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Epidemiology of Domestic Violence and sexual coercion

Issues covered

1. Magnitude of the problem globally
2. Prevalence and risk factors
3. Health consequences
 - Physical
 - Reproductive and sexual health
 - Birth outcomes/child survival
4. Methodological/ethical research issues

Many forms of violence to women: beginning early....

- selective abortion
- female infanticide
- neglect, malnutrition
- sexual abuse
- child prostitution
- forced early marriage

Continuing throughout the life cycle...

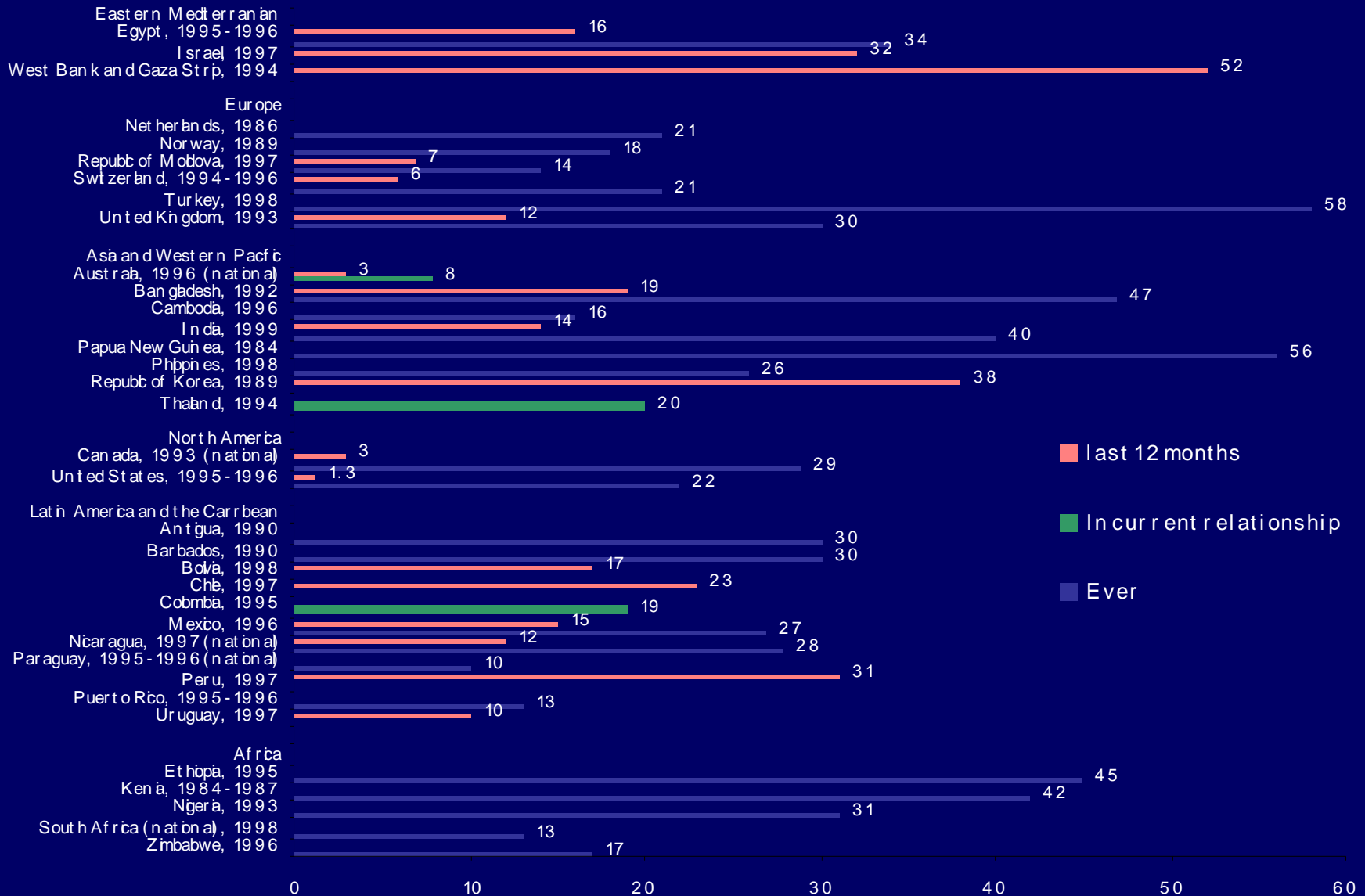
- physical partner abuse
- dowry related violence
- non-consensual sex (within marriage or outside)
- forced prostitution & trafficking
- sexual harassment at work and at school
- violence against women in conflict situations

Domestic (or intimate partner) violence

- Most common form of violence experienced by women
- WHO definition: “ the range of sexually, psychologically and physically coercive acts used against adult and adolescent women by current or former male intimate partners.”
- Also female-to-male, female-to-female violence

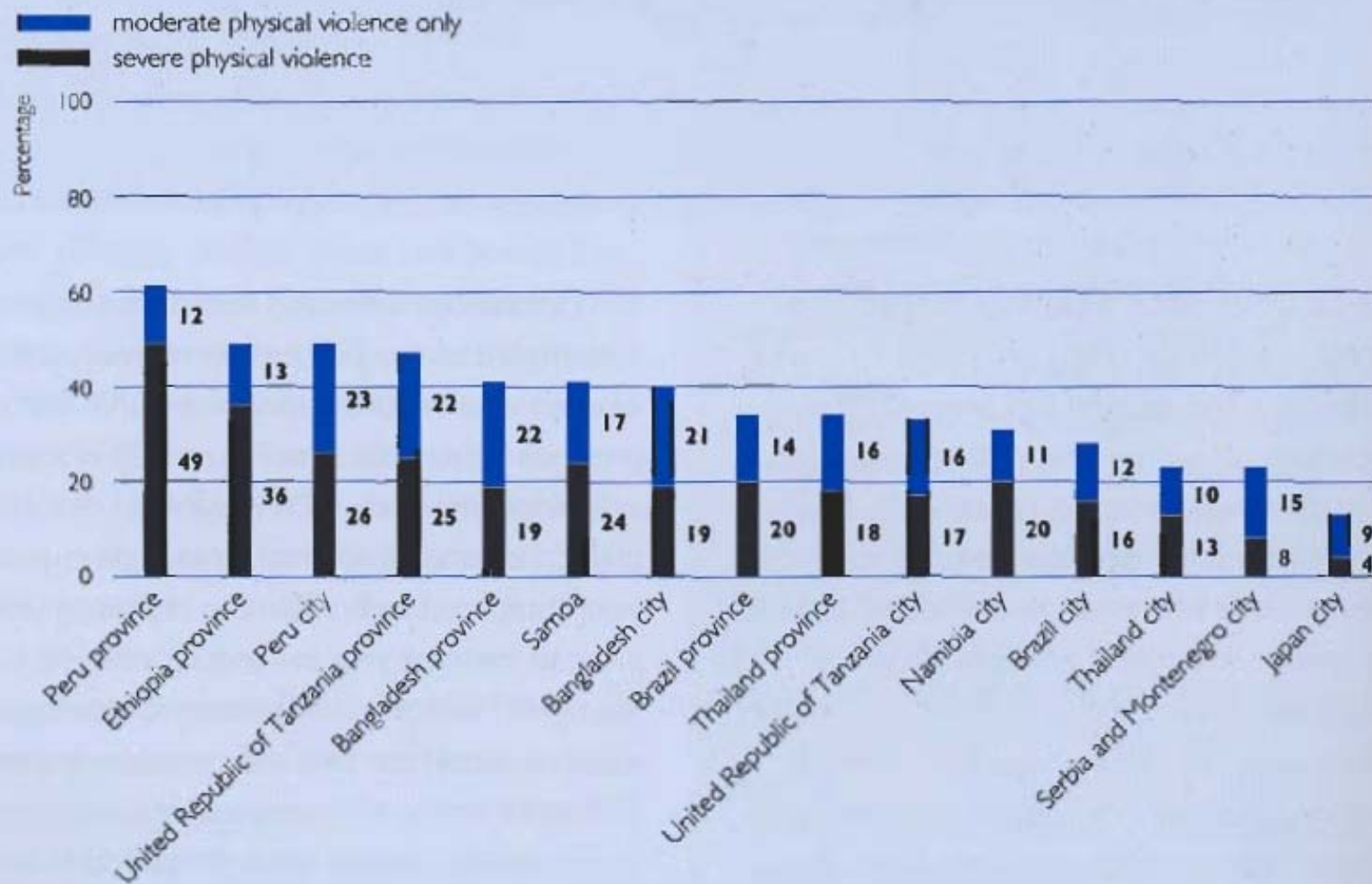
Prevalence and Risk Factors

Physical assault on women by an intimate male partner: selected population-based studies, 1982-1999



Source: World Report on Violence and Health. WHO, Geneva, 2002.

Figure 4.3 Prevalence of physical violence by an intimate partner according to severity of violence among ever-partnered women, by site



WHO Multi-country Study on Women's Health and Domestic Violence against Women, 2002.

Frequency of lifetime and recent male against female domestic violence: Rakai, Uganda, 2000-01

Type of domestic violence	% reported	
	Ever (<i>n</i> = 4996) ^a	In last 12 months (<i>n</i> = 5107) ^a
Verbal abuse	40.1	31.3
Physical threats or violence	30.4	19.9
Physical threats	20.1	13.3
Physical violence	24.8	15.1

Source: Koenig et al. Bulletin of the WHO, 2003; 81(1):53-60.

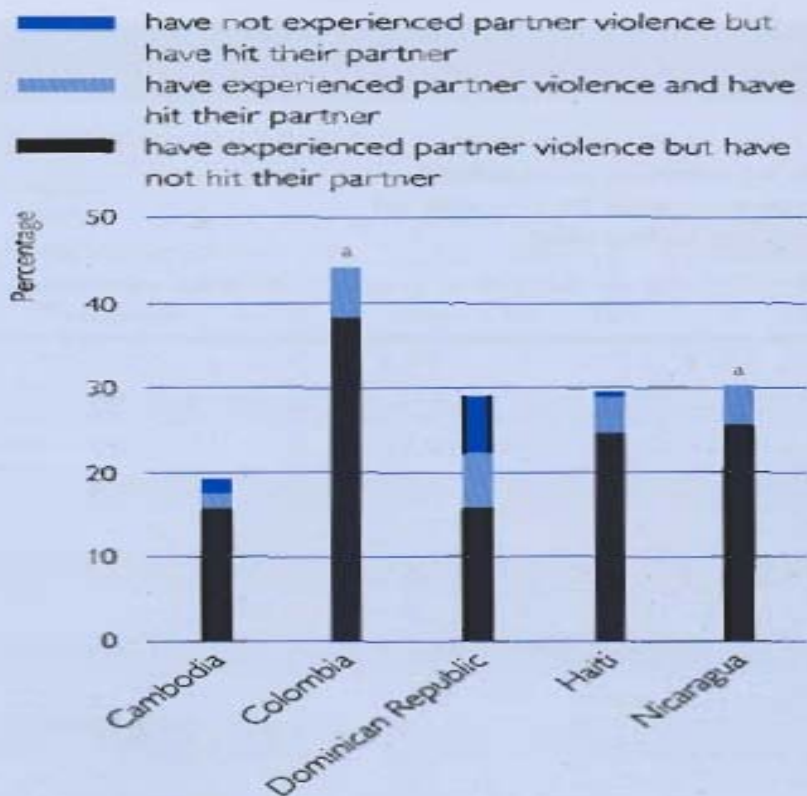
Specific types of lifetime and recent male against female domestic violence: Rakai, Uganda, 2000-01

Type of domestic violence	Women reporting violence (%)	
	Ever (<i>n</i> = 4996) ^a	In last 12 months (<i>n</i> = 5107) ^a
Physical threats		
Threatening gestures	13.6	9.6
Threats with stick or weapon	14.7	8.7
Physical violence		
Pushed, slapped, held down	23.1	14.0
Punched, beat, kicked	9.0	5.1
Hit with stick or weapon	6.2	3.3
Burned or scalded	0.3	0.2
Other	0.6	0.5
Either physical threats or violence	30.4	19.9

Source: Koenig MA et al. Bulletin of the WHO, 2003; 81(1):53-60.

Figure 4.5

Percentage of ever-married women who have hit their partner under different circumstances of male violence

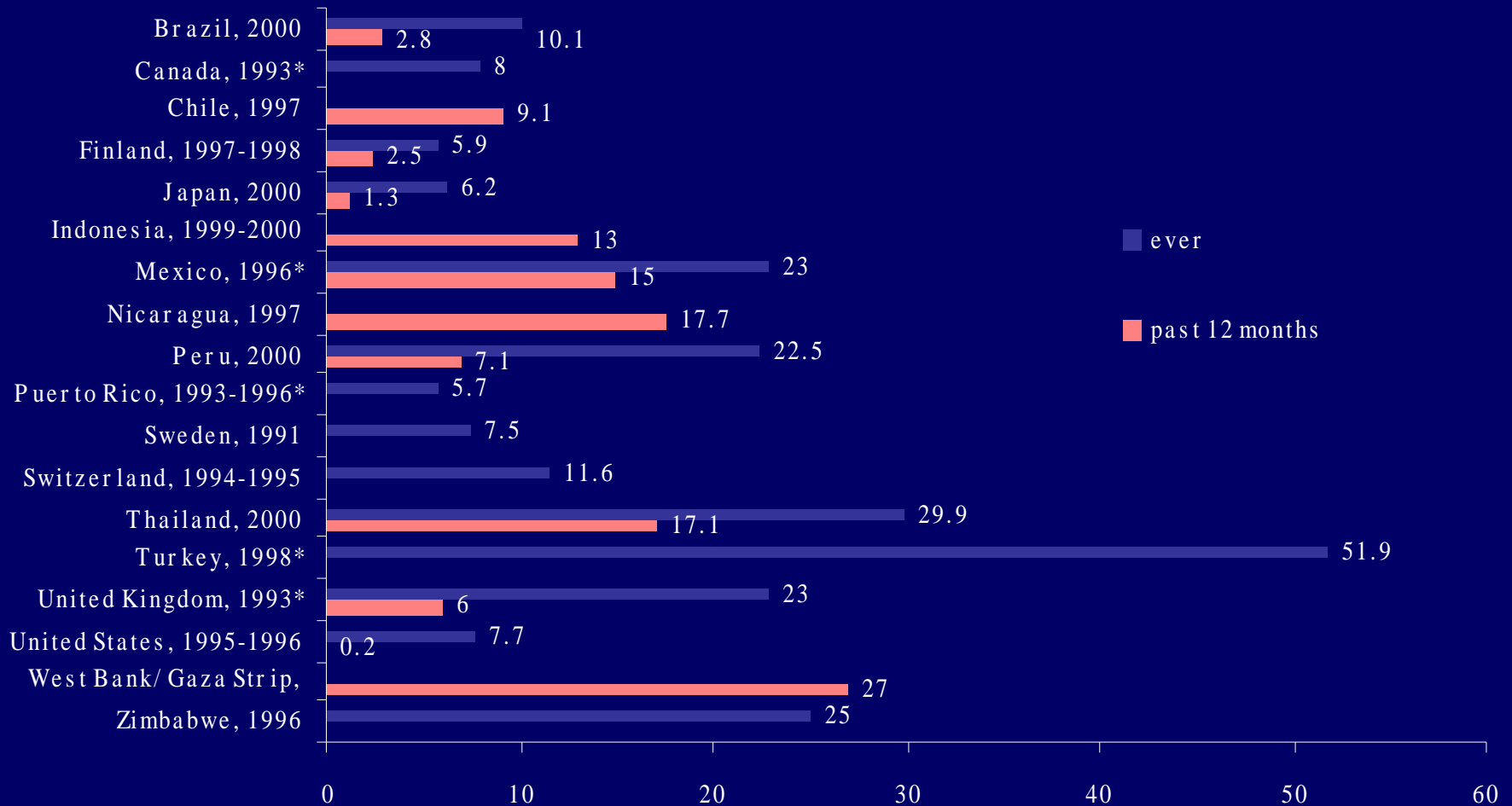


^a In Colombia and Nicaragua, the percentage of women who had hit their partners but had not experienced partner violence was not assessed.

Source: Adapted from reference 6, with the permission of the authors.

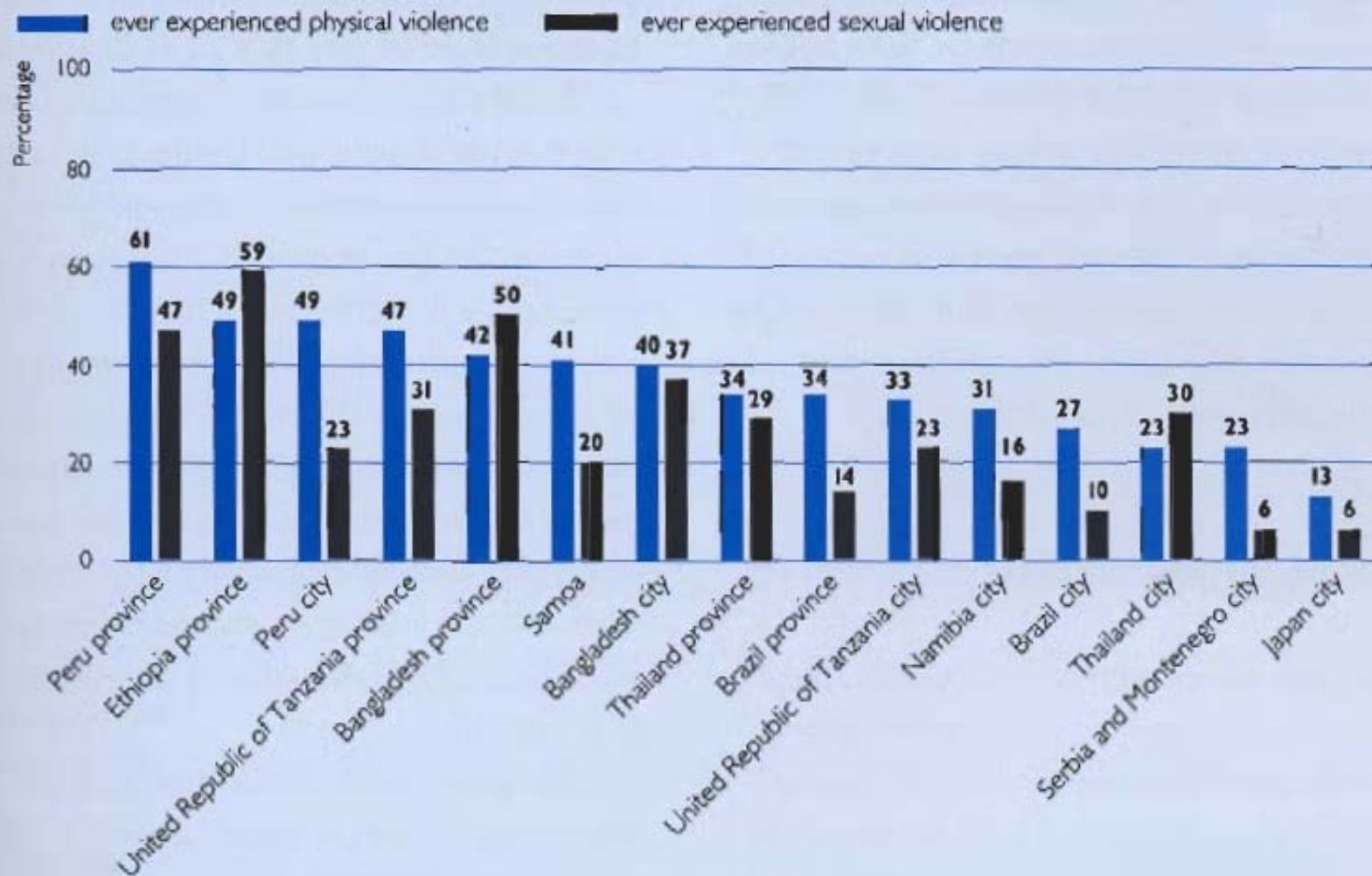
Sexual coercion and violence

Sexual victimization by an intimate male partner: selected population-based studies, 1989-2000



Source: World Report on Violence and Health. WHO, Geneva, 2002.

Figure 4.1 Prevalence of lifetime physical violence and sexual violence by an intimate partner among ever-partnered women, by site



Source: World Report on Violence and Health. WHO, Geneva, 2002.

Figure 4.4 Frequency distribution of types of violence by an intimate partner among ever-abused women, by site

