DOI: 10.1590/1413-81232022275.06542021EN

Intimate partner violence during pregnancy: a focus on partner characteristics

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Abstract *This study analyzes the association between violence against women during pregnancy and intimate partner socioeconomic and behavioral characteristics. We conducted an analytical cross-sectional study with 327 postpartum women admitted to a maternity hospital in a city in Espírito Santo, Brazil using a questionnaire to collect data on intimate partner socioeconomic and behavioral characteristics. Intimate partner violence was assessed using questions based on the World Health Organisation instrument "Violence against Women (WHO VAW STUDY)". Associations were tested using crude and adjusted Poisson regression. The prevalence of psychological violence during pregnancy was higher among women whose partners consumed alcohol, refused to use condoms, and were not the infant's biological father. Physical violence was associated with women whose partners did not work and refused to use condoms. The prevalence of sexual violence during pregnancy was more than nine times higher among women with partners who refused to use condoms. The findings demonstrate that antenatal care is an opportune time to approach partners about health care and address violence. It is necessary to promote the utilization of health services by men in order to address risk factors for violence during pregnancy.*

Key words *Intimate partner violence, Violence against women, Spouse abuse, Masculinity, Pregnancy*

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Introduction

The World Health Organisation report "The World Report on Violence and Health" defines Intimate partner violence (IPV) as any behavior within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship, including acts of physical aggression, sexual coercion, psychological abuse and controlling behaviors[1].

National and international studies show that victims of IPV are predominantly women and that women experience more serious forms of violence than men[2,3]. Data from the United States reveal that 36.0% of American women have experienced IPV during their lifetime[3]. In Brazil, a study undertaken in 15 state capitals and the Federal District reported that the prevalence of psychological violence ranged from 61.7% in Campo Grande to 85.6% in Belo Horizonte, while physical violence ranged from 13.2% in João Pessoa to 34.7% in Belém[4]. The prevalence of lifetime psychological, physical and sexual IPV in Vitória was 57.6%, 39.3%, and 18.0%, respecitvely[5].

In light of the above, it is important to investigate gender asymmetry in relationships, as although social changes have taken place over time, we continue to witness the reproduction of inequalities in intimate relationships[6]. Traditionally the hegemonic concept of masculinity has been used to refer to ideas of men's domination over women, virility, strength and power, characteristics that counterpose the attributes of femininity, such as fragility and submission. These characteristics are part of the social construction of masculine identity, demarcating expected and socially legitimate conduct, such violent behavior[7,8].

With regard to perpetrators of IPV against women, a number of characteristics are associated with acts of violence. Women whose partners are unemployed, have a low level of education, consume alcohol, and are controlling, are more likely to experience violence[9]. Other factors that are precipitators of violence include jealousy, suspicions of infidelity, refusal to have sex, different approaches to raising children, and unplanned fatherhood[8,10].

It is important to highlight that violence is a reality in the life of women and manifests itself throughout all stages of life, including pregnancy. There is no consensus in the literature as to whether pregnancy is a risk factor or protective factor against violence. Silva et al.[11] point out that different types of violence can overlap, with around 11.0% of women experiencing psychological, physical and sexual violence during pregnancy. Other studies show that the prevalence of violence is similar before and during pregnancy, but during pregnancy there is a pronounced increase in psychological violence and reduction in physical violence. Another study showed that the incidence of IPV during pregnancy was 9.7%.

The consequences of IPV during pregnancy are greater as it directly affects the health of both the mother and infant. Studies show that pregnant women who experience IPV are more likely to develop symptoms of depression and post-traumatic stress disorder and have an increased risk of early cessation of breastfeeding and misscarriage[12-14]. Violence is also associated with newborn health outcomes, including prematurity, low birth weight, and fetal and neonatal death[15].

In view of the complexity and impacts of violence against women, including violence during pregnancy, combined with the fact that men are the main perpetrators of IPV, the aim of the present study was to explore the association between violence against women during pregnancy and the socioeconomic and behavioral characteristics of the intimate partner.

Methodology

We conducted an analytical cross-sectional study with postpartum women admitted to a public maternity facility in Cariacica in the state of Espírito Santo between August and October 2017.

