8-13-2013

Intimate Partner Violence Prevention in Africa: What Has Been Done and What Still Needs to be Done

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Intimate Partner Violence Prevention in Africa: What has been done and what still needs to be done

By

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Master of Public Health
GEORGIA STATE UNIVERSITY

A Thesis Submitted to the Graduate Faculty
of Georgia State University in Partial Fulfillment
of the
Requirements for the Degree

MASTER OF PUBLIC HEALTH

ATLANTA, GEORGIA
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Acknowledgements

I would like to thank Dr. Dan Whitaker for all of his help and support throughout this process. He has been extremely patient and attentive since the day I began brainstorming an idea for this thesis. I would never have been able to produce this review without his encouragement and assistance which I am very grateful for.

Additionally I would like to thank Dr. Jill Lee-Barber for her continued support throughout my time in the MPH program. She has been a great mentor and model for me since I began my graduate research assistantship with the Department of Student Health Promotion and I have learned invaluable lessons there under her guidance.

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APPROVAL PAGE

Intimate Partner Violence Prevention in Africa: What has been done and what still needs to be done

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ABSTRACT

BACKGROUND: Intimate partner violence (IPV) is defined as any violent or ill intended behavior that could cause harm to the other person within the confines of an intimate relationship. IPV has very serious consequences for the individual, the community, and the larger society. Much of what is known about IPV comes from studies conducted in the U.S. or other Western countries. However, women who live in developing countries have an increased risk of experiencing IPV because of poor living conditions and different social norms. Yet, little is known about specific risk factors and intervention approaches for IPV conducted in developing countries. Consequently, this thesis will focus on IPV risk factor research and interventions that have taken place in countries in Africa. To date there has not been a systematic review of this work. The project will help identify risk factors for IPV in an African context, and to determine what intervention approaches appear successful and which are not.

AIM: This thesis examines all the literature on intimate partner violence risk factors and intimate partner violence prevention interventions in African countries and provides an up to date analysis on strengths and weaknesses of the programs and future implications.

METHODS: A literature search was conducted using PUBMED and EBSCO databases using key word searches intimate partner violence and gender based violence. Restrictions were placed on study location as only interventions conducted in Africa were analyzed. The abstracts were examined based on validity of an intervention or program. Research studies were chosen based on whether or not risk factors were being tested and confirmed as contributing to IPV. Any abstracts from countries outside Africa were excluded from the review. The full texts of the articles were retrieved. There were 13 interventions and 22 research studies included in the analysis.

RESULTS: The results of the risk factor studies found that in regards to male perpetration of IPV, the five risk factors most tested for were alcohol abuse, household financial difficulties, having multiple sexual partners, living in a rural area, and religion. In regards to female victimization of IPV, the four risk factors most tested for were alcohol abuse, low education, unmarried, and religion. The interventions yielded a variety of strategies employed including the utilization of the intersection of HIV and IPV, using financial incentives to recruit and sustain participants, and a school based intervention targeting adolescents.

DISCUSSION: Based on the results of the study there is still a lot of work that needs to be done in the area of IPV in Africa. Based on the risk factors, alcohol abuse was the most tested and confirmed risk factor of victimization and perpetration of IPV. Interventions must attempt to address this problem as it is extremely pervasive in Africa. It is also crucial to address pervasive cultural norms surrounding gender, education, and religion.

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Chapter I
Literature Review

1.1 Overview of IPV

Intimate partner violence (IPV) has been identified as one of the major public health concerns women face today. IPV has been defined as "physical, sexual, or psychological harm by a current or former partner or spouse. This type of violence can occur among heterosexual or same-sex couples and does not require sexual intimacy" (Saltzman et al., 2002). The definition of IPV has changed over time as communities began to acknowledge the occurrence of violence within relationships. In the past, violence within the family or between married couples had been viewed as a private matter that did not need to be discussed outside the home. Due to shifting cultural norms, IPV has been highlighted as a public health concern by the Centers for Disease Control and Prevention (CDC), the nation's chief public health agency. The Division of Violence Prevention at the CDC has been focusing its efforts on primary prevention programs in order to prevent IPV from occurring (Hammond et al., 2006). Although men and women can both perpetrate IPV, men are more likely than women to exhibit more serious acts of physical aggression (Archer 2002). Acts of physical aggression may include throwing something at the other, pushing, shoving, kicking, choking, or threatening with a knife or gun (Archer 2012). Additionally, women living with female partners experience less IPV than women living with male partners (Black et al., 2011). Thus, this thesis will specifically focus on IPV perpetrated by males towards their female partