Artículo de Revisión

Intimate partner violence against women during pregnancy: a critical reading from a gender perspective

Violencia de la pareja íntima contra las mujeres en el embarazo: una lectura crítica con perspectiva de género

Violência por parceiro íntimo contra mulheres durante a gravidez: uma leitura crítica a partir de uma perspectiva de gênero

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ABSTRACT

This paper conducted a critical review from a gender perspective, identifying selected studies addressing intimate partner violence against women during pregnancy. Seventy-two studies from 23 countries between 1994 and 2013 were analyzed. Intimate partner violence in pregnancy is associated with obstetric and birth complications, mental health consequences, and effects on the newborn as low birth growth. Countries with lower human development scores show higher rates of these ramifications. Socio-demographic conditions such as educational level, social status, age and marital status appear associated. While in most countries pregnancy reduces partner violence, there are exceptions suggesting that it is not necessarily a protective factor. The significance given to motherhood and pregnancy in different social groups and the level of presence of patriarchal relations may offer an explanation for this phenomenon. Psychological violence is the most frequently reported. Research must strengthen the qualitative approach. Ongoing issues in contexts where intimate partner violence increase and where physical violence prevails during pregnancy require to be studied. It is imperative to train health providers to detect and prevent intimate partner violence. It is required to consider the empowerment of women as a central axis in sexual and reproductive health.

Palabras clave: domestic violence, pregnancy, sexual and reproductive health.

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RESUMEN

Este artículo presenta una revisión crítica, basada en la perspectiva de género, en la que se identificaron y seleccionaron estudios sobre violencia de la pareja íntima en el embarazo. Se analizaron 72 artículos provenientes de 23 países, publicados entre 1994 y 2013. La violencia de la pareja íntima durante el embarazo se asocia con complicaciones obstétricas y del parto, tiene consecuencias sobre la salud mental y efectos en el recién nacido como bajo peso al nacer. Los países con puntajes más bajos de desarrollo humano muestran tasas más altas de estas implicaciones. Se ven asociadas condiciones sociodemográficas como el nivel educativo, el estatus social, la edad y el estado civil. Si bien en la mayoría de los países, en el embarazo se reduce la violencia de pareja, hay excepciones que sugieren que no es necesariamente un factor protector. La importancia dada a la maternidad y el embarazo en diferentes grupos sociales y el nivel de presencia de relaciones patriarcales pueden ofrecer una explicación a este fenómeno. La violencia psicológica es la más frecuentemente reportada. La investigación en este campo debe fortalecer el enfoque cualitativo. Los contextos en que se incrementa la violencia de pareja y donde prevalece la violencia física durante el embarazo requieren ser estudiados. Es imprescindible capacitar a los proveedores de salud para detectar y prevenir la violencia de pareja. Es necesario tener en cuenta la autonomía de la mujer como un eje central en la salud sexual y reproductiva.

Key words: violencia doméstica, embarazo, salud sexual y reproductiva.

RESUMO

Este trabalho realiza uma análise crítica a partir de uma perspectiva de gênero, identificando estudos selecionados que apresentam violência por parceiro íntimo contra mulheres durante a gravidez. Setenta e dois estudos de 23 países, entre 1994 e 2013, foram analisados. Violência por parceiro íntimo na gestação está associada a complicações obstétricas e no parto, consequências para a saúde mental e efeitos no recém-nascido, como baixo crescimento ao nascer. Países com pontuações mais baixas de desenvolvimento humano apresentam maiores taxas dessas ramificações. Condições sócio-demográficas aparecem associadas, tais como: nível educacional, status social, idade e estado civil. Enquanto na maioria dos países a gestação reduz violência por parceiro, há exceções que sugerem que não é, necessariamente, um fator de proteção. O significado dado para maternidade e gravidez em diferentes grupos sociais, e o nível de presença de relações patriarcais podem oferecer uma explicação para este fenômeno. Violência psicológica é a mais frequentemente relatada. A pesquisa deve fortalecer a abordagem qualitativa. Situações em andamento, em contextos onde a violência por parceiro íntimo aumenta e onde a violência física prevalece durante a gestação, devem ser estudadas. É necessário treinar profissionais de saúde para detectarem e impedirem violência por parceiro íntimo. Assim como é necessário considerar o fortalecimento das mulheres como um eixo central na saúde sexual e reprodutiva.

Palavras-chave: violência doméstica, gestação, saúde sexual e reprodutiva.

INTRODUCCIÓN

The study of intimate partner violence (IPV) during pregnancy represents a field of inquiry of crucial importance because violence involves women in the course of one of the most complex processes of their existence. Violence contributes to personal injuries, affects the fetus and impacts the newborn's health.

Throughout this paper, conceptual issues that expand the understanding of this phenomenon are identified with particular emphasis in the field of sexual and reproductive health. Trends and research findings are described, and models and tools that have been implemented in the recognition of this issue are noted, that can guide future studies.

Violence against women constitutes a violation of human rights. In the first article of the Declaration on the Elimination of Violence Against Women, the United Nations defines violence against women as '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 in private life' (1).

The relationship between women's rights and sexual and reproductive health, as well as the need to address violence against women, are central aspects of the social policy of the United Nations. These aspects were highlighted both in the Cairo International Conference on Population and Development (ICPD) held in 1994 (2) and the Fourth Conference on Women in Beijing in 1995 (3).

Women's health and lives are seriously threatened by gender-based violence (4-5). The prevalence and frequency of intimate partner violence and sexual violence against women represent a serious public health problem (6). Advances in research have recognized that there is a close relationship between gender-based violence against women and aspects that affect their sexual and reproductive health (7-9). Gender-based violence is associated with sexual and reproductive health issues that include pelvic inflammation, unwanted pregnancies, abortions and sexually transmitted infections (10).

One in every three women in the world is likely to be abused in some way and women of reproductive age face the greatest consequences. Violence can be associated with the inability to prevent unwanted pregnancies, miscarriages, or abortions. One in four women may suffer violence during pregnancy in their domestic environment (7).

The violence inflicted on a woman during pregnancy has detrimental effects on the quality of life of the mother and her child (11). The Pan American Health Organization, PAHO, contends that domestic violence against women during pregnancy can cause cervical, vaginal and uterine damage, vaginal bleeding, abdominal trauma, hemorrhage, low birth weight, abortion and death of mother and child (12).

According to the Center for Disease Control of the United States, (CDC), pregnancy may represent a unique opportunity for the vulnerable woman to have contact with health care providers, making it an important time for the detection of patients who experience violence during and after the pregnancy (13).

While there are studies that reveal that fewer women in some countries experience less violence during pregnancy, the International Federation of Gynecology and Obstetrics (FIGO) notes that in Latin America, women living in a violent relationship are forced into adopting a careless attitude towards their own body. They are exposed to unwanted pregnancies and sexually transmitted diseases. They are beaten during pregnancy and forced to have sex even at the beginning of birth (14).

Given the importance of advances in research related to the nature and patterns of intimate partner violence against women during pregnancy, including its consequences, a review oriented by a critical analysis with a focus on gender was developed. The review began with the assumption that violence during pregnancy, while closely reflecting patriarchal paradigms associated with gender relations, is a global phenomenon that is more widespread in countries where the culture of subjugation of women prevails. With respect to patterns and the factors associated with gender violence in pregnancy, it is anticipated that common situations could occur in different contexts since both, maternity and pregnancy, are mediated by universal values traversed by gender constructions. On the other hand, different representations according to the local conditions and the views on violence and its expressions may vary between cultures (15).

This inquiry process has been built based on a study of scientific literature produced in different regions of the world since 1994, when the Declaration on the Elimination of Violence Against Women was adopted in United Nations (1), marking a turning point in the global recognition of the phenomenon. The review was conducted between January, 1994 and December, 2013, of health databases in Spanish, English and Italian obtaining 72 references of studies referring to intimate partner (domestic or spousal) violence in pregnancy.

METHODOLOGY

Utilizing a critical review from a gender perspective, intimate partner violence (IPV) against women during pregnancy was identified. The analysis is based on a documentary study on research advances that allows a reflection on trends and gaps. Its preparation involves the development of a hermeneutical methodology summarized in three major steps: contextualization, classification

and categorization (16). Studies were chosen that addressed intimate partner (domestic or spousal) violence against women during pregnancy, published in scientific journals between 1994 and 2013. The keywords queried were: pregnancy, pregnant, intimate partner violence, domestic violence and spousal violence.

A search for articles and scientific reports in English, Spanish and Italian was completed utilizing the following health databases: Bireme, Redalyc, Index, Medline, Publine, Pubmed, Medscape, SciELO, Dialnet, Inbiomed, Lilacs, NIH, Epub, Nursing Consult, Friuli-Venezia-Giulia and EMBASE. A total of 72 items were identified and properly classified according to the following parameters: 1) region and country of origin of production, 2) methods and tools of approach, 3) background 4) prevalence and associated factors, 5) patterns and expressions of violence and 6) prominent findings. From these classifications, an analytical process explored the research developments in the light of methodological trends, the most significant findings, future prospects and gaps in knowledge, leading to a comprehensive review.

MAIN FINDINGS

There is a diversity of approaches and findings aiming to uncover the antecedents and effects of violence perpetrated against women during pregnancy. The interest of sexual and reproductive health in this matter is evident in different regions of the world.

In the 1980s and early 1990s research in intimate partner violence in pregnancy was carried out predominantly in developed countries. Only after the second part of the 1990s and into the 2000s is there evidence of a decisive global advance (17-19). The developments in gendered international politics, derived from the Conference on Population and Development in Cairo (2) and the Beijing Women´s Conference (3), marked the construction of a favorable perspective to addressing violence against women as a public health problem that ostensibly affect their sexual and reproductive health.

Seventy-two papers from 23 countries, published between 1994 and 2013, were analyzed. Table 1 represents the results categorized according to regions and countries where studies were focused and the number of papers.

Region	Country	Number of papers
Europe		**12**
	England	3
	Spain	4
	Italy	2
	Turkey	1
	Germany	1
	Belgium	1
Australia		**3**
	Australia	3
Asia		**11**
	China	3
	Hong Kong	3
	Iran	1
	Bangladesh	1
	India	1
	Lebanon	1
	Taiwan	1
Africa		**9**
	Nigeria	3
	Kenya	2
	Tanzania	1
	South Africa	1
	Uganda	1
	Zimbabwe	1
North America		**19**
	United States	13
	Canada	6
Latin America		**18**
	Mexico	5
	Argentina	1
	Brazil	1
	Colombia	3
	Costa Rica	1
	Chile	1
	Bolivia	1
	Ecuador	1
	Guatemala	1
	Nicaragua	1
	Peru	1
	Venezuela	1
Total		**72**

Table 1. Analyzed papers focused on intimate partner violence in pregnancy by countries and region

Note that in the analyzed studies, 37 come from American countries (19 from North America and 18 from Latin America); 12 from Europe; nine from Africa; 11 from Asia and two from Australia.

About themes, methods and tools of approach

Exploration of the relationship of intimate partner violence with maternal and perinatal complications and effects on the newborn is the main interest of research in the analyzed studies. The establishment of risk factors and associated factors with the phenomenon represents another important aspect of IPV research that occurs during pregnancy. There are some studies that are centered on patterns that characterize the type of violence such as physical, psychological/emotional, sexual and verbal. Other studies are oriented to compare the violence before, during and after pregnancy and establishing whether violence increases, decreases or remains the same with the advent of pregnancy. Some approaches are geared to knowing the perspective of women or health staff. Finally, relatively few reported therapeutic techniques, education programs, or social interventions that minimize the presence of violence.

Different methodologies and varying paradigms of approach were considered. The types of studies reviewed, are presented in Table 2.

Type of approach	Number of studies (n=72)
Prevalence studies/associated factors	43
Case-control analysis/cohorts analysis	5
Correlational studies/predictive studies	2
Prospective studies/longitudinal studies	5
Systematic reviews	5
Quasi-experiment studies	2
Qualitative analysis	4
Analysis of medical records	2
Analysis of police reports and legal documents	2
Topic review	2

Table 2. Studies by type of approach

Published research papers have been primarily from the quantitative paradigm, most commonly descriptive studies. Cross-type approaches focused on the analysis of prevalence and associated factors. Studies addressing intimate partner violence against women during pregnancy, are consistent with the exploratory nature present in many of the works found that have included correlational studies. There were few qualitative studies focused on the experiences of women and/or health staff.

Frequently used surveys in intimate partner violence against women in pregnancy research include the five-item Abuse Assessment Screen (AAS), useful in the detection of physical, emotional, and sexual violence (19-23). WHO´s 'Multi-Country Study on Women's Health and Domestic Violence' looks at violence against women from a public health perspective (24-25). The international comparative surveys 'Demographic and Health Surveys' are used to explore women´s health including gender violence events (18). The 'International Violence against Women Surveys' is based on three time frames: adult lifetime, the five preceding years and the 12 months preceding the survey (18). In the United States, a frequently used instrument is the 'Pregnancy Risk Assessment Monitoring System' (PRAMS) created for the Centers of Diseases Control and Prevention (CDC) to collect women's experiences and attitudes during and after pregnancy (18-19, 26). Mexico commonly uses the National Survey Violence against Women to detect intimate partner violence against women in public health services (27-28).

An approach around prevalence data for IPV during pregnancy

Despite the lack of quantitative parameters for comparison, the prevalence data from 42 of the studies represents an important and interesting finding for the analysis. The lower prevalence of intimate partner violence during pregnancy (1.2%) was found in a population study conducted in Vancouver, Canada with 4,750 women from local hospitals (29); the higher prevalence (63.1%) was found in a study with 2042 post-natal low-income women in Zimbabwe (30).

In Europe, figures ranged from 3.0%, found in a study with 200 women from prenatal and postpartum services conducted in London England (23) to 13% in Seville, Spain in a study conducted with 300 women utilizing public hospitals (31). In Brisbane, Australia, a hospital study of 1,014 women showed a prevalence of 5.8% (32) while in Melbourne, in a work that addressed 400 women, 20% incidence was recorded (33).

The highest percentage observed in African studies reviewed (63.1%) was found in the work carried out in Zimbabwe involving 2,042 low-income post-natal women in six public primary health-care clinics, where respondents reported physical, emotional and/or sexual intimate partner violence during pregnancy (30). The lowest percentage in Africa was observed in Nkagala, South Africa, in a longitudinal study with 1,502 pregnant women. During the second prenatal appointment a prevalence of 9% was found (34).

In Asia, the highest percentage was observed in the Islamic Republic of Iran where there was a prevalence of intimate partner violence during pregnancy of 42.0% (that increases to 52.5% after pregnancy), in a hospital study conducted with 300 married women (35). The lowest prevalence was found in China, where 4.3% during the approximate 9 months of pregnancy was detected in a study of 12,440 women from 32 communities (36).

The lowest prevalence in North America, 1.2%, was found in Vancouver, Canada in a study with 4,750 women from local hospitals (29). A 6% prevalence was found in a study conducted in the United States by the University of Texas with 16,041 women (37). In Latin America, the lowest prevalence (18.3%) was found in a hospital study conducted with 672 women from southern Brazil (38), while the highest (44.4%) was found in a study with 163 hospitalized women from Arica, Chile (39).

Devries et al. who analyzed data in 2010 from 19 countries, states that the prevalence rates appear to be higher in African and Latin American countries compared to European and Asian countries (18). The information presented in this subchapter is consistent with the finding of that author.

Patterns of intimate partner violence in pregnancy

One aspect that separates the analyzed studies is whether or not intimate partner violence against women increases during pregnancy. It seems that although the intimate partner violence prevalence is usually minimized during pregnancy in several countries, there are contexts where this does not occur. According to studies conducted in a variety of countries with diverse social and cultural contexts, discrepancies between violence before, during and after pregnancy are evident. Intimate partner violence commonly decreases with pregnancy (23, 35-36, 40). In Mexico, however, pregnancy does not appear to be a protective factor against couple violence (41). Intimate partner violence continues during pregnancy, although there is a change in patterns of expression (27). Similarly, in Peru, based on the results found by Tavara-Orozco and colleagues 'pregnancy seems not to be a protective factor against gender violence'(42). One in every five women surveyed suffered physical violence (42). In Italy, intimate partner violence begins during pregnancy in 15% of cases (43). 'Although pregnancy may be a protective period for some women, for a substantial minority it is a period of increased risk' conclude Taillieu and Brownridge who made from the extant research an analytical study on violence against pregnant women in both developed and developing countries (44).

Types of intimate partner violence

The differences in the expressions of violence during pregnancy contribute to an understanding of this phenomenon (41). Nineteen studies aimed at establishing a characterization of the intimate partner violence types in pregnant women. The most frequent types of violence are described in Table 3.

According to data reported by those studies, psychological violence (including verbal) appears to prevail in intimate partner violence during pregnancy (4, 21-22, 24, 27, 35, 38, 45-53). Although a psychological violent tendency is evident, reviewing the studies that focused on the types of violence that have been reported shows no evidence of a universal expression pattern and the difference between contexts (even in the same region or country)

Most frequent type of violence	Number of studies	Authors	Countries
Psychological/emotional	15	Medina-Meza, 2001 (45)	Colombia
		Castro and Ruiz, 2004 (41)	Mexico
		Mendoza et al., 2004 (27)	Mexico
		Valladares et al., 2005 (24)	Nicaragua
		Doubova et al., 2007 (4)	Mexico
		Tiwari et al., 2008 (46)	China
		Zhang et al., 2008 (22)	China
		Lau et al., 2008 (21)	Hong Kong
		López et al., 2008 (47)	Colombia
		Nunes et al., 2009 (38)	Brazil
		Mohammadhosseini et al., 2010 (35)	Iran
		Babu et al., 2012 (48)	India
		Makayoto et al., 2012 (49)	Kenya
		Ezeanochie et al.,2012 (50)	Nigeria
		Groves et al., 2012 (51)	South Africa
Verbal	2	Cloutier et al., 2002 (52)	USA (North Carolina)
		Jeremiah et al., 2011 (53)	Nigeria
Physical	2	Matseke et al., 2012 (54)	South Africa
		Arslantas, 2012 (55)	Tukey
Sexual	1	Guo et al., 2004 (36)	China

Table 3: Most frequent type of intimate partner violence in pregnancy

is noticeable. A convergence of ethnic-cultural, social, economic and gender aspects, make this particularly multifaceted. This complex phenomenon deserves in-depth exploration. For example, while in Hong Kong, psychological violence seems to be most prominent (21, 46), in Changsha, China, the prevailing type of violence detected in a longitudinal study was sexual (36). Furthermore, in a study conducted in the city of Durban, South Africa, psychological violence showed a great degree (51), while in Nkangala, a rural district in that country, physical abuse prevailed (54).