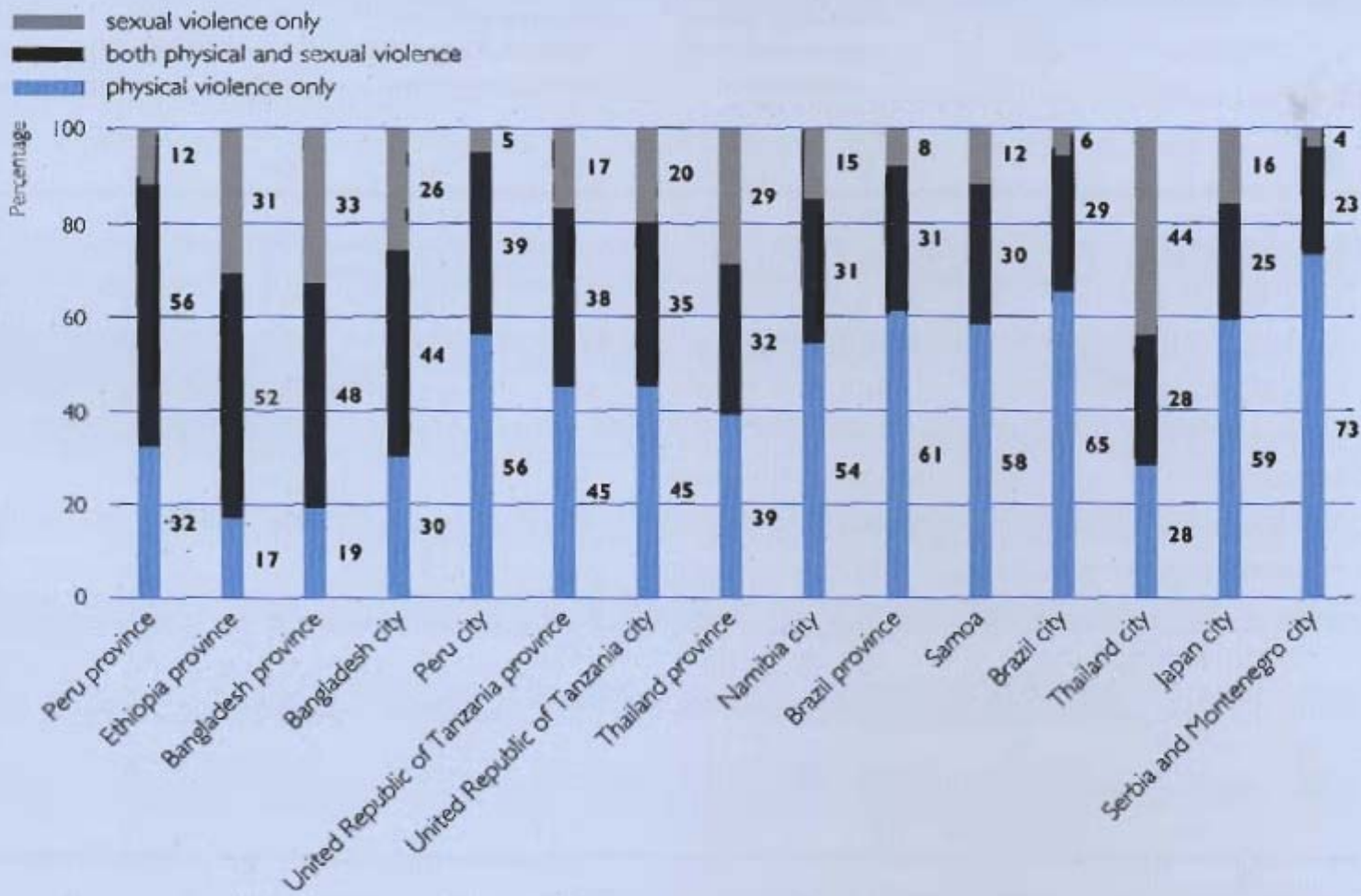
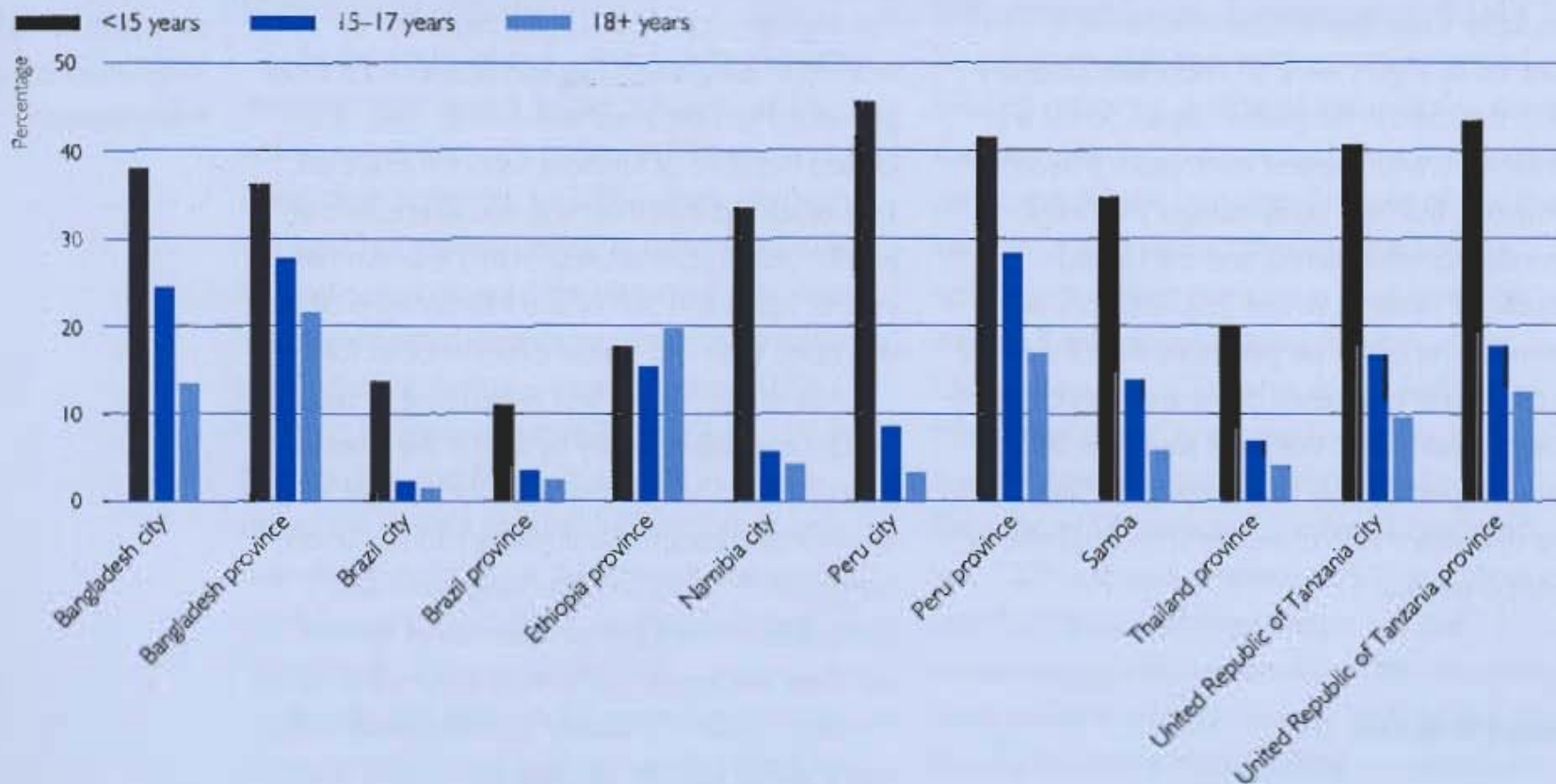


Figure 6.1 Percentage of women reporting forced first experience of sexual intercourse among sexually experienced women, by site and by age at the time of first sexual experience^a



^a Japan city, Serbia and Montenegro city, and Thailand city are not represented because of the very low percentages reporting first sex before age 15 years.

Risk factors

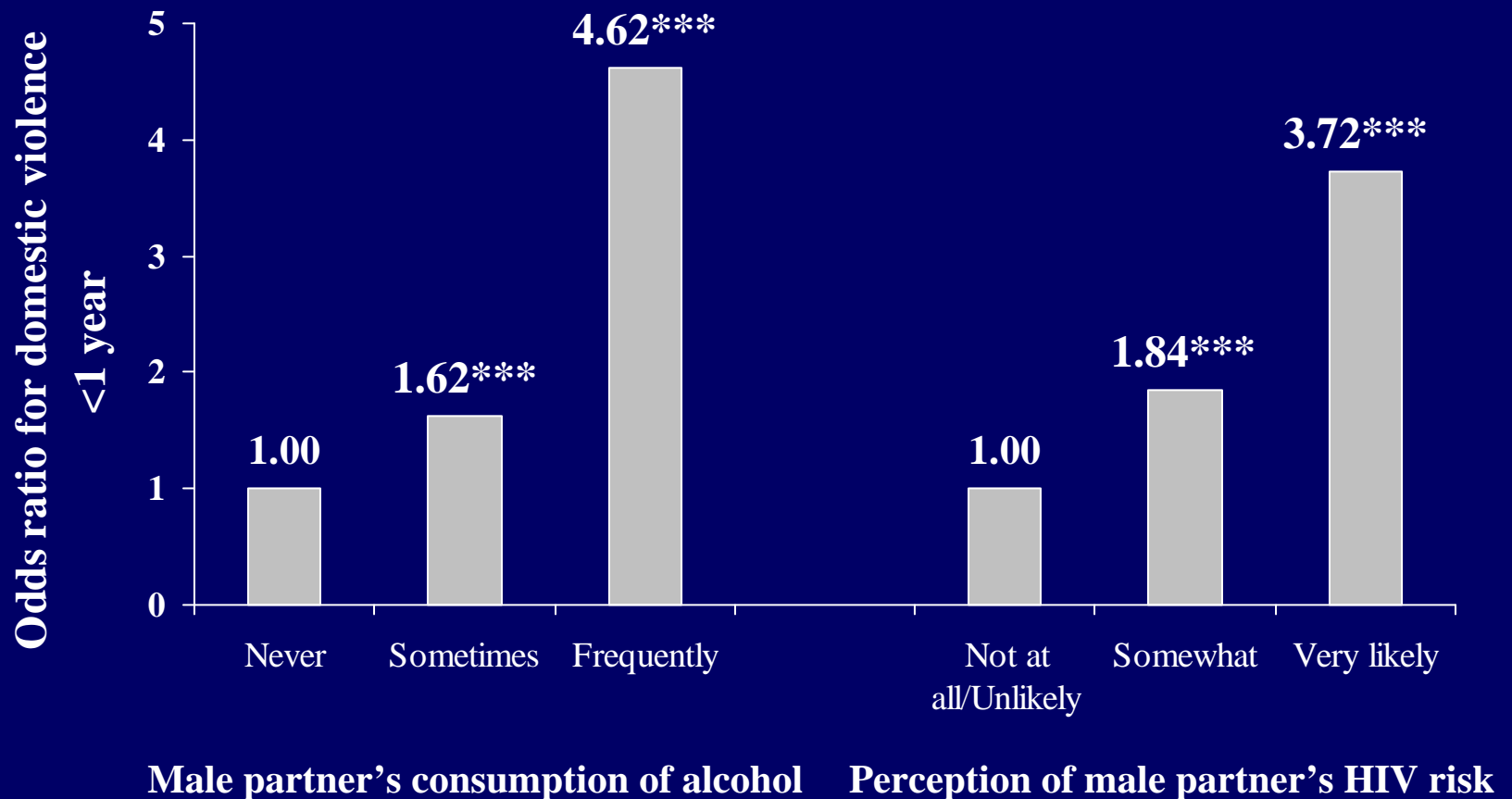
Risk factors

- Individual level
 - Education (--)
 - Socioeconomic status (-)
 - Life cycle (age, marital duration, parity) (-)
 - Extended family structure (-)
 - Intergenerational transmission of violence (++)

Risk factors

- Individual level risk behaviors
 - Alcohol/substance abuse (++)
 - HIV risk/risk perceptions (++)
 - Infidelity (perception, no. of partners) (+)
- Women's status
 - Savings and credit (-) or (+)
 - Women's autonomy/control of resources (-) or (+)

Risk Factors for Physical Violence: Rakai, Uganda

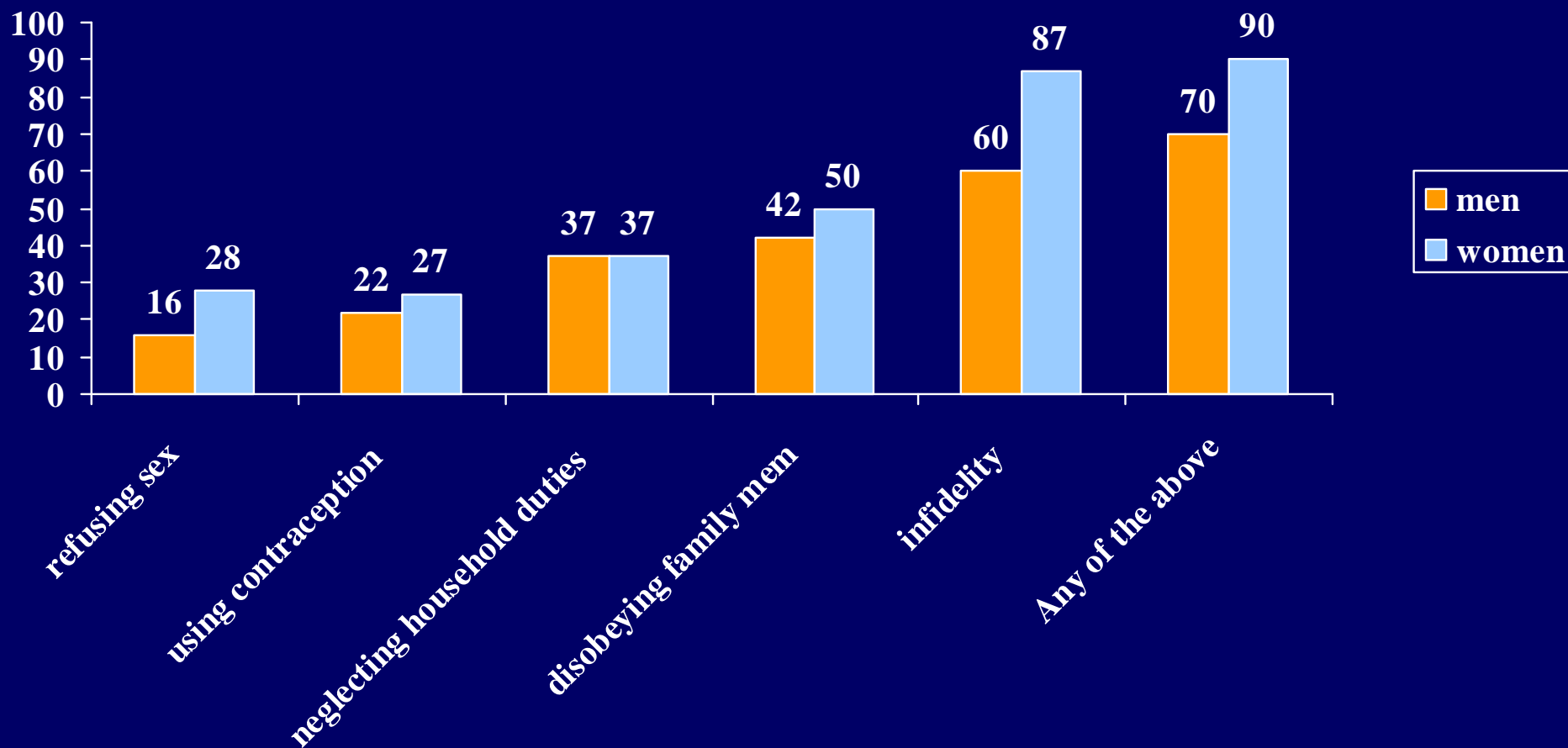


Risk factors: contextual

- Contextual factors
 - Neighborhood crime, house ownership levels (U.S.) (+)
 - Community-level women's status (Bangladesh) (-) or (+)
 - Levels of violent crime (India) (+)
 - Norms regarding domestic violence (India) (++)

Figure 2: Attitudes of men and women toward domestic violence: Rakai District, Uganda, 2000-2001

Beating of wife/female partner justified for:



Health Consequences of Domestic Violence

Domestic violence associated with adverse:

- women's physical health
- women's reproductive health
- women's mental health**
- birth outcomes/child survival

Physical consequences

- Abdominal/thoracic injuries
- Bruises, lacerations, abrasions
- Disability
- Fractures
- Gastrointestinal disorders
- Ocular damage
- Reduced physical functioning
- *Death*

Injuries resulting from domestic violence in past 12 months: Rakai, Uganda, 2000-01

Type of injury	Women reporting injury (%)
Any injury	44.4
Physical pain lasting more than one day	39.9
Sprain, bruise or cut	18.5
Broken bone	1.4
Other	8.8
Required medical attention	21.5

Source: Koenig MA et al. *Bulletin of the WHO*, 2003; 81(1):53-60.

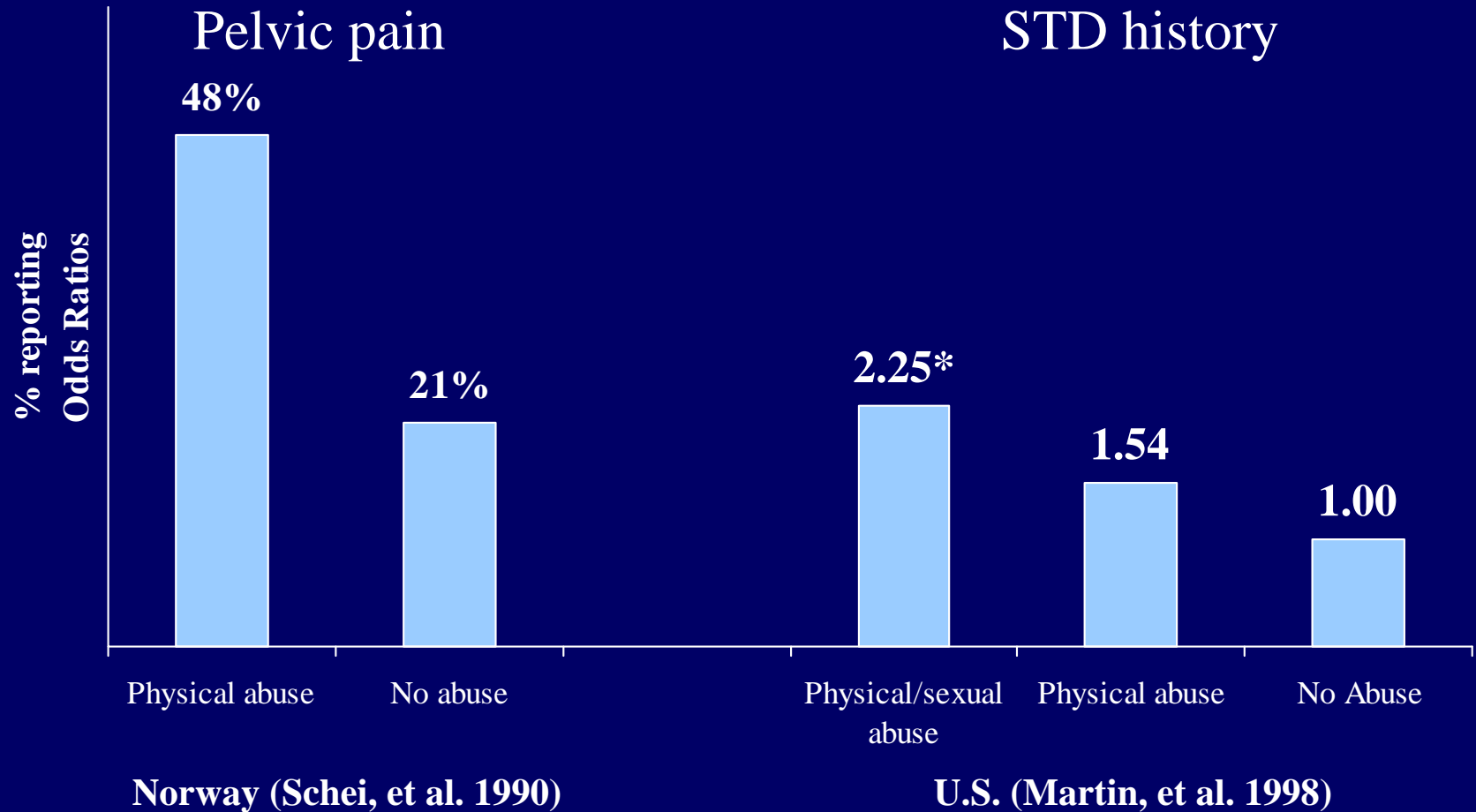
Domestic violence and reproductive health