The eligibility criteria for participants were as follows: postpartum women admitted to the maternity facility for at least 24 hours after birth with a live baby (weighing > 500 grams) who had had an intimate partner during pregnancy. Intimate partner was defined as the woman's partner/ex-partner, regardless of whether or not there was a formal commitment, and boyfriends, provided they had sexual relations.

The sample size was calculated using a prevalence of IPV violence during pregnancy of 20%[16], adopting a 5% sampling error and 95% confidence interval, and adding 10.0% to account for sample losses and 30.0% for confounding factors, resulting in a final sample of 327 postpartum women.

We used a standardized questionnaire developed for the study with closed-ended questions devised to collect information on intimate partner socioeconomic (age, race/color, level of education, paid work) and behavioral (alcohol

Ciência & Saúde Coletiva, 27(5):1873-1882, 2022

consumption, smoking, drug use, jealous behavior, controlling behavior and refusal to use a condom) characteristics, and whether the partner was the father of the newborn. The variables controlling behavior and jealousy were assessed using the following dichotomous question (yes/no): "Is he jealous?" and "Is he controlling?"

Information on the dependent variables (psychological, physical, and sexual violence during pregnancy) was collected using questions based on the World Health Organisation instrument "Violence against Women (WHO VAW STUDY)". The instrument characterizes these different types of violence as follows: physical violence – physical aggression or the use of objects to cause injury; psychological violence – threatening behavior, humiliation and insults; and sexual violence – physically forced sexual relations or threats and humiliating acts. Victimization was classified according to type of violence based on yes answers to specific questions relating to each type of violence[17].

The eligible postpartum women were invited to participate in the study and those who accepted signed an informed consent form. A copy of the form was given to the participant and another copy remained with the interviewer for filing. In the case of underage mothers, one of the parents or guardians signed the informed consent form. The interviews were conducted in a private area by previously trained interviewers, who undertook a pilot study in the same maternity facility a month before data collection. The training emphasized guidance on ethical aspects such as the appropriate application of the questionnaire.

The data were inputted into Microsoft Office Excel version 2010 by a previously trained digitizer. Data entry was crosschecked for possible inconsistencies. The data were analyzed using STATA 13 and the following descriptive statistics: raw frequencies, relative frequencies, and 95% confidence interval. To identify the distribution of violence during pregnancy and partner socioeconomic and behavioral characteristics we used the Pearson's chi-squared test or Fisher's exact test. To examine the association between the outcomes and exposures we ran a multivariate Poisson regression model including all variables with a p-value of < 0.20 and maintaining variables with a p-value of < 0.05. The results are presented using crude and adjusted prevalence ratios and their respective 95% confidence intervals.

The study protocol was approved by the research ethics committee (approval code 2.149.430).

Results

The majority of the partners were aged up to 40 years (89.3%) and were predominantly brown (44.8%) and had completed at least nine years of education (60.5%). Almost one- quarter (23.8%) did not have paid work. With regard to behavioral characteristics, 56.0% did not drink and 89.6% did not use drugs. Over half of the partners were reported to be jealous (51.4%), while 36.1% were considered controlling. Finally, 27.2% of the partners refused to use a condom and 95.7% were the father of the newborn (Table 1).

The results of the bivariate analysis presented in Table 2 show that the frequency of psychological, physical and sexual violence during pregnancy was higher in women whose partners refused to use a condom, while the prevalence of psychological and physical violence was higher among women whose partners did not have paid work. The frequency of psychological violence was higher in women with partners who consumed alcohol, were controlling, and were not the father of the newborn ($p < 0.05$).

After adjustment for possible confounding variables, the results show that the prevalence of psychological violence was 1.72 times higher in women whose partners consumed alcohol (PR: 1.72; 95%CI: 1.05-2.83) and 1.77 times higher among women whose partners refused to use a condom (PR: 1.77; 95%CI: 1.10-2.86) (Table 3).

Table 4 shows that the prevalence of physical violence during pregnancy was higher in women whose partners did not have paid work (PR: 2.70; 95%CI: 1.27-5.72) and refused to use a condom (PR: 2.22; 95%CI: 1.04-4.71).

Prevalence of sexual violence during pregnancy was 9.36 times higher among women whose partners refused to use a condom (PR: 9.36; 95%CI: 1.97-44.31) (Table 5).

Discussion

Our findings show that the prevalence of violence during pregnancy was higher among women whose partners consumed alcohol, did not work, refused to use a condom, and were not the father of the newborn. The variables race/color, use of illicit drugs, and having a jealous and/or controlling partner did not maintain their association after adjusted multivariate analysis.

Although women report experiencing violence in various life stages, violence during pregnancy is particularly worrying because it can

have health consequences for both the mother and infant[11]. Faced with changes in routine, ambivalent feelings and the possibility of an unplanned pregnancy, pregnancy is period of profound change in which couples can either come closer together or grow apart[18]. Evidence shows that an unwanted pregnancy on the part of the partner is a factor that triggers marital conflict and violence[7].

In the present study, the prevalence of psychological violence during pregnancy was 1.72 times higher in women whose partners consumed alcohol, which is similar to the findings of previous studies[19,20]. A study undertaken in Campinas in the state of São Paulo with pregnant women using primary health care services found that alcohol consumption in women whose partners consumed alcohol at least twice a week were more than twice as likely to experience psychological, physical violence, and/or sexual violence during pregnancy[19]. A study using data from the 1st Nationwide Survey on Alcohol Consumption Patterns in Brazil showed that the prevalence of alcohol consumption was four times higher in men who commit IPV[21].

The association between alcohol consumption and intimate partner violence is therefore recognized[9,22,23]. Alcohol consumption can lead

Table 1. Socioeconomic and behavioral characteristics of the partners of postpartum women admitted to a maternity facility. Cariacica-ES, August to October 2017 (N = 330).

Variables	N	%	95%CI
Age (years)			
Up to 40	292	89.3	85.4 – 92.2
41 and over	35	10.7	7.8 – 14.6
Race/color[a]			
White	95	29.1	24.4 – 34.3
Black	85	26.1	21.6 – 31.1
Brown	146	44.8	39.4 – 50.2
Level of education[b]			
Up to 8 years	128	39.5	34.3 – 44.9
9 years or over	196	60.5	55.0 – 65.7
Paid work			
No	78	23.8	19.5 – 28.8
Yes	249	76.2	71.2 – 80.5
Alcohol consumption			
No	184	56.3	50.8 – 61.6
Yes	143	43.7	38.4 – 49.2
Illicit drug use			
No	293	89.6	85.8 – 92.5
Yes	34	10.4	7.5 – 14.2
Jealous			
No	159	48.6	43.2 – 54.1
Yes	168	51.4	45.9 – 56.8
Controlling			
No	209	63.9	58.5 – 69.0
Yes	118	36.1	31.0 – 41.5
Refuses to use a condom			
No	238	72.8	67.7 – 77.4
Yes	89	27.2	22.6 – 32.3
Father of the newborn[a]			
No	14	4.3	2.5 – 7.1
Yes	312	95.7	92.9 – 97.4

[a]326; [b]324

Source: Authors.

Table 2. Prevalence of psychological, physical and sexual violence against women during pregnancy by partner socioeconomic and behavioral characteristics. Cariacica-ES, August to October 2017 (N = 330).

Partner characteristics	Psychological violence		Physical violence		Sexual violence	
Variables	% (CI95%)	p-value	(CI95%)	p-value	(CI95%)	p-value[a]
Age (years)		0.627		0.325		0.605
Up to 40	16.8 (12.9-21.5)		7.2 (4.7-10.8)		3.08 (1.6-5.8)	
41 and over	11.4 (4.3-27.1)		11.4 (4.3-27.1)		0.0	
Race/color [a]		0.185		0.881		0.580
White	22.1 (14.8-31.6)		8.4 (4.2-16.0)		3.2 (1.0-9.4)	
Black	14.1 (8.2-23.3)		8.2 (3.9-16.4)		1.2 (0.1-8.0)	
Brown	13.7 (9.0-20.3)		6.8 (3.7-12.3)		3.4 (1.4-8.0)	
Level of education[b]		0.307		0.632		0.491
Up to 8 years	18.0 (12.2-25.7)		8.6 (4.8-14.9)		1.6 (0.3-7.3)	
9 years or over	13.8 (9.6-19.4)		7.1 (4.2-11.7)		3.6 (1.7-7.3)	
Paid work		0.010		0.003		1.000
No	25.6 (17.1-36.6)		15.4 (8.9-25.3)		2.6 (0.6-9.8)	
Yes	13.2 (9.6-18.1)		5.2 (3.0-8.8)		2.8 (0.1-5.8)	
Alcohol consumption		0.018		0.198		1.000
No	12.0 (8.0-17.5)		6.0 (3.3-10.5)		2.7 (1.1-6.4)	
Yes	21.7 (15.6-29.3)		9.8 (5.8-15.9)		2.8 (1.0-7.3)	
Illicit drug use		0.086		0.311[A]		1.000
No	15.0 (11.3-19.6)		7.2 (4.7-10.8)		2.7 (1.4-5.4)	
Yes	26.5 (14.2-43.9)		11.8 (4.4-27.8)		2.9 (0.3-18.7)	
Jealous		0.083		0.098		0.503
No	12.6 (8.2-18.7)		5.0 (2.5-9.8)		1.9 (0.6-5.7)	
Yes	19.6 (14.3-26.4)		10.1 (6.4-15.7)		3.6 (1.6-7.7)	
Controlling		0.014		0.391		0.076
No	12.4 (8.6-17.7)		6.7 (4.0-11.0)		1.4 (0.4-4.4)	
Yes	22.9 (16.1-31.4)		9.3 (5.2-16.1)		5.1 (2.3-10.9)	
Refuses to use a condom		0.011		0.015		0.002
No	13.0 (9.3-17.9)		5.5 (3.2– 9.2)		.0.8 (0.2-3.3)	
Yes	24.7 (16.8-34.8)		13.5 (7.8-22.4)		7.9 (3.8-15.7)	
Father of the newborn[a]		0.005		0.292		1.000
No	42.9 (19.9-69.3)		14.3 (3.4-4.4)		0.0	
Yes	14.7 (11.2-19.2)		7.4 (4.9-10.9)		2.9 (1.5-5.5)	

[a]326; [b]324.

Source: Authors.

to tension between the couple, aggravating and intensifying violence. Alcohol consumption by the partner can act as a factor that externalizes an impulsive and aggressive personality and predisposition to violence[22,23]. However, it is known that violence is a complex and multifactorial phenomenon and that alcohol is not the only explanatory factor[1].

Another characteristic that was associated with higher prevalence of physical violence during pregnancy was the partner not having paid work, which is similar to the findings of a study in Maringá in the state of Paraná, which reported that physical violence during pregnancy was more frequent among women with partners who were unemployed[24]. A study with 1,379 pregnant women in Campinas found that women whose partners were unemployed were more likely to experience physical/sexual violence during pregnancy[19], while research with patients in primary care centers in Vitória in the state of Espírito Santo observed that the prevalence of physical IPV was 1.11 times higher in women whose partners did not have paid work[9].

Table 3. Crude and adjusted analysis of the effects of partner socioeconomic and behavioral characteristics on psychological violence during pregnancy. Cariacica-ES, August to October 2017.

Variables	Psychological violence			
	Crude analysis		Adjusted analysis	
	Crude PR* (95%CI)	P-value	Adjusted PR (95%CI)	P-value
Race/color		0.182		0.139
White	1.61 (0.93-2.81)		1.69 (0.98-2.88)	
Black	1.03 (0.53-2.00)		1.13 (0.59-2.17)	
Brown	1.0		1.0	
Paid work		0.009		0.096
No	1.93 (1.18-3.17)		1.54 (0.92-2.58)	
Yes	1.0		1.0	
Alcohol consumption		0.020		0.030
No	1.0		1.0	
Yes	1.81 (1.09-2.99)		1.72 (1.05-2.83)	
Illicit drug use		0.075		0.849
No	1.0		1.0	
Yes	1.76 (0.94-3.29)		0.92 (0.43-1.97)	
Jealous		0.088		0.146
No	1.0		1.0	
Yes	1.56 (0.93-2.60)		1.45 (0.87-2.40)	
Controlling		0.015		0.360
No	1.0		1.0	
Yes	1.83 (1.12-3.00)		1.28 (0.74-2.22)	
Refuses to use a condom		0.010		0.019
No	1.0		1.0	
Yes	1.89 (1.16-3.09)		1.77 (1.10-2.86)	
Father of the newborn		0.002		0.000
No	2.90 (1.49-5.63)		2.87 (1.61-5.13)	
Yes	1.0		1.0	

Source: Authors.

Table 4. Crude and adjusted analysis of the effects of partner socioeconomic and behavioral characteristics on physical violence during pregnancy. Cariacica-ES, August to October 2017.

Variables	Physical violence			
	Crude analysis		Adjusted analysis	
	Crude PR* (95%CI)	P-value	Adjusted PR (95%CI)	P-value
Paid work		0.004		0.009
No	2.95 (1.40-6.20)		2.70 (1.27-5.72)	
Yes	1.0		1.0	
Alcohol consumption		0.203		0.455
No	1.0		1.0	
Yes	1.64 (0.76-3.50)		1.34 (0.62-2.88)	
Jealous		0.092		0.175
No	1.0		1.0	
Yes	2.01 (0.89-4.53)		1.75 (0.78-3.95)	
Refuses to use a condom		0.018		0.037
No	1.0		1.0	
Yes	2.47 (1.17-5.21)		2.22 (1.04-4.71)	

Source: Authors.

Table 5. Crude and adjusted analysis of the effects of partner socioeconomic and behavioral characteristics on sexual violence during pregnancy. Cariacica-ES, August to October 2017.

Variables	Sexual violence			
	Crude analysis		Adjusted analysis	
	Crude PR* (95%CI)	P-value	Adjusted PR (95%CI)	P-value
Controlling		0.070		0.229
No	1.0		1.0	
Yes	3.54 (0.90-13.93)		2.33 (0.58-9.22)	
Refuses to use a condom		0.005		0.005
No	1.0		1.0	
Yes	9.36 (1.97-44.31)		9.36 (1.97-44.31)	

Source: Authors.

The social norms that establish gender roles assign men the role of provider. Men who do not have a job or source of income are more likely to make threats and commit physical violence as a way of dominating and exercising power over the woman and family[8,10,25]. In a study interviewing men being prosecuted for IPV, the respondents emphasized that providing for the family is a male activity and that women should not do paid work. Working women living with unemployed men may therefore be more likely to experience episodes of violence, including physical violence[8,20].

In addition, pregnancy leads to an increase in the number of family members. For men who perpetrate violence against women, this factor may act as a threat to their masculinity, as they may find themselves unable to carry out the socially-conditioned function of partner/provider and father. The lack of policies that provide women and couples with the enabling conditions to perform the roles of motherhood and fatherhood in a responsible and safe manner may also act as an aggravating factor[26].

Our findings also show that the prevalence of psychological, physical, and sexual violence was also higher among women whose partners refused to use a condom. Schraiber et al.[27] found that women whose partners had refused to use a condom were 0.62 times more likely to experience violence during pregnancy. This association was also observed by a study with patients in Porto Alegre in the state of Rio Grande do Sul, which showed that the frequency of physical violence was greater in women whose partners refused to use a condom[28].

Although sex in an intimate relationship is seen as obligatory by both men and women, the sexual desires of men tend to override those of women and the latter often find it difficult to negotiate sex, condom use and contraceptive methods. However, this conduct can lead to unwanted pregnancy. Women with less control over their sexual and reproductive health, where the man holds the decision-making power, experience privation and are prevented from deciding what is best for themselves[26,28,29].

A study with health professionals showed that on occasions pregnant women go to the clinic accompanied by their partners with excessive doubts and concerns about sex during pregnancy, indicating difficulties in negotiating sex and the occurrence of sexual violence during pregnancy[26]. It is also worth highlighting that men are more likely to neglect their health than women as self-care is conventionally associated with women, exposing themselves and their partners to a series of risks[30].