Expressions of violence, such as withholding rest and food, demands for sex, failure to provide prenatal care and 'pressure on male child' were found in a study conducted in three states of India (48). In a study developed in Nigeria, shouting and cursing was prominent (53). 'Shaming in front of her friends or family', 'ridiculing' and 'put-downs regarding appearance or behavior' are the most frequently cited examples of psychological partner abuse in women from Hong Kong while 'throwing something at her', 'pushing her' and 'slapping her' were the most common examples of physical abuse reported by the women in a prospective study involving a group of pregnant women in a teaching hospital (46).

Women's sexual and reproductive health is severely affected in contexts where IPV is frequent. Unwanted pregnancy and sexually transmitted diseases are strongly associated with IPV. In Turkey, physical violence was the most common type of violence reported. Women in an unwanted marriage suffered more from violence during pregnancy (55). A significant association between history of partner violence and a positive syphilis test among pregnant women was found in Bolivia (56). A systematic review of African studies remarks that the prevalence of IPV among pregnant women in Africa is one of the highest reported globally and that the major risk factors included human immunodeficiency virus (HIV) infection (30).

The severity of physical and sexual violence increases the chances of a failed pregnancy (57). Cuevas et al. found in four deprived areas of states in Mexico that one in three women who were victims of violence during their pregnancies was hit in the stomach (28). In Leon, Nicaragua, among those who have been victims of physical abuse (13.4%), half have been kicked and punched in the abdomen (24). These developments lead us to focus on the complexity of the intersection between violence and pregnancy. The significance given to motherhood and pregnancy in different social and cultural groups and the level of presence of patriarchal relations may offer

an explanation to this phenomenon. Which cultural contexts are associated with physical intimate partner violence during pregnancy? What kind of narratives underlies physical violence during pregnancy within the dyad?

Impact of intimate partner violence on perinatal and maternal health

Complications as a result of intimate partner violence during pregnancy can be severe, according to the studies reviewed. Table 4 summarizes the main consequences of this violence on maternal and perinatal health, based on the analysis of 21 studies.

Consequences	Type of effects
Obstetric and birth complications, and other effects on sexual and reproductive health	• Miscarriage: Jeremiah et al., 2011 (53); Johri et al., 2004 (57) • Pain / abdominal trauma: Valladares et al., 2005 (24); Johri et al., 2004 (57) • Prepartum hemorrhage: Urquía et al., 2011 (58); Janssen et al., 2003 (29) • Intrauterine growth restriction: Urquía et al. 2011 (58) • Perinatal death: Urquía et al., 2011 (58); Tavara-Orozco et al., 2007 (42) • Preterm childbirth: Lipsky et al., 2010 (40) • Increased frequency of cesarean: Tavara-Orozco et al., 2007 (42)
Mental health effects	• Symptoms of depression: Talley et al., 2006 (59); Sánchez et al., 2008 (60); Salazar-Pousada et al., 2012 (61); Mahengue et al., 2013 (62) • Postpartum depression: Urquía et al., 2011 (58); Quelopana et al., 2012 (39); Ramirez, 2012 (63) • Emotional distress: Groves et al., 2008 (51)
Effects on the newborn	• Low birth weight: Campbell et al., 1999 (64); Bohn et al., 2002 (65); Yost et al., 2005 (37); Lipsky et al., 2010 (40); Núñez-Rivas et al., 2003 (66); Nunes et al., 2009 (38) • Neonatal death: Lipsky et al., 2010 (40)
Neuroendocrine effects on mother and child	• Alterations in the relationship of hypothalamic-pituitary-adrenal-placental axis in mother: Talley et al., 2006 (59) • Increased excitatory and inhibitory levels in the newborn: Zhang et al., 2008 (22)

Table 4: Maternal and perinatal health consequences of violence in pregnancy

According to this review, intimate partner violence in pregnancy is associated with obstetric and birth complications and other effects on sexual and reproductive health (24, 29, 40, 42, 53, 56, 58, 64), mental health consequences (51, 58-63), the newborn (37-38, 40, 64-66), and neuroendocrine ramifications on mother and child (59). It is crucial to highlight the implications for the newborn, given that low birth weight is closely associated with these cases (19, 67). Low birth weight can be responsible for neonatal, infant and child mortality and morbidity in early life. It is also responsible for inhibited growth, impaired cognitive development, and chronic health problems in later life (68).

Neuroendocrine effects on mother and child are another effect of intimate partner violence in pregnancy. Despite the lack of absolute differences in blood levels, maternal experience of stress alters the relationship of hypothalamic-pituitary-adrenal-placental axis hormones. In battered women, beta-endorphin and ACTH levels showed a significant linear relationship but not in non-battered women (59). One study showed neuroendocrine effects in neonates. Zhang et al., identified a significant positive correlation between the severity of psychological abuse in pregnancy and plasma amino acid levels and cortisol in neonates. This conclusion reveals that domestic violence in pregnancy can alter the excitatory and inhibitory levels and change neuroendocrine function in infants. Newborns with high levels of these stress-related hormones appear to result from intimate partner violence in pregnant women (22).

Factors associated with intimate partner violence during pregnancy

One of the most prominent associated factors identified with intimate partner violence during pregnancy is the low educational level of women (50, 61, 69-71). Compounding the effect is the women's low socioeconomic status (24, 27, 36, 47, 65). Multiparity was also associated with violence during pregnancy in several African countries (49, 54). In Nigeria, however, it is noteworthy that low parity becomes a risk factor (53). Maternal age under 19 years is a contributing risk factor in the urban area of Bangladesh (72) and Mexico (45).

Marital status is a relevant demographic factor in England (23), Australia (69), South Africa (54) and Mexico (27, 60), where not to be married or cohabitating is associated with increased partner violence during pregnancy. Partner characteristics identified as contributing factors include: alcohol and/or psychoactive substance use (28, 30, 48-49, 71), low education level (49, 50, 72) and low income (27). In India suspected infidelity, use of alcohol in the partner, dowry harassment and low education are factors associated with partner violence (73).

In Iran (35) and Hong Kong (74), a history of abuse of women during pregnancy often includes conflicts with their partner's family. In Taiwan, a patriarchal family is one of the main associated factors with partner violence during pregnancy (71). In Bangladesh, the history of intimate partner abuse of their mothers and their mothers-in-law is among the strongest determinants of a woman being abused during pregnancy by their husbands. Patriarchal attitudes of both families (spouses' families, although most clearly those of the husband's family), seem to indicate an association between dowry demand and violence (25).

In London, in a qualitative study that included 16 women, participants reported that the abuse within the relationship was centered around the arrival and care of the newborn. Financial concerns, decreasing physical and emotional availability of a woman during pregnancy, lack of practical and emotional support from the male partner and doubts about parenting increases risks of violence (75). In Germany in a study based on 19 in-depth semi-structured qualitative interviews with women who experienced violence during pregnancy, women perceived pregnancy as a turning point; it reduces "women's acceptance of their partner's unemployment, alcohol abuse and lack of relationship commitment or by increasing women's vulnerability because they felt too young to raise a child alone" (76).

Socio-demographic conditions such as education, economic status, age, parity and marital status, as well as having a partner who uses psychoactive substances or alcohol, appear as prominent risk factors of violence during pregnancy in different contexts and cultures.

The perspective of health staff and interventions in intimate partner violence

It is necessary to improve women's awareness regarding abuse and their help-seeking behavior at a public health level (77). Routine perinatal care visits offer opportunities for healthcare professionals to screen and refer abused women to effective interventions (78-79). Although there is importance given to intimate partner violence in pregnancy, a lack of time and clear recommendations for screenings often limit providers of antenatal services asking women specific information (19). Studies found that less than half of the providers in the United States routinely screen for violence during pregnancy at the time of the prenatal visit and usually only under the suspicion of violence. Physicians' reluctance to screen can be explained by not knowing how to respond if a woman discloses violence and reflects a lack of training (80). While health team members are knowledgeable about the phenomenon of violence in pregnancy and its relevance, they often feel unprepared for detection as well as being unprepared for their perceived required responses (81-83). Institutional training and coordination beyond the individual provider's contact is needed (83). Prenatal care providers should be encouraged to screen their patients for intimate partner violence and assure that women in abusive situations are offered appropriate services and interventions, working with others in their community. In addition, it is important to include alternatives to staying in unsatisfactory relationships with abusive partners, which are safe and feasible (52).

A review that included nine randomized trials involving 2,391 women found interventions in intimate partner violence during pregnancy consisting of brief individualized consultation, case management and referral to a social worker and multiple therapies. Due to a reported lack of data and the different way outcomes were reported, it is difficult to identify methods that are more effective than others. Studies are required to focus on evaluating the development and effectiveness of interventions to find consistent evidence (79).

CONCLUSIONS AND RECOMMENDATIONS

Intimate partner violence in pregnancy causes complications and other effects on sexual and reproductive health, has mental health consequences, affects the newborn and has neuroendocrine ramifications on mother and child.

There is no doubt, upon evaluating research on intimate partner violence during pregnancy, that the large number of factors that are associated with this violence is present in all regions of the world, in various contexts, making this a highly complex phenomenon.

Aspects closely linked to structural patterns immersed in violence during pregnancy, such as women's education and social status, age and parity, suggest an association between this form of violence and imbalances in terms of social and gender equality. In developing countries, women seem to be abused the most during their pregnancies.

Although the diversity in relation to expressions of intimate partner violence was noticeable, similar associated factors were found in different cultures and contexts, which are findings of great interest. The realities associated with gender, such as undervaluation of women, are transcultural and are often tied to patriarchy, a belief system reinforced by cultural values derived from systems of male dominance that survives as a universal way of human inequality (84). Psychological violence is the most frequent form of violence detected. It not only affects the women but the mother-child unit, giving continuity to a dynamic of abuse that begins for many human beings before birth, since serious effects on the fetus and newborn have been identified.

While in most countries pregnancy reduces violence against women, there are exceptions that suggest that this is not necessarily a protective factor. Ongoing issues in contexts where intimate partner violence seems to increase and where physical violence prevails during pregnancy require further study. It is necessary to deepen the qualitative understanding of the contexts where violence is higher during pregnancy. Women´s narratives about their experiences should be explored to contribute to a greater understanding of this phenomenon.

Intimate partner violence during pregnancy is a form of violence against women that must be faced from a sexual and reproductive health point of view, recognizing it as a severe health problem that deserves to be understood and studied. It requires comprehensive screening protocols integrating sociocultural aspects that guide the development and provision of services. It is imperative to train health providers in this field.

Research must support the development of policies and programs related to prevention and social intervention to include a gender perspective, looking to examine women in their reality. Contexts and meanings have a crucial importance in the world of research on gender violence in pregnancy.

In sexual and reproductive health, it is important to consider the empowerment of women and the recognition of their rights as a central axis (55). Interventions that address prevalent norms of masculinity and femininity are needed, because commonly, violence against women is gender-based. Such action can help address community factors as well as interpersonal factors (7). 'Consciousness about their rights makes women stronger and better suited to act in the face of abuse' (5).This approach will encourage women to take control of their lives and will reinforce the idea that pregnancy, giving birth and being born, should represent joyful occasions, not scenarios where intimate partner violence can takes place.

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REFERENCES

1. United Nations. Declaration on the Elimination of Violence against Women, 1994.
2. United Nations. Cairo International Conference on Population and Development, 1994.
3. United Nations. Fourth Conference on Women, 1995.

4. Doubova SV, Pámanes-González V, Billings D, Torres-Arreola LP. Violencia de pareja en mujeres embarazadas en la Ciudad de México. Rev Saúde Pública, 2007, 41(4), 582-590.

5. Lafaurie MM, Betancourt Z, Tovar P. Achik Ñan (Luminous trail). The sexual and reproductive health of Chimborazo women, Bogota: Fundación ESAR, 2009.

6. Panamerican Health Organization, PAHO. Preventing intimate partner and sexual violence against women: taking action and generating evidence, 2010.

7. De Bryn M. La Violencia, el embarazo y el aborto. Cuestiones de salud pública. Second Ed. Chapel Hill, NC: IPAS, 2003.

8. Lafaurie MM. Tras la detección y prevención de la violencia contra la mujer: el compromiso de la ginecología y la obstetricia. Rev Col Obs Ginec, 2008, 59 (1), 8-9.

9. Ortega-Ceballos PA, Mudgal J, Flores Y, Rivera-Rivera L, Díaz-Montiel JC, Salmerón J. Determinantes de violencia de pareja en trabajadoras del IMSS Morelos. Salud Pública Méx, 2007, 49(5):357-366.

10. Langer A, Nigenda G. Salud sexual y reproductiva. Reforma del Sector Salud en América Latina y el Caribe. Desafíos y oportunidades. Population Council, Instituto Nacional de Salud Pública, Banco Interamericano de Desarrollo, 2000.

11. Kendall-Tackett KA. Violence against women and the perinatal period: the impact of lifetime violence and abuse on pregnancy and postpartum. Trauma Psychology Newsletter. Trauma Violence Abuse, 2007, 8 (3):344-353.

12. Panamerican Health Organization, PAHO. Domestic violence during pregnancy. Fact Sheet, 2002.

13. Center for Disease Control. Intimate partner violence during pregnancy. A guide for clinicians. (Web Site) 2009 (Retrieved 22 September 2012) Available: http://www.cdc.gov/reproductivehealth/violence/intimatepartnerviolence/sld001.htm#2

14. International Federation of Ginecolgy and Obstetrics (Federación Internacional de Ginecología y Obstetricia), FIGO. Grupo de trabajo violencia contra la mujer. Rev. Chil. Obstet. Ginecol, 2002, 67(2): 170-171.

15. WHO. Violence prevention the evidence. Changing Cultural and social norms that support violence, 2009.

16. Molina NP. Qué es un estado del arte. Salud Visual y Ocular, 2005, 5: 73-75.

17. Jasinsky J. Pregnancy and domestic violence. A review of the literature. Trauma, Violence, & Abuse, 2004, 5, (1): 47-64.

18. Devries KM, Kishor S, Johnson H, Stöckl H, Bacchus LJ, García-Moreno C et al. Intimate partner violence during pregnancy: analysis of prevalence data from 19 countries. Reprod Health Matters, 2010, 18 (36): 158-70.

19. Bailey BA. Partner violence during pregnancy: prevalence, effects, screening, and management. J Womens Health, 2010, 2: 183–197.

20. Gyuse ANI, Ushie AP. Pattern of domestic violence among pregnant women in Jos, Nigeria. SA Fam Pract, 2009, 51 (4): 343-345.

21. Lau Y, Keung Wong DF, KS Chan. The impact and cumulative effects of intimate partner abuse during pregnancy on health-related quality of life among Hong Kong Chinese women. Midwifery, 2008, 24(1): 22-37.

22. Zhang Y, Zhang YL, Zou SH, Zhang XH, Cao YP, Yang SC. Correlation between domestic violence in pregnancy and the levels of plasma amino acids and cortisol in the neonates. Zhonghua Nei Ke Za Zhi. 2008, 47(3):209-212.

23. Bacchus L, Mezey G, Bewley S. Domestic violence: prevalence in pregnant women and associations with physical and psychological health. European Journal of Obstetrics & Gynecology and Reproductive Biology, 2004, 113: 6-11.

24. Valladares E, Peña R, Persson LA, Högberg U. Violence against pregnant women: prevalence and characteristics. A population-based study in Nicaragua. BJOG, 2005, 112(9):1243-1248.

25. Tabassum NR, Persson L. Factors associated with physical spousal abuse of women during pregnancy in Bangladesh. IFPP, 2008, 34(2):289-300.

26. Martin SL, MackyeL, Kupper LI, Buescher PA, Moracco KE. Physical abuse of women before, during, and after pregnancy. JAMA, 2001, 285(12):1581-1584.

27. Mendoza M, Martinez G, Pizano ML, Lartigue T. Violencia de género, embarazo y autoestima en un área urbana de la ciudad de México. Rev. Enferm. Herediana 2008, 01 (1), 40-47.

28. Cuevas S, Blanco J, Juárez C, Palma O, Valdez-Santiago R. Violencia y embarazo en usuarias del sector salud en estados de alta marginación en México. Salud Pública Mex, 2006, 48 (2): S239-S249.

29. Janssen P, Holt V, Sugg N, Emanuel I, Critchlow C, Henderson A. Intimate partner violence and adverse pregnancy outcomes: a population-based study. Am J Obstet Gynecol, 2003, 188:1341-1347.

30. Shamu S, Abrahams N, Zarowsky C, Shefer T, Temmerman M. Intimate partner violence during pregnancy in Zimbabwe: a cross-sectional study of

prevalence, predictors and associations with HIV Trop Med Int Health, 2013, 18(6):696-711.

31. Alonso MJ, Bedoya JM, Cayuela A, Dorado MI, Gómez MC, Hidalgo D. Violencia contra la mujer. Resultados de una encuesta hospitalaria. Prog Obstet Ginecol, 2004, 47 (11), 511-520.

32. Taggart L, Mattson S. Delay in prenatal care as a result of battering in pregnancy: cross-cultural implications. Health Care for Women Int., 1996, 17(1): 25-34.

