Physical and emotional violence against women during pregnancy in Zambia

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Abstract

This study used data from the 2013 Zambia Demographic Health Survey (ZDHS) based on a nationally representative sample carried out by Central Statistical Office of Zambia. This paper analyzed a special module designed to collect information on the extent to which women experience physical, emotional and sexual violence in Zambia. The analysis of this paper is based on 1,420 pregnant women aged between 15 and 49 years. It was found that 31% of the pregnant women had experienced physical violence from their partners whereas 17% of the pregnant women had experienced emotional violence from their partners in their relationships. Regression analysis further showed that age, number of children, exposure to media and alcohol consumption by the partner were all related to both physical and emotional Intimate Partner Violence (IPV). It is recommended that the government in Zambia and other organizations involved in curbing Gender Based Violence (GBV) and in particular IPV should also focus on pregnant women and re-double their efforts in the fight. It is also recommended that a cultural mental shift was required by both men and women in order to effectively fight the scourge of IPV.

Keywords: *Physical violence; Emotional violence; Domestic violence, Pregnancy*

Introduction

Intimate partner violence (IPV) has been defined by the World Health Organization (WHO) as ‘‘behaviour within an intimate relationship that causes physical, sexual or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse and controlling behaviours’’ encompassing both current and past intimate partners (WHO, 2010). IPV occurs in all settings and among all socioeconomic, religious and cultural groups. The overwhelming global burden of IPV is borne by women (Heise et al. 1999).

A multi country study by Gracia- Moreno (2005) confirmed that IPV is widespread in all countries which were studied. Among women who had ever been in an intimate partnership,13–61% reported ever having experienced physical violence by a partner; 4–49% reported having experienced severe physical violence by a partner; 6–59% reported sexual violence by a partner at some point in their lives; and 20–75% reported experiencing one emotionally abusive act, or more, from a partner in their lifetime. A comparative analysis of Demographic and Health Survey (DHS) data from nine countries also found that the percentage of women who reported ever experiencing any physical or sexual violence by their current or most recent husband or cohabiting partner ranged from 18% in Cambodia to 48% in Zambia for physical violence, and 4% to 17% for sexual violence (Hindin, 2008).

It has been almost a decade since violence against women in Africa has reached an epidemic proportion, but this seems to be accepted as normal (Klomegah, 2008). The previous Zambia Demographic and Health Survey data (2002) show that in the age group of 15-49 years, more wives than husbands are likely to justify wife beating. The data also suggested that duration of marriage, place of residence, cultural beliefs about wife beating, and membership in non-Orthodox religion are some risk factors that relate to IPV in Zambia.

Research carried out in IPV suggests that different types of violence often coexist: physical IPV is often accompanied by sexual IPV, and is usually accompanied by emotional abuse. For example, in the WHO multi-country study, 23–56% of women who reported ever experiencing physical or sexual IPV had experienced both (Gracia-Moreno, 2005). Studies have also found substantial levels of physical IPV during pregnancy in settings around the world. The WHO multi-country study found prevalence of physical IPV in pregnancy ranging from 1% in urban Japan to

28% in provincial Peru, with prevalence in most sites of 4–12% (Gracia-Moreno, 2005). Similarly, a review of studies from 19 countries found prevalence ranging from 2% in settings such as Australia, Denmark and Cambodia, to 13.5% in Uganda, with the majority ranging between 4% and 9% (Devries et al. 2010). A few facility-based studies in some settings have found even a higher prevalence including one from Egypt with an estimated prevalence of 32% (Campbell, 2004) and a review of studies from Africa that found a prevalence as high as 40% in some settings (Shamu, 2011).

IPV have various adverse consequences in pregnancy, health consequences of IPV are known to include, but not be limited to, increased physical injuries and gastrointestinal,gynaecological, and psychiatric co-morbidities (Davries et al.2013; Howard et al. 2013). Violence may begin or intensify during pregnancy and is associated with adverse obstetric outcomes (Silverman et al. 2006) and maternal death (Cantwell, 2011). Increased homicide (Abrahams et al. 2013) and suicide are found among individuals experiencing IPV (Davries et al. 2011).