- Gynecological morbidity/ STIs
- HIV
- Contraceptive use
- Unintended pregnancy
- Abortion

Gynecological morbidity associated with intimate partner violence

- Gynecological disorders
- Infertility
- Pelvic pain
- Sexual dysfunction

Domestic violence and gynecological morbidity

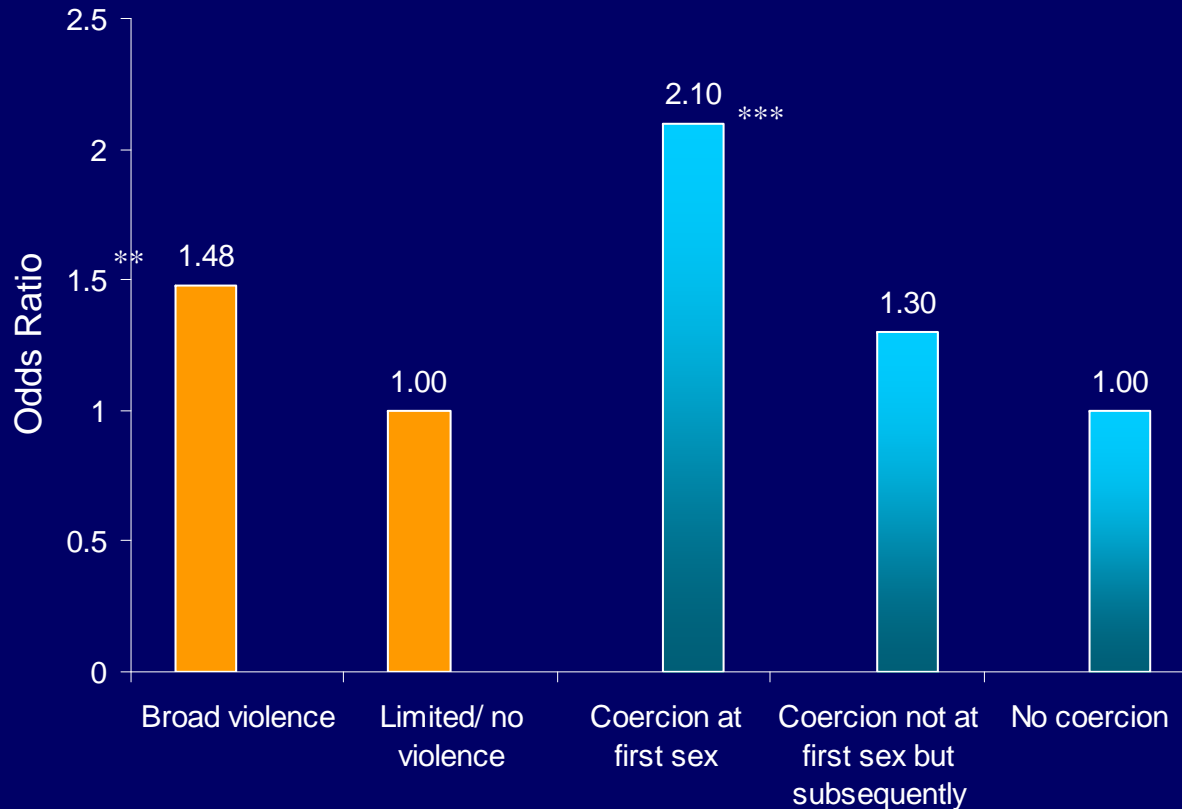


Violence and HIV/AIDS

Recent studies in the U.S. and Africa suggest a complex dynamic:

- Violence as a risk factor for HIV
- Violence as a consequence of disclosure of HIV status
- Epidemics overlap in SS Africa
- Many similar risk factors
- Direct link:
 - Coerced sex with infected partner → HIV
- Indirect link
 - Violence limits women's ability to negotiate safe sex with or by partner (monogamy, condom use, non-risky sexual practices)
 - Women's early experience with sexual abuse leads to later high risk sexual behavior (~ U.S.-based evidence)

Associations between physical/sexual violence and HIV risks



South Africa

Dunkle, et al. (2004)

Uganda

Koenig, et al. (unpublished)

** p<.01

***p<.001

Violence and Non-use of Contraception

- Violence or threat of abuse makes birth control negotiation difficult
- Women may be deterred from independent contraceptive behavior
- Barrier methods may not be feasible

Evidence on domestic violence and non-use of contraception

- Several U.S. studies show small but significant differences in current use
- Rakai, Uganda (class reading)
- North India (Stephenson, et al.2005)
- Qualitative evidence (Ghana, Uganda, Bolivia)

Evidence on domestic violence and non-use of contraception

Outcome	Adjusted OR (95% CI)
Current use of contraception	0.46 (0.24-0.87)
Condom use at last sex	0.27 (0.13-0.57)
Consistent condom use < 6 mos	0.21 (0.08-0.53)

Adjusted for age at first sex, education, religion and current marital status

Source: Koenig MA et al. (2004)

Unintended pregnancy and violence: U.S. and international studies

- Women whose pregnancy was unintended had 2-4 times increased risk of physical violence versus women whose pregnancy was intended
 - both population- and clinic-based studies
- Unintended pregnancy results from partner's violence through partner's control of contraception, unprotected forced sex, and/or coercing a woman to have a child
 - qualitative research

Violence and abortion

- Little research: two studies among women seeking abortion services
 - found physical violence related to likelihood of reporting previous pregnancy termination or miscarriage

Sources: Amaro H et al. Am J Public Health. 1990 May;80(5):575-9.
Webster et al. Am J Obstet Gynecol. 1996 Feb;174(2):760-7.

Domestic Violence and Birth Outcomes

- Direct effects
 - Physical trauma
 - Resulting chronic maternal condition
- Indirect effects
 - Elevated stress levels
 - Delay in seeking prenatal care
 - Poor nutrition
 - Substance abuse