33. Walsh D. The hidden experience of violence during pregnancy: a study of 400 pregnant Australian women. Australian Journal of Primary Health 2008, 14(1): 97-105.

34. Matseke G, Peltzer K, Mlambo G. Partner violence and associated factors among pregnant women in Nkagala district South Africa. Human Sciences Research Council, Southafrica. (Online) 2012 (Retrived August 7, 2013) Available: http://www.hsrc.ac.za/Research_Publication-22342.phtml

35. Mohammadhosseini E, Sahraean L, Bahrami T. Domestic abuse before, during and after pregnancy in Jahrom, Islamic Republic of Iran. EMHJ, 2010, 16 (7): 752-758.

36. Guo SF, Wu JL, Qu C, Yan RY. Domestic abuse on women in China before, during, and after pregnancy. Chin Med J (Engl), 2004, 117(3): 331-336.

37. Yost NP, Bloom SL, McIntire DD, Leveno KJ. A prospective observational study of domestic violence during pregnancy. Obstet Gynecol. 2005, 106(1):61-65.

38. Nunes MA, Camey S, Ferri CP, Manzolli P, Manenti CN, Schmidt MI. Violence during pregnancy and newborn outcomes: a cohort study in a disadvantaged population in Brazil. European Journal of Public Health, 2009, 21(1), 92-97.

39. Quelopana AM. Violence against women and postpartum depression: the experience of Chilean women. Women Health, 2012, 52 (5), 437-53.

40. Lipsky S, Holt VL, Easterling TR, Critchlow CW. Impact of police-reported intimate partner violence during pregnancy on birth outcomes. Interpers Violence, 2010, 25(10):1928-1940.

41. Castro R, Ruiz A. Prevalencia y severidad de la violencia contra mujeres embarazadas, México. Rev Saúde Pública, 2004, 38(1),62-70.

42. Tavara-Orozco L, Zegarra-Samamé T, Huamaní S, Félix F, Espinoza-Tarazona K, Chumbe-Ruiz O et al. Repercusiones maternas y perinatales de la violencia basada en género. Rev Per Ginecol Obstet, 2007, 53: 10-17.

43. Istituto Nazionale di Statistica ISTAT. 2007. La violenza e i maltrattamenti contro le donne dentro e fuori la familia, anno 2006 (Web Site) 2007(Retrieved August 9, 2013) Available: http://www3.istat.it/salastampa/comunicati/non_calendario/20070221_00/testointegrale.pdf-

44. Taillieu T, Brownridge D. Violence against pregnant women: prevalence, patterns, risk factors, theories, and directions for future research. Aggression and Violent Behavior 2010, 15: 14–35.

45. Medina-Meza P, Martínez-Salgado JC, Suarez-Rodríguez JC, Castro-Naranjo LJ, Muriel-Perea YY, Obando-Gómez NN. Violencia física y psicológica contra la mujer embarazada. Educ Invest Enf , 2001, 19(1): 18.

46. Tiwari A, Chan KL, Fong D, Leung WC, Brownridge DA, Lam H, et al. The impact of psychological abuse by an intimate partner on the mental health of pregnant women. BJOG, 2008, 115:377-384.

47. López S, Gómez-Sánchez PI, Arévalo-Rodríguez I. Violencia contra la mujer. Análisis en el Instituto Materno Infantil de Bogotá, Colombia, 2005. Estudio de corte transversal. Rev Colomb Obstet Ginecol, 2007, 59(1): 10-19.

48. Babu BV, Kar SK. Abuse against women in pregnancy: a population-based study from Eastern India. WHO South-East Asia Journal of Public Health, 2012, 1(2):133-143.

49. Makayoto LA, Omolo J, Kamweya AM, Harder VS, Mutai J. Prevalence and associated factors of intimate partner violence among pregnant women attending Kisumu District Hospital, Kenya. Matern Child Health J. 2012, 17, (3): 441-447.

50. Ezeanochie MC, Olagbuji BN, Ande AB, Kubeyinje WE, Okonofua FE. Prevalence and correlates of intimate partner violence against HIV-seropositive pregnant women in a Nigerian population. Acta Obstet Gynecol Scand, 2011, 90 (5):35-539.

51. Groves AK, Kagee A, Maman S, Moodley D, Rouse P. Associations between intimate partner violence and emotional distress among pregnant women in Durban, South Africa. J Interpers Violence, 2012, 27 (7):1341-1356.

52. Cloutier S, Martin SL, Moracco KE, Garro J, Clark KA, Brody S. Physically Abused pregnant women's perceptions about the quality of their relationships with their male partners. Women Health, 2002, 35:149-163.

53. Jeremiah I, Kalio GB, Oriji VK. Domestic violence in pregnancy among antenatal attendees at the University of Port Harcourt Teaching Hospital, Port Harcourt. Niger J Med. 2011, 20(3):355-359.

54. Matseke G, Peltzer K, Mlambo G. Partner violence and associated factors among pregnant women in Nkagala

district South Africa, Human Sciences Research Council, Suráfrica (Web Site) 2012 (Retreived November 03 2012) Available: http://www.hsrc.ac.za/Research_Publication-22342.phtml

55. Arslantas H, Adana F, Ergin F, Gey N, Biçer N, Kiransal N. Domestic violence during pregnancy in an eastern city of Turkey: a field study. J Interpers Violence, 2012, 27(7):1293-1313.

56. Díaz-Olavarrieta C, Wilson KS, García SG, Revollo R, Richmond K, Paz F, et al. The co-occurrence of intimate partner violence and syphilis among pregnant women in Bolivia. J Womens Health (Larchmt), 2009 Dec;18(12):2077-86.

57. Johri M, Morales RE, Boivin JF, Samayoa BE, Hoch J, Grazioso C et al. Increased risk of miscarriage among women experiencing physical or sexual intimate partner violence during pregnancy in Guatemala City, Guatemala: cross-sectional study BMC Pregnancy Childbirth, 2011, 11: 49.

58. Urquía M, O'Campo P, Heaman MI, Janssen PA, Thiessen K. Experiences of violence before and during pregnancy and adverse pregnancy outcomes: an analysis of the Canadian maternity experiences survey. BMC Pregnancy and Childbirth, 2011, 11:42.

59. Talley P, Heitkemper M, Chicz-Demet A, Sandman C. Male violence, stress, and neuroendocrine parameters in pregnancy: a pilot study. Biol Res Nurs, 2010, 7(3): 222-233.

60. Sánchez B, Hernández M, Lartigue T. Violencia conyugal y depresión durante el embarazo. Salud Pública Méx, 2008, 50 (5): 353-354.

61. Salazar-Pousada D, Astudillo C, Gonzaga M, Hidalgo L, Pérez-López FR, Chedraui P. Intimate partner violence and psichoemotional disturbance among pregnant women admitted to hospital with prenatal complications. Int J Gynaecol Obstet, 2012,118(3):194-197.

62. Mahenge B, Likindikoki S, Stöckl H, Mbwambo J. Intimate partner violence during pregnancy and associated mental health symptoms among pregnant women in Tanzania: a cross-sectional study. BGOG, 2013, 120(8),940-946.

63. Ramirez E. Relación entre violencia de pareja contra la mujer y la aparición de depresión en el postparto. Bogotá: Universidad Nacional de Colombia, Facultad de Enfermería, Postgrados en Enfermería, Tesis de Grado para optar por el título de Magister en Enfermería, 2012.

64. Campbell J, Torres S, Ryan J, King C, Campbell D, Stallings R et al. Physical and nonphysical partner abuse and other risk factors for low birth weight among full term and preterm babies: a multiethnic case-control study. AJE, 1999, 150 (7): 714-726.

65. Bohn D, Tebben KJG, Campbell JC. Influences of income, education, age and ethnicity on physical abuse before and during pregnancy, JOGNN, 2004, 33: 561-571.

66. Núñez-Rivas HP, Monge-Rojas R, Grios-Davila C, Elizondo-Ureña AM, Rojas-Chavarría A. La violencia física, psicológica, emocional y sexual: riesgo reproductivo predictor de bajo peso al nacer en Costa Rica. Rev Panam Salud Pública/Pan Am J Public Health, 2003, 14(2): 75-83.

67. Shah PS, Shah J. Maternal exposure to domestic violence and pregnancy and birth outcomes: a systematic review and meta-analyses. J Womens Health (Larchmt), 2010, 19(11): 2017-2031.

68. Sharma M, Mishra NK. Maternal risk factors and consequences of low birth weight in infants. IOSR-JHSS, 2013, 13, (4), 39-45.

69. Webster J, Sweett S, Stolz TA. Domestic violence in pregnancy. A prevalence study. Med J Aust. 1994 Oct 17;161(8):466-70.

70. Hammoury N, Khawaja M, Mahfoud Z, Afifi A, Madi H. Domestic Violence against women during pregnancy: The case of Palestinian refugees attending an Antenatal Clinic in Lebanon. jwh, 2009, 18 (3): 337-345.

71. Yang MJ, Chou FH, Yang HM, Wei SL, Lin JR. Physical abuse against pregnant aborigines in Taiwan: prevalence and risk factors. IJNS, 2006, 43(1): 21-27.

72. Naved T, Persson L. Factors associated with physical spousal abuse of women during pregnancy in Bangladesh. Persson L. IPPF, 2008, 34 (2): 289-300.

73. Peedicayil A, Sadowsky LS, Jeyasselan L, Shankar V, Jain D, Suresh S, et al. Spousal physical violence against women during pregnancy. BJOG, 2004, 111 (7),682-687.

74. Chan KL, Tiwari A, Fong DY, Leung WC, Brownridge DA, Ho PC. Correlates of in-law conflict and intimate partner violence against Chinese pregnant women in Hong Kong. J Interpers Violence, 2009, 24 (1): 97-110.

75. Bacchus L, Mezey G, Bewley S. A qualitative exploration of the nature of domestic violence in Pregnancy. Violence Against Women, 2006, 12, (6): 588-604.

76. Stöckl H, Gardner F. Women's perceptions of how pregnancy influences the context of intimate partner violence in Germany cult health sex. 2013,15(10):1206-1220.

77. Roelens K, Verstraelen H, Van Egmond K, Temmerman M. Disclosure and health-seeking behaviour following intimate partner violence before and during preg-

nancy in Flanders, Belgium: a survey surveillance study. Eur J Obstet Gynecol Reprod Biol., 2008, 137(1):37-42.

78. Koenig LJ, Whitaker DJ, Royce Ra, Wilson T, Callahan M, Fernandez I. Violence during pregnancy among women with or at risk for hiv infection. Am J Public Health, 2002, 92:367-370.
79. Jahnfar S, Janssen PA, Howard LM, Dowswell T. Interventions for preventing or reducing domestic violence. Rev Against Pregnant Women. Cochrane Database, 2013. Syst.(2) [CD009414], doi: 10.1002/14651858. CD009414.pub2
80. United States General Accounting Office, GAO. Violence against women. Data on pregnant victims and effectiveness of prevention strategies are limited. (Web Site) 2002 (Retrieved July 30, 2013) Available: http://www.gao.gov/new.items/d02530.pdf.
81. Martínez Galiano JM. Detección y atención a la violencia de género en el embarazo. Una asignatura pendiente. Revista Enfermería Global, 2011, 24: 352-357.
82. Denham SA. Describing abuse of pregnant women and their healthcare workers in Rural Appalachia. MCN Am J Matern Child Nurs, 2003, 28:264-269.
83. Colombo G, Ynoub RC, Veneranda L, Iglesias MG, Viglizzo M. Violencia familiar contra la mujer en las etapas de embarazo, parto y puerperio: la mirada de los profesionales de un servicio público de maternidad y obstetricia. Rev. Argent. Sociol. 2006, 4 (7), 73-98.
84. The People's Movement for Human Rights Learning. Transforming the patriarchal order to human rights system (Web Site) 2005 (Retrieved 29 February 2015) Available: http://www.pdhre.org/patriarchy.html