Violence during pregnancy has also been associated with miscarriage; late entry into prenatal care; stillbirth; premature labour and birth; fetal injury; and low-birth-weight or small-for-gestational-age infants (Devries et al. 2010; Shamu, 2011). IPV may also account for a proportion of maternal mortality. In a study designed to explore the impact of wife abuse on the general and psychological well-being of Chinese women and their children in Hong Kong, Tang (Tang, 1997) found that husbands' verbal abuse, but not their physical abuse, was related to women's general distress including insomnia, anxious mood, and depression. The impact of verbal abuse on mental health was also found in Chinese pregnant women. In a prospective study involving a group of pregnant Chinese women in Hong Kong (Leung et al. 2002) verbal abuse was significantly related to postnatal depressive symptoms. Another study identified psychological intimate partner violence as a major predictor of posttraumatic stress disorder (PTSD) in abused women (Picco-Alfonso, 2005)

Violence against women by an intimate partner is pervasive in society with negative consequences for women who experience it as well as for their children (Garcia-Moreno et al. 2005). Randomised trial evidence has shown that training primary care professionals in selective questioning of women about IPV increases disclosure and referral to specialist IPV services (Feder

et al. 2011).The aim of this study was to identify factors associated with IPV in pregnant women in Zambian.

Methodology

The present study used data from the 2013 Zambia Demographic Health Survey (ZDHS). The sample for the survey was designed to provide the estimates of population and health indicators at provincial and national levels. The survey was based on nationally representative sample carried out by Central Statistical Office with technical assistance from the Demographic Health Surveys Programme at ICF International which was funded by the United States Agency for International Development (USAID). The survey used a two-stage stratified cluster sampling design. At the first age, 722 Enumeration Areas (EA) were selected using systematic random sampling with probability proportional to size. At the second stage, 25 households per EA were selected again using systematic random sampling. Methods and data collection procedures have been published (ZDHS, 2014). The ZDHS included a special module designed to collect information on the extent to which women experience physical, emotional and sexual violence in Zambia. The household questionnaires collected information on the demographic and economic characteristics of all household members. The analysis of this paper is based on 1,420 pregnant women.

The following operational definitions were used:

Experience of physical violence is indicated if a pregnant woman has ever been pushed, shaken or something thrown at her, if she has ever been slapped, or if she has ever been punched with a fist or something harmful, if she has ever been kicked, if an attempt has been made to strangle her, burn her, if her arm has ever been twisted, if her hair has ever been pulled and if she has ever been attacked with a knife/gun or any other weapon by her spouse.

Experience of emotional violence is indicated if a pregnant woman has ever been humiliated, if she has ever been threatened, if she has ever been insulted or if her spouse has ever made her to feel bad.

Data Analysis

In this paper, data analysis was carried out in two stages. Firstly, cross tabulations were used to examine the relationship between the independent variables (socio-economic and demographic) and dependent variables (physical and emotional violence). In addition, chi-square tests were conducted at the bivariate level for independent variables at $p < 0.01$ and $p < 0.05$ significant levels. Secondly, Logistic Regression Analysis was used to identify factors influencing physical and emotional violence by considering socio-economic and demographic variables. The results of the logistic regression models were converted into odds ratios, which represented the effect of a one-unit change in the explanatory variable on the indicator of experiencing physical and emotional violence. Odds ratios larger than one indicate a greater likelihood of experiencing physical and emotional violence than for the reference category; odds ratios smaller than one indicate a smaller likelihood compared to the reference category.

Results

Background characteristics of the sample

Demographic information (table1) showed that 42.4% of the respondents were aged 15-29, 42.5% were aged 30-39 and 15% were aged 40-49. A majority of the respondents were married (82.2%) while the rest of the respondents were not married (17.8%). With regards to number of children, 42% had one child, 30% had 2-3 children and 28 % had 4 or more children. Protestants were the majority (81.6%) and Catholics were a minority (18.4%). For place of residence, 60.4% were from urban areas while 39%were from rural areas. Furthermore, educational level showed that 37% of the respondents had completed secondary education, 50.7% had primary education and 11.4% had no schooling. Majority of the respondents were exposed to media less than once a week (71.4%) while only 28.6% had media exposure at least once a week. The wealth distribution index showed that 44.6% of the respondents were classified as poor, 22% were classified middle while 33.7% were from rich background. About 50% of the respondents were not working while 50% of them were working. With regard to alcohol consuming patterns, 32% of the women had partners who took alcohol while 68% had partners who did not take alcohol.

Table1: Sample Distribution of pregnant women in Zambia

Characteristics		%	n
Age			
	15-29	42.4	602
	30-39	42.5	604
	40-49	15.1	214
Marital status			
	Not married	17.8	253
	Currently married	82.2	1167
Number of children			
	1	42.3	600
	2-3	30.0	426
	4+	27.7	394
Religion			
	Catholic	18.4	264
	Protestant	81.6	1156
Place of residence			
	Rural	39.6	562
	Urban	60.4	858
Educational level			
	No schooling	11.4	162
	Primary	50.7	721
	Secondary or higher	37.8	537
Exposure to media			
	Less than once in a week	71.4	1014
	At least once a week	28.6	406
Wealth Index			
	Poor	44.6	633
	Middle	21.8	309
	Rich	33.7	478
Work status			
	Not-working	50.1	711
	Working	49.9	709
Partner drinks alcohol			
	No	68.0	966
	Yes	32.0	454

Physical and Emotional violence

Overall, about 31% of the respondents reported having experienced physical violence. The raw percentage results showed that respondents aged 30-39 (36%) were more likely to have experienced physical violence as compared to respondents aged 40-49 (26%) and those aged 15-29 (32.2%). Moreover, pregnant women who were currently married (34.4%) were more likely to have experienced physical violence compared to those who were pregnant but not currently married (15%). Women with four or more children (39%) were more likely to report having experienced physical violence compared to those who had one child (20.5%). Furthermore, women who never been to school (38%) were more likely to report having experienced physical violence as compared to those who had secondary education (23.5%).The wealth index shows that pregnant women from poor backgrounds (34%) were more likely to report having experienced physical violence as compared to those coming from middle (33%) and rich backgrounds (25%). Pregnant women who were currently working (33.4%) were more likely to report having experienced physical violence as compared to those who were not working (28.7.%). Those whose partners took alcohol (52.2%) were more likely to report experiencing physical violence as compared to those whose partners did not take alcohol (21%).

About, 17% of the respondents reported having experienced emotional violence. The results showed that respondents aged 30-39 (21%) were more likely to have experienced emotional violence as compared to those in the age groups 40-49 (26%) and 15-29 (12%). Those who were currently married (18.2%) were more likely to have experienced emotional violence compared to those who were not married (11%). Pregnant women with four or more children (23%) were more likely to report having experienced emotional violence compared to those who had one child (9.2%). Furthermore, women who had no schooling (22%) were more likely to have experienced emotional violence as compared to women who had secondary education (12%). The wealth index showed that pregnant women from poor backgrounds were more likely to report having experienced emotional violence as compared to those coming from rich backgrounds, (poor 19%, middle 18% and the rich 14%). Those working (27%) were more likely to have experienced emotional violence as compared to those not working (32.8%). Those whose partners took alcohol (30.2%) were more likely to report experiencing emotional violence as compared to those whose partners did not take alcohol (11%).

Table 2: Percentage of pregnant women who reported having experienced physical and emotional violence.

	% who reported having experienced physical violence	% who reported having experienced emotional violence	Total Number of pregnant women
Age			
15-29	25.7**	12.0**	602
30-39	35.6	21.0	604
40-49	32.2	18.7	214
Marital status			
Not married	14.6**	10.7**	253
Currently married	34.4	18.2	1167
Number of children			
1	20.5**	9.2**	600
2-3	38.5	21.8	426
4+	38.6	23.1	394
Religion			
Catholic	31.9	15.4	264
Protestant	30.8	17.2	1156
Place of residence			
Rural	28.8	16.2	562
Urban	32.3	17.2	858
Educational level			
No schooling	37.7**	21.6**	162
Primary	35.0	19.4	721
Secondary or higher	23.5	11.9	537
Exposure to media			
Less than once in a week	30.5	15.7*	1014
At least once a week	32.0	19.7	406
Wealth Index			
Poor	34.3**	18.8*	633
Middle	33.0	17.8	309
Rich	25.1	13.6	478
Work status			
Not-working	28.7*	13.6**	711
Working	33.4	20.3	709
Partner drinks alcohol			
No	20.9	10.6	604
Yes	52.2	30.2	454
Total	30.9	16.8	1420

*** Significant at P < 0.01; ** Significant at P < 0.05

Relationship between physical and emotional violence and socio-economic and demographic characteristics

Logistic regression analysis identified age, marital status, number of children, educational level, exposure to media and a partner who took alcohol as predictors of physical violence experienced among pregnant women. Results showed that pregnant women aged 30-39 and 40-49 were negatively associated with having experienced physical violence. Moreover, marital status emerged as a strong predictor of those having experienced physical violence. Pregnant women who were married were twice more likely to report experiencing physical violence as compared to those who were not married. Women who were exposed to media at least once a week were 1.3 times more likely to report having experienced physical violence compared to those who were not exposed to media less than once a week. Respondents whose partners took alcohol showed a strong likelihood of reporting having experienced physical violence at some point in their marriage. Those who had drinking partners were 3.6 times more likely to report having experienced physical violence as compared to those whose partners did not drink alcohol.

Table 3: Logistic Regression Analysis examining factors affecting experience of physical violence among pregnant women

Variables		Beta (β)	Standard Error (SE)	Exp (β)	Significant level (P)
Age					
	15-29				
	30-39	-0.3990	0.1833	0.6710	0.0295
	40-49	-0.8708	0.2627	0.4186	0.0009
Marital status					
	Not married				
	Currently married	0.6756	0.2035	1.9652	0.0009
Number of children					
	1				
	2-3	0.8005	0.1807	2.2266	0.0000
	4+	0.9927	0.2338	2.8986	0.0000
Religion					
	Catholic				
	Protestant	0.0717	0.1612	1.0746	0.6567
Place of residence					

Rural				
Urban	-0.1345	0.1673	0.8742	0.4215
Educational level				
No schooling				
Primary	-0.0243	0.1988	0.9760	0.9028
Secondary or higher	-0.2629	0.2357	0.7688	0.2647
Exposure to media				
Less than once in a week				
At least once a week	0.2714	0.1427	1.3118	0.0572
Wealth Index				
Poor				
Middle	0.1229	0.1742	1.1307	0.4805
Rich	-0.2313	0.2027	0.7935	0.2540
Work status				
Not-working				
Working	0.0645	0.1282	1.0666	0.6151
Partner drinks alcohol				
No				
Yes	1.2798	0.1300	3.5960	0.0000

With regard to emotional violence, Logistic regression analysis identified age, number of children, exposure to media and a partner who drank alcohol as predictors of emotional violence among pregnant women in the study. Results also showed that respondents aged 30-39 and 40-49 were negatively associated with reports of having ever experienced physical violence among pregnant women. Those who had 2-3 children and those who had 4 children were 2.4 and 2.8 times respectively more likely to report experiencing emotional violence as compared to those who had one child. Pregnant women who were exposed to media at least once a week were 1.6 times more likely to report emotional violence as compared to those who were exposed to media less than once a week. Respondents whose partners took alcohol reported a strong likelihood of having experienced emotional violence. Those whose partners took alcohol were 3.2 times more likely to have experienced emotional violence as compared to those whose partners did not drink alcohol.

Table 4: Logistic Regression Analysis examining factors affecting experience of emotional violence among pregnant women

Variables	Beta (β)	Standard Error (SE)	Exp (β)	Significant level (P)
Age				
15-29				
30-39	-0.1533	0.2230	0.8579	0.4918
40-49	-0.5805	0.3109	0.5596	0.0619
Marital status				
Not married				
Currently married	0.0320	0.2376	1.0325	0.8929
Number of children				
1				
2-3	0.8592	0.2268	2.3613	0.0002
4+	1.0166	0.2847	2.7637	0.0004
Religion				
Catholic				
Protestant	0.2484	0.1999	1.2820	0.2140
Place of residence				
Rural				
Urban	-0.2694	0.2024	0.7638	0.1832
Educational level				
No schooling				
Primary	-0.1121	0.2304	0.8939	0.6265
Secondary or higher	-0.4605	0.2822	0.6310	0.1028
Exposure to media				
Less than once in a week				
At least once a week	0.4909	0.1690	1.6337	0.0037
Wealth Index				
Poor				
Middle	0.0781	0.2109	1.0812	0.7111
Rich	-0.2247	0.2475	0.7988	0.3640
Work status				
Not-working				
Working	0.3181	0.1559	1.3746	0.412
Partner drinks alcohol				
No				
Yes	1.1766	0.1553	3.2433	0.0000

Discussion

It is worrying to note that 31% of women in this sample reported having experienced intimate physical violence during pregnancy. Pregnant women who reported emotional intimate partner violence in this study were 17% and it is possible that this figure is understated because it can logically be assumed that those who experience physical intimate partner violence do also experience emotional violence as well (Garcia-Moreno, 2005).

Intimate partner violence is a common occurrence throughout the world but statistics show that it is especially high in Africa (Mwaba, 2016). A study in South Africa in 1998 showed that 7% of 15-19 year olds had been assaulted in the past 12 months by a current or ex-partner. A survey in 2003 in Kenya found that 43% of 15-49 year old women reported experiencing intimate partner violence in their relationship. In rural Ethopia a study by the World Health Organization (WHO) in 2005found that 49% of ever-partnered women had experienced intimate partner violence while 59% had experienced sexual violence. In Tanzania 47% of ever-partnered women had experienced intimate partner violence while 31% specifically experienced sexual violence (Population Council, 2008)

As earlier indicated 17% of the respondents reported having experienced emotional intimate partner violence as compared to those who had experienced physical IPV at 31%. As in the case of physical IPV pregnant women from poor backgrounds were more likely to report having experienced emotional violence as compared to those coming from rich backgrounds and those whose partners took alcohol were more likely to report experiencing emotional violence as compared to those whose partners did not take any alcohol. These results support the findings of Simona et. al.(2015) where alcohol was identified as one of the causes of Intimate Partner Violence in Zambia. A study in the United States by Coker et al(2002) whose participants were both men and women survivors found that for both gender physical IPV was associated with an increased risk of poor health, depressions, substance abuse, chronic mental illness, and suffering an injury. When physical and psychological IPV scores were included in the logistic regression models, Coker et.al. report that higher psychological IPV scores were more strongly associated with the above health outcomes than were physical IPV scores. Their conclusion was that both physical and psychological IPV were associated with significant physical and mental health consequences for both male and female survivors.

Cocker and colleagues findings are interesting because as alluded to earlier emotional IPV would tend to be under reported in a third world country such as Zambia because of cultural reasons(Klomegah, 2008) where only physical violence might be considered to be harmful as compared to emotional or psychological violence. The fact that psychological IPV scores in Cocker et. al's study elicited a higher association with mental and physical wellbeing of the respondents means that it ought to be taken more seriously even in third world countries such as Zambia when preventive measures are being tackle.

In the current survey it was shown across the two conditions of physical IPV and emotional IPV that age was a salient factor with old age in both conditions being negatively associated with IPV. In terms of physical violence alone married pregnant women were 2 times more likely to have experienced IPV than unmarried pregnant women. Marital status was a non- factor in terms of predicting emotional violence in the pregnant women in this survey. For both physical and emotional violence the pregnant women who experienced more exposure to the media and those whose partners took alcohol were more likely to experience IPV than those less exposed to the media and those whose partners did not take alcohol.

It is interesting to note that for both physical and emotional IPV more exposure to media also meant more likelihood to experience IPV from their partners. This is a finding which requires more enquiry because in some studies it has been shown that exposure to media such as newspapers and television was negatively associated with women justifying IPV whereas frequent exposure to radio was positively associated to the women justifying IPV (Krause.et.al, 2016). The results in relation to alcohol intake by a partner in both conditions where the pregnant women whose partners took alcohol experienced more IPV might be easier to explain. Alcohol is a drug which in most cases induces unreasonableness and violence and therefore the result of women with alcohol partner partakers more likely to experience IPV was perhaps expected as other studies have shown (Zaleski et. al 2010).

In this survey it has been shown that both physical and emotional Intimate Partner Violence is prevalent amongst 15 – 49 years pregnant women in Zambia. Following the trend of the results in this survey we wish to recommend that:

(i) The Government of Zambia as well as other organizations involved in the fight against Gender Based Violence and in this case Intimate Partner violence re - double their efforts in order to curb this calamitous scourge.

(ii) Married men with pregnant partners be counseled and educated about the ill effects of IPV on their partners which may lead to depression, mental illness and other physical health ailments.

(iii) Married men with pregnant partners be encouraged to avoid the intake of alcohol by engaging them in counseling and affording them economically empowering opportunities.

(iv) Survivors of IPV be empowered with positive negotiating skills which will help them to prevent the occurrence of IPV where possible.

In conclusion as argued by Mwaba (2016) ultimately cultural beliefs that encourage the perpetuation of negative societal attitudes even if tacitly, that IPV is normal in any society should be tackled vigorously so that there is a mindset shift where all members of society will begin to regard GBV and IPV as criminal activities.

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