a young age, having limited social support, living in city areas, desiring a specific gender, and living with the husband's family were found to be positively associated with IPV during pregnancy in a study from Rwanda.^{12,41}

Health Consequences of IPV During Pregnancy

Four studies reported that women who had experienced IPV during pregnancy had increased rates of poor maternal and fetal outcomes, including maternal mental health diagnoses and low birth weight (LBW).^{38, 43} Women who experienced physical violence and/or sexual violence during pregnancy were significantly more likely to have moderate postpartum traumatic stress disorder (PTSD), anxiety, and postpartum depressive symptoms.³⁸

Certain cultural attitudes or beliefs may also contribute to IPV during pregnancy. For example, women participating in a qualitative study in Nepal

reported that the identification of the fetal gender as female increased the experiences of physical violence in pregnancy. Some also described that forced sex during pregnancy may occur because it may increase the chances of considering the boy child that the husband desired.¹²

Prevention of IPV During Pregnancy

Two studies mentioned strategies to prevent IPV during pregnancy.^{43,49} Young pregnant Nepalese women desired actions for young women to reduce IPV, including female education, economic independence, banning identification of fetal gender, and establishing institutions to manage IPV during pregnancy.^{12,47} Another study conducted in Uganda suggested that health education and health services targeted to young women and girls, the imprisonment of perpetrators, and community services for the youth can prevent sexual violence. Neither study tested interventions.

Discussion

The purpose of this review was to better understand the intersections between IPV during pregnancy and young women in LMICs, and to identify what is known about factors contributing to IPV. The 12 studies represented 9 LMICs. Overall, findings in these included the type and prevalence of violence; family, social, and other resources; husband's demographics; reasons for IPV; IPV and unwanted pregnancy; consequences; factors associated with IPV; prevention strategies; and implications for practice, policy, and further research.

High IPV During Pregnancy among Young Women

IPV during pregnancy among young women is prevalent in LMICs, especially in countries where gender inequality is an issue, and particularly in the case of when their partners are older men.¹ Arguments with a husband's family members, denying a request to have sex, and the husband coming home intoxicated are additional reasons that cause husbands to abuse young pregnant women in Nepal.¹² A high rate of

child marriage⁵⁰⁻⁵¹ also leads to a higher rate of physical and/or sexual abuse during pregnancy in LMICs.⁵² Child marriage has a higher rate in developing countries; there is a higher risk of IPV, and these women often are limited to effectively negotiate with safe sex.⁵³ These would make them valuable to early and unintended pregnancy.⁵³

IPV During Pregnancy and Unwanted Pregnancy

Our study found that the rates of IPV, particularly sexual violence and unwanted pregnancy, are high in young women living in LMICs. It is consistent with findings from previous studies conducted in developing countries indicating that IPV during pregnancy and unwanted pregnancy are very high in LMICs.^{44,54} IPV during young women's pregnancy is critical and needs to be recognized and prioritized because of the adverse health outcomes (e.g., unwanted pregnancy).³¹ Our findings indicate that low socioeconomic status is associated with delayed access to antenatal care³⁸ and an increase in postpartum depression.⁴⁰

In addition, young pregnant women in LMICs often do not have adequate knowledge about the use of contraceptives.⁵⁵ For example, a study in South Asia indicates that even though pregnant women with having experienced sexual violence were more likely to use contraceptives, they did not have a reduced risk of unwanted pregnancy.²⁸ Moreover, young pregnant women may also need the approval from their partners when using contraceptives. A systematic review focusing on the relationship between IPV and contraception revealed that women who experience physical, psychological, and sexual violence are less likely to use contraceptive use, particularly condoms because they require approval from their partners.⁴⁴ In addition, women are more likely to use contraceptives that they could hide from their partners.⁴⁴

Health Consequences

Our findings reveal that IPV during pregnancy among young women is strongly associated with negative health consequences of mothers and unborn babies.⁵³ This is similar to the results of previous

studies.⁵⁶⁻⁵⁸ A cohort study showed that physical violence was associated with premature rupture of membrane (PROM) and low birth weight (LBW); women, who have experienced with physical violence, had 1.9 times the risk of PROM, and 2.9 times the risk of LBW.⁵⁹ A cross-sectional study about the relationship between IPV, forced sex, and maternal and newborn health outcomes from Zimbabwe conducted with 2,042 women aged 15 and 49 years attending postpartum departments had similar findings.⁶⁰ The results show that 50.9% registered for antenatal care late, 5.6% never booked, and 9.4% experienced newborn death, while 8.6% of recent livebirths were LBW babies. It is possible that the negative outcomes affecting mothers can be related to psychological issues, such as postpartum depression.

A possible reason why IPV among young pregnant women in LMICs increases the rates of negative consequences is that women are entering into prenatal care too late.^{38, 60} Being late means there is a loss of opportunity to get health education, which is significantly associated with low utilization of antenatal care such as consumption of iron and folic acid, dietary diversity, rest and sleeping during the daytime.⁶¹ Another reason that there are more negative consequences is that because many women who have experienced IPV are young and might not have been adequately educated about pregnancy. Therefore, young pregnant women who are experiencing IPV are extremely vulnerable during any period of their pregnancy, including the partum period.

Risk Factors Related to Culture

The findings of this review suggest that unique cultural factors such as desiring a specific gender, and women living with the husband's family raise the risk of IPV during pregnancy. Some social groups in LMICs believe that the son will take care of the parents when they grow to adulthood, and if women do not have a son, then this reflects bad karma on them and their families.⁶² The woman has an important role to produce a son for her husband's family.⁶² A qualitative

study in Nepal reported that when a family prefers a son, there is a higher risk of IPV during pregnancy.¹² Another study from Nepal confirmed that the pressure to give birth to sons leads to one type of culturally specific violence during pregnancy.⁶³ Another cultural belief is that when a woman gets married then she belongs to the husband's family. The issue of the wife living with the husband's family also contributes to IPV as well. The findings show that young pregnant women get physically abused when they argue with their husband's family members, especially about cleaning the house.⁵ Since, according to the culture, the wife belongs to the husband's family, and her negotiation power is limited, the woman becomes stressed and depressed in various ways.⁴

Moreover, speaking about IPV issues is unacceptable and stigmatized in some local communities,⁶⁴⁻⁶⁵ making it hard to encourage women to talk and report the situation to the husband's family members or even their own family members. On the other hand, there is another social norm from India, which is to help victims of IPV who cannot talk about IPV to anybody, but the community knows about it. This is called "jati-panchayat."⁶⁴ The elderly men in some northern Indian villages will call and ask a man to speak about IPV in his family and make decisions together about issues related to IPV.⁶⁴

Implications for Practice, Policy, and Research

The results from this review can be useful to better understand why researchers and health providers should advocate for resources and IPV screening for young pregnant women in LMICs. Indeed, IPV screening should be a priority for practical implications. The World Health Organization highly recommends routine IPV screenings for pregnant women.¹ However, this issue needs more interventions in LMICs to change healthcare providers' attitudes and knowledge about IPV and IPV screening. Regardless, it is wise to begin to increase community awareness about this issue now. Gender inequality is one of the important causes that contributes to IPV during pregnancy in LMICs; therefore,

creating effective intervention programs that can promote women's rights as human rights and reduce gender inequality based on culture will be an appropriate way to reduce IPV during pregnancy. As women in LMICs still tend to live within an extended family and they have known each other in their community, it is important to increase community awareness about IPV especially during pregnancy. Furthermore, guiding and counselling young women closely about contraceptive methods can be helpful for those who experience IPV to prevent them from dropping out of school, which will reduce unwanted pregnancy in young women.

Implications for policy are also noted. It is important to create well-organized referral pathways and support systems to help the survivors. Continuing care systems are needed for after the baby is born because the literature shows that postpartum depression is prevalent and can lead to suicide attempts. In addition, continuing care allows for observation of a baby's health and growth development. Long-acting, reversible contraceptives such as implants and intrauterine devices are recommended to prevent pregnancy and repeat pregnancy for young women experiencing violence and who are not ready to get pregnant. Captured in the ecological conceptual framework of this study, complexities arise from the fact that IPV and risk factors and consequences can maintain. Immensity changing and reducing risk factors of IPV during pregnancy in individual, relationship, community, and society characteristics as mentioned in ecological framework, are needed.

There are a few studies conducted about IPV during pregnancy in young age groups in LMICs, even though it is highly prevalent. Therefore, longitudinal studies are needed to examine and analyze negative health outcomes related to mother and baby and the actual factors and outcomes of IPV during pregnancy for young women in LMICs. Because we wanted to analyze young age groups, we were not able to include certain studies that had a wider range of participant ages. More longitudinal cohort studies about the negative

consequences of a fetus's or infant's health who were born of young women experiencing IPV are needed because it will be important evidence to educate these women and their health care providers. Research is needed to find the appropriate measurements and definitions of IPV in terms of screening, IPV during pregnancy, and outcomes of pregnancy. While IPV is a sensitive topic, to get a better understanding of this topic we also need more qualitative research to understand the mechanisms and the nature of relationships between the variables (i.e., health outcomes and physical violence). As there are no reviewed studies conducting intervention research, we also need more preventive intervention programs on this issue targeted at young pregnant women.

Limitations

There are some limitations of this current study. Firstly, because a number of studies were focused on young pregnant women, we could not represent the phenomena of IPV during pregnancy in women older than 25. Secondly, there are six studies included in our research with at least 50% of young pregnant women experiencing IPV. That is, these studies may include results from adult pregnant women and would bias the results. Lastly, as most studies were conducted in Asian and African countries, the generalizability of our findings is limited.

Conclusion

The findings from this systematic review helps elucidate the intersections between IPV and young pregnant women in LMICs. There are several risk factors contributing to IPV during the pregnancy of young women, including gender preference, low socioeconomic status, and husband's low level of education. Negative health outcomes of the mother and fetus during pregnancy, such as low birth weight and abortion can be prevented if pregnant women

came to the antenatal care earlier. Providing sex education and reproductive health services for girls are the main prevention strategies. Qualitative and longitudinal study designs should include women's views to better understand the complexity of IPV during pregnancy in LMICs. Efforts to increase IPV screening among all pregnant women, particularly those who are young, are required.

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อุบัติการณ์ ความเสี่ยง และผลกระทบทางด้านสุขภาพ ของหญิงตั้งครรภ์วัยรุ่น ที่ได้รับความรุนแรงในครอบครัว: การทบทวนวรรณกรรมอย่างเป็นระบบ

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บทคัดย่อ: ความรุนแรงในครอบครัวในระหว่างตั้งครรภ์ของวัยรุ่นมีอุบัติการณ์ที่แพร่หลายทั่วโลก แต่ยังมีข้อมูลที่จะมาอธิบายการเกิดความเสี่ยงของหญิงตั้งครรภ์กลุ่มนี้น้อยมากโดยเฉพาะผู้หญิงตั้งครรภ์ที่อยู่ในประเทศรายได้ปานกลางและรายได้ต่ำ ดังนั้นวัตถุประสงค์ของการศึกษาวิจัยในครั้งนี้เพื่อที่จะศึกษาอุบัติการณ์ ความเสี่ยง และผลกระทบทางด้านสุขภาพกับผู้หญิงกลุ่มนี้ในกลุ่มประเทศรายได้ปานกลางและรายได้ต่ำ การวิจัยในครั้งนี้ได้สืบค้นข้อมูลจากฐานข้อมูลอิเล็กทรอนิกส์ ได้แก่ PubMed, Medline (OVID) และ CINAHL เกณฑ์ที่ใช้ในการนำวิจัยหรือวรรณกรรมมาทบทวนอย่างเป็นระบบ ประกอบด้วย 1) ต้องเป็นงานวิจัยที่อยู่ในประเทศที่มีรายได้ปานกลางหรือรายได้ต่ำ 2) วิจัยเกี่ยวกับความรุนแรงในครอบครัวในระหว่างตั้งครรภ์ 3) อย่างน้อย 50% ของกลุ่มตัวอย่าง เป็นผู้หญิงที่มีอายุระหว่าง 15-24 ปี และ 3) มีการพิมพ์เผยแพร่เป็นภาษาอังกฤษ อยู่ในปี พ.ศ. 2552 ถึง 2561

ผลการวิจัยพบว่า มีจำนวนวิจัย 12 เรื่องที่เกี่ยวข้อง ความรุนแรงในครอบครัวในระหว่างตั้งครรภ์มีอุบัติการณ์ที่สูงในประเทศที่มีรายได้ปานกลางและรายได้ต่ำ อุบัติการณ์ของความรุนแรงทางร่างกาย อยู่ระหว่าง 5-28% ความรุนแรงทางด้านเพศอยู่ระหว่าง 2.8-21% และความรุนแรงทางด้านจิตใจอยู่ระหว่าง 17-67.4% ผลกระทบทางด้านสุขภาพของมารดาและทารกประกอบด้วย ภาวะซึมเศร้า หลังคลอด ทารกน้ำหนักน้อย และตั้งครรภ์ไม่พึงประสงค์ ความเสี่ยงที่นำไปสู่การเกิดความเสี่ยงในครอบครัวในระหว่างตั้งครรภ์ ประกอบด้วย สามีหรือคู่ชีวิตมีการศึกษาน้อย รายได้ของครอบครัวต่ำ สามีหรือคู่ชีวิตติดสุรา ปัจจัยที่สามารถป้องกันปัญหาความรุนแรงในครอบครัวในระหว่างตั้งครรภ์ ประกอบด้วย การสอนเพศศึกษาสำหรับหญิงวัยรุ่น การให้บริการแก่วัยรุ่นและการลดความไม่เท่าเทียมกันระหว่างผู้หญิงและผู้ชาย ซึ่งเกี่ยวข้องกับวัฒนธรรมที่เป็นเอกลักษณ์หรือสามารถพบเห็นได้ในประเทศที่มีรายได้ปานกลางและรายได้ต่ำ ถ้าไม่มีการส่งเสริมความเท่าเทียมกันระหว่างเพศหญิงและเพศชาย ปัญหาความรุนแรงนี้จะยังคงอยู่ต่อไป การออกแบบการวิจัยในการป้องกันปัญหาความรุนแรงในครอบครัวในหญิงตั้งครรภ์วัยรุ่นที่ครอบคลุมและเหมาะสมกับวัฒนธรรมของประเทศที่กำลังพัฒนา เป็นสิ่งที่จำเป็นและต้องการ

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คำสำคัญ: อุบัติการณ์ ความเสี่ยง ผลกระทบทางด้านสุขภาพ ความรุนแรงในระหว่างการตั้งครรภ์ การตั้งครรภ์ไม่พึงประสงค์ วัยรุ่น ประเทศที่มีรายได้ปานกลางและรายได้ต่ำ

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