The findings of the present study show that the prevalence of psychological violence during pregnancy was 2.87 higher among women whose partners were not the biological father of the newborn. A study in two public maternity facilities showed that postpartum women with children from other relationships were 3.4 time more likely to experience physical violence during pregnancy[24]. Having children from other relationships can trigger disagreements as it generates insecurity and concerns of involvement with the ex-partner. The findings of a study with a group of men undergoing criminal prosecution for domestic violence revealed that some did not accept the cohabitation of children from previous relationships[10].

After adjusting for possible confounding factors, the association between the variables having

a jealous and controlling partner and violence during pregnancy was not maintained. However, studies show a strong association between IPV and controlling behavior[9,31]. A study in Ethiopia showed that pregnant women with a partner who had aggressive behavior were 2.8 times more likely to experience IPV during pregnancy (95%CI = 1.7-4.6)[31], while a study in Vitória reported that the prevalence of violence was 1.96 times higher in women with a controlling partner (95%CI = 1.50-2.62)[9]. It is important to note that women often have difficulty in realizing that they are victims of IPV and may confuse controlling behavior and jealously with love and care[32,33].

Controlling behavior is characterized by constant domination and monitoring, inhibiting forms of expression, ways of relating and dressing in clothes considered inappropriate by the partner[8]. Regardless of the type of behavior, controlling behavior distances the victim from their family and friends and other people who could potentially help them[32]. Although naturalized, controlling behaviors constitute a violation of women's rights to come and go and to dignity, harming their well-being and quality of life[8].

Another element that can trigger violence in jealously. Be it motivated by the partner's social life and family or suspicion of infidelity, jealously involves gender issues that perpetuate possessiveness[34]. Jealously can be understood as a form of understanding traditional masculinity, as it legitimizes violence when pre-established gender attributes are not observed[25].

This study has some limitations. First, the data were collected in the postpartum period, which is a time when women feel especially vulnerable, possibly resulting in the underestimation of the prevalence of violence. Second, the fact that answers to the questions on partner characteristics were responded by the postpartum women means that the answers, particularly those about behavioral characteristics, may be subject to participant bias. Finally, the fact that the study population was made up of women admitted to a public maternity facility means that the results should be interpreted with caution and should not be generalized to the overall population of postpartum women.

Conclusion

Our findings show an association between IPV during pregnancy and intimate partner socioeconomic and behavioral characteristics.

In view of the above, it is worth bearing in mind that the factors that determine the occurrence and permanence of IPV constitute a complex social dynamic in which social services must engage. The findings demonstrate the need to promote the utilization of health services by men in order to address social and behavioral risk factors for violence during pregnancy. With regard to pregnancy and the postpartum period, it is worth highlighting that the involvement partners from the beginning of antenatal care is essential, as it is an opportune time to approach men about health care and offer treatment.

With regard to aggressive partners, there is an urgent need to discuss how to approach this issue in health services and develop effective multi-sectorial actions that promote changes in behavior within family and social relations. In this respect, improving understanding among health professionals about IPV during pregnancy can help enable the adoption of individual and collective violence prevention and coping strategies. Finally, actions to change individual attitudes and behavior need to be developed in networks in order to safeguard rights and ensure the provision of adequate care.

Collaborations

FMC Leite was responsible for study conception. FMC Leite and RP Silva were responsible for developing the study, data collection, analysis and interpretation, and drafting this article. ET Santos-Netto and SF Deslandes contributed to data interpretation and the drafting and revision of the manuscript. All authors approved the final version of this manuscript and declare responsibility for all aspects of this work, including its accuracy and integrity.

Acknowledgements

Fundação de Amparo à Pesquisa e Inovação do Espírito Santo – FAPES (call for proposals FAPES/CNPq 04/2017. Code 80641393/2017).

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Article submitted 01/12/2020
Approved 15/06/2021
Final version submitted 17/06/2021

Chief editors: Romeu Gomes, Antônio Augusto Moura da Silva