Violence during pregnancy

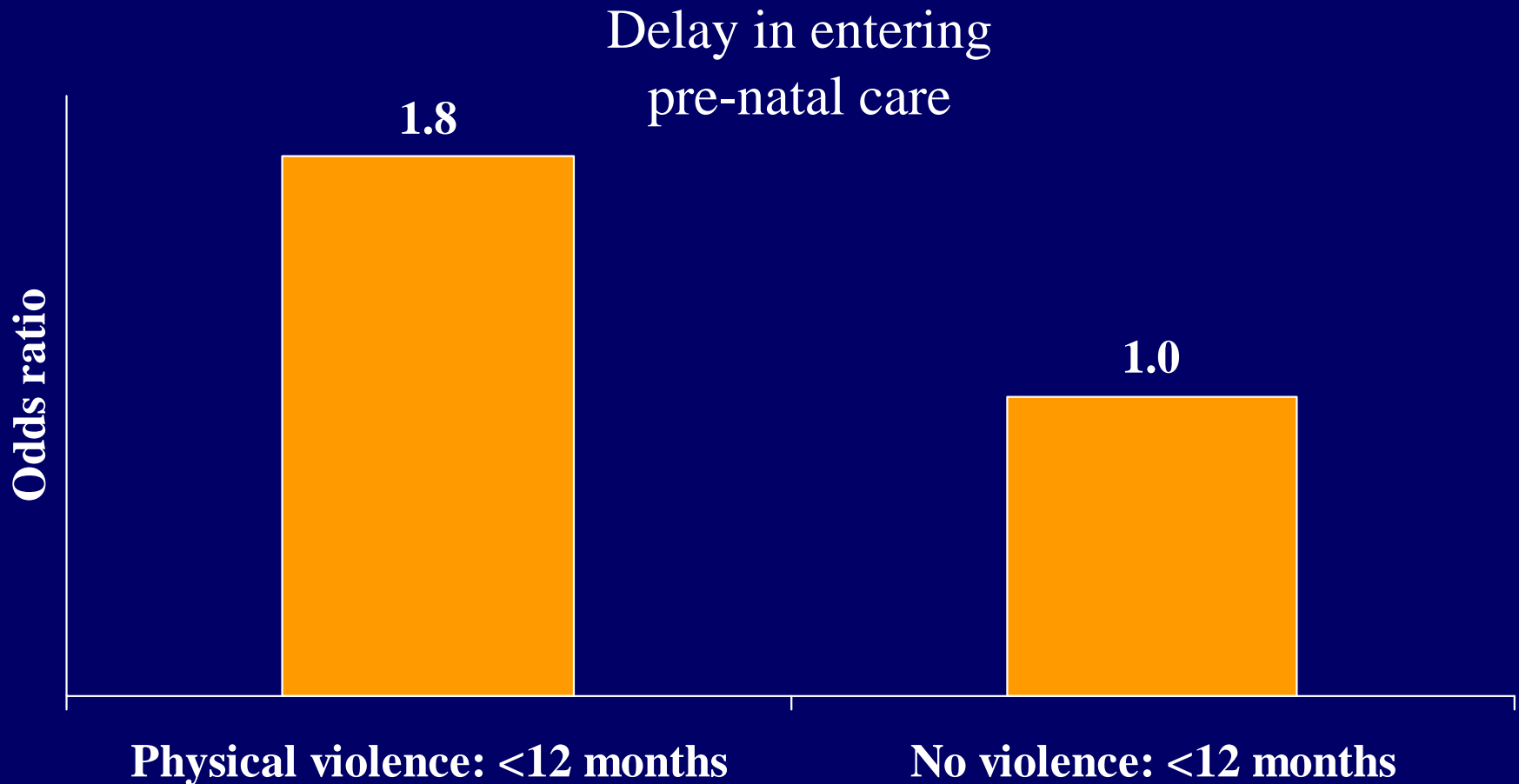
US:

- 1%-20% - any time during pregnancy
 - majority of the studies report <10%

Developing countries:

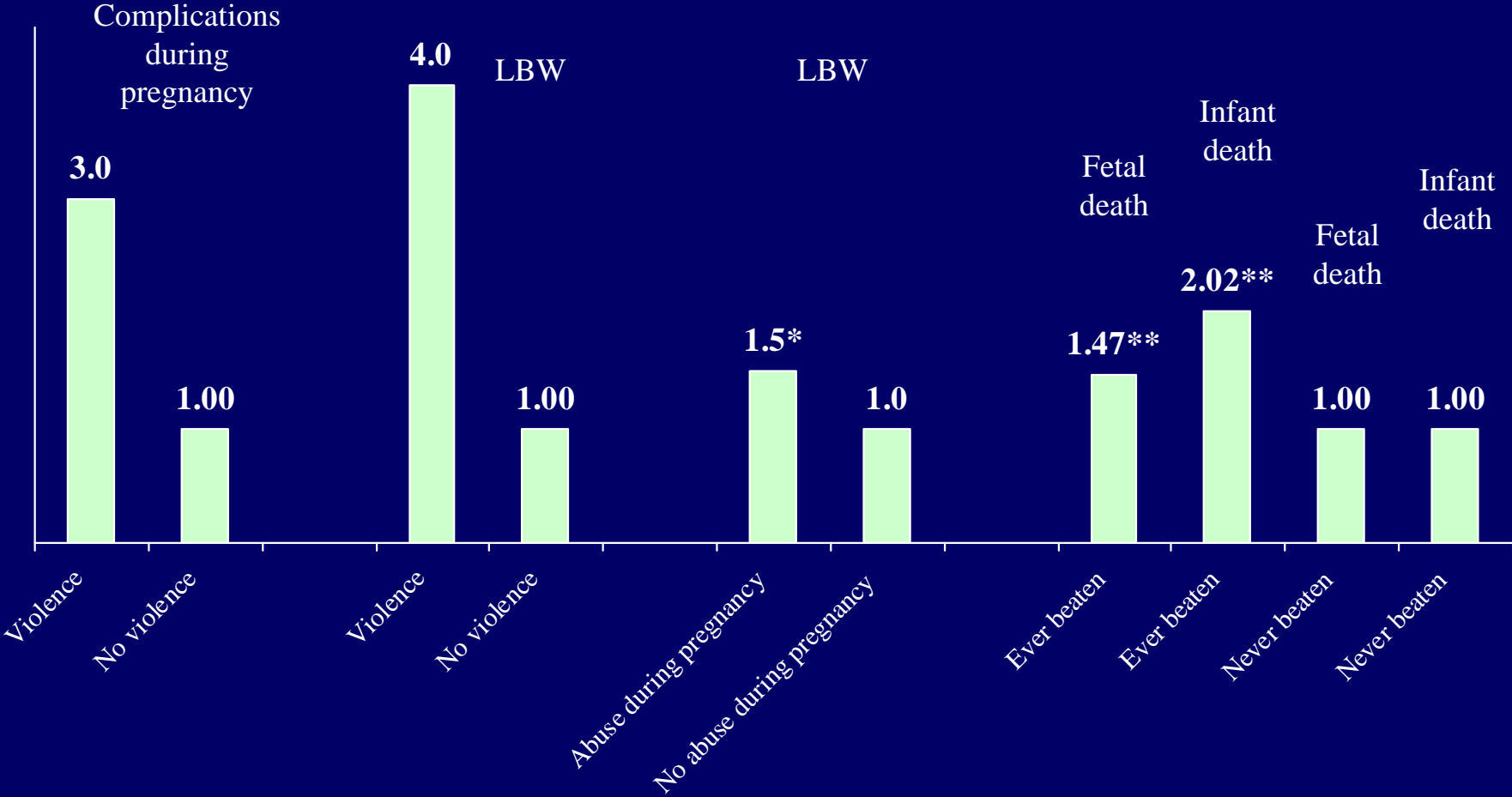
- Significantly higher, poor birth outcomes also much higher (4%-28% in WHO study)
- 10% -18% during most recent pregnancy in India study
- More common than many key risk factors for poor birth outcomes (pre-eclampsia, gestational diabetes, placenta previa)

Domestic violence and pre-natal care



Dietz et al. (1997): U.S.

Domestic violence and pregnancy outcomes



Mexico (Valdez- Santiago, et al. 1996)

U.S. (McFairlane, et al. 1996)

India (Jejeebhoy, 1998)

Logistic Regression Results for Maternal Care Utilization by Violence Status

	Crude		Adjusted	
	OR	95% CI	OR	95% CI
Antenatal care	<i>0.48</i>	<i>0.36-0.63</i>	<i>0.66</i>	<i>0.49-0.88</i>
Tetanus toxoid	<i>0.57</i>	<i>0.44-0.74</i>	<i>0.81</i>	<i>0.63-1.04</i>
Delivery care	<i>0.49</i>	<i>0.30-0.79</i>	<i>1.05</i>	<i>0.64-1.73</i>
Postpartum care	<i>0.41</i>	<i>0.26-0.66</i>	<i>0.61</i>	<i>0.37-0.99</i>

Adjusted for: women's age, parity, women's education, husband's education, socio-economic status, caste, gender and wantedness of the index child.

	Crude		Adjusted	
	HR	95% CI	HR	95% CI
Perinatal	<i>2.05</i>	<i>1.20-3.49</i>	<i>2.59</i>	<i>1.48-4.51</i>
Neonatal	<i>1.91</i>	<i>1.13-3.26</i>	<i>2.37</i>	<i>1.36-4.15</i>
Post-neonatal	<i>1.03</i>	<i>0.53-2.02</i>	<i>0.997</i>	<i>0.50-1.98</i>
Child	<i>1.38</i>	<i>0.17-11.54</i>	<i>0.998</i>	<i>0.07-14.37</i>

Adjusted for: women's age, parity, women's education, husband's education, socio-economic status, caste, gender and wantedness of the index child.

Methodological and Ethical Issues in Domestic Violence Research

Methodological issues

- Definition of violence
- Study population
- Facilitating the disclosure of violence

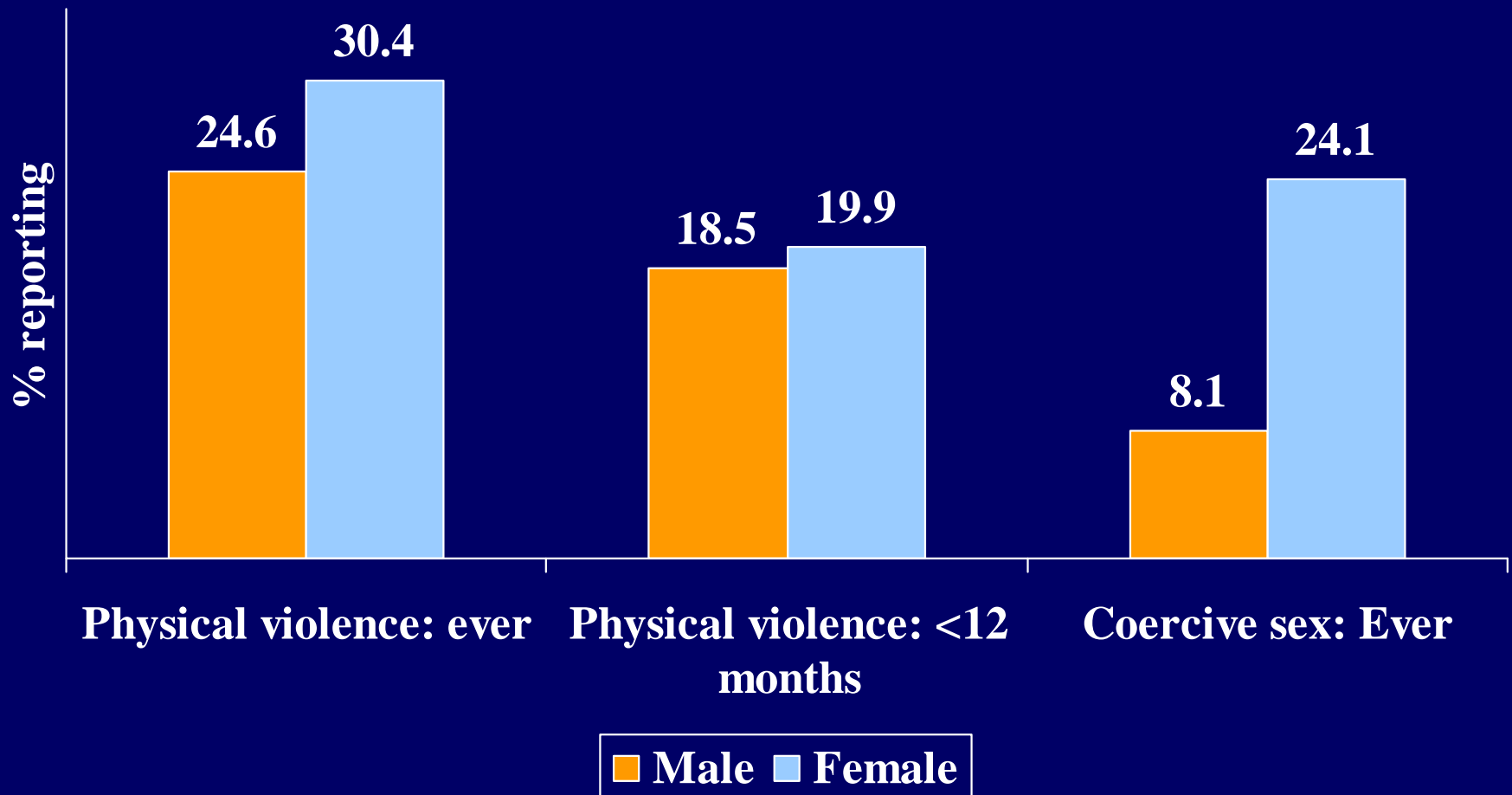
Definition of violence

- Who defines violence: the researcher or the respondent?
- Types and severity of violence included in the questions
- Lifetime vs. recent (<12 mos) experience
- From current partner vs. any male partner? Male partner vs. any family member?
- Inclusion of questions on sexual violence
- Sexual abuse/rape prior to/outside of primary relationship

Defining the study population

- Age range
- Marital status
- Sex of respondent

Male vs. Female Reports of Domestic Violence: Rakai, Uganda 2000-2001



Factors that affect disclosure of violence

- How questions are phrased
- Number of opportunities to disclose
- Context in which questions asked
- Interviewer characteristics and skill
- Stigma attached to issue (may vary across settings)

Ethical guidelines for violence research (WHO recommendations)

- Measures included to protect safety of respondents and interviewers
 - Total privacy/confidentiality
 - Interview only one member per household
 - Presented as a woman's health survey
 - Referral mechanisms for services/counseling
- Special training and emotional follow-up for interviewers
- Incorporation into multi-purpose surveys only when ethical/methodological requirements can be met

Interventions to prevent violence

Structural intervention to prevent IPV and HIV in South Africa

Pronyk et al Lancet 2006;368:1973

- Community randomized trial in Limpopo province, South Africa
- Pair-matched communities randomized to either:
 - Structural intervention of microfinance and “learning/action” education (N = 4)
 - Control communities, no intervention for 3 years, then provided with the intervention
- **Endpoints:**
 - Intimate partner violence past 12 months
 - Unprotected sex with a non-spouse past 12 months
 - HIV incidence

Exposure groups

- **Cohort 1:** Women who applied for a loan in intervention villages, age and sex matched with controls from control villages (n = 860). Follow up 2 years
- **Cohort 2:** Woman aged 15-35 co-resident with a loan acceptor in intervention arm compared with co-resident with a control arm subject (n = 1835). Follow up 2 yrs
- **Cohort 3:** 14-35 year old randomly selected men and women in intervention arm, compared similarly selected with control arm residents (n = 3881). Follow up 3 years

Interventions

- **Poverty focused microfinance**
 - Field workers identify poorest households, form groups of 5 and offer microfinance loans, repaid over 10-20 weeks
 - Meet every 2 weeks for business assessment, 10 session “life, gender and HIV” training program
 - Community mobilization with leaders

Effects in cohort 1. Matched loan applicants vs controls

Selected outcomes	Intervent %	Control %	Adj RR (955CI)
Household assets > 2000 rand	58	49	1.15 (1.04-1.28)
Communication about sexual matters	86	55	1.58 (1.21-2.07)
Intimate partner violence < 12 months	6	12	0.45 (0.23-0.91)

Are women who accept loans self-selected for greater autonomy, or does loan acceptance increase a woman's status and deter violence?

Effects in cohort 2. Matched co-resident women in intervention vs controls

Selected outcomes	Intervent %	Control %	Adj RR (955CI)
Communication about sexual matters	66	50	1.32 (0.90-1.95)
> 1 sexual partner past 12 mths	18	16	1.16 (0.85-3.32)
Unprotected sex with non-spousal partner	48	48	1.02 (0.85-1.23)

Household loan acceptance does not affect behaviors in co-residents

Effects in cohort 3. Matched males and females in intervention vs controls

Selected outcomes	Intervent %	Control %	Adj RR (955CI)
> 1 sexual partner past 12 mths	15	19	0.64 (0.19-2.16)
Unprotected sex with non-spousal partner	43	48	0.89 (0.66-1.19)
HIV incidence	11	11	1.06 (0.66-1.69)

Intervention did not affect population-level behaviors
Or HIV incidence

Authors conclusions

- Combined microfinance and training interventions can reduce intimate-partner violence in program participants
- Social and economic development interventions have the potential to alter risk environments for HIV and intimate partner violence

Caveats

- This was a community randomized trial analyzed as an individual-level trial
- The main effects in loan applicants vs controls is an “as-treated”, not intent-to-treat analysis (i.e., selected on most compliant intervention arm participants.)
- No “spill over” effects to household co-residents
- No impact on HIV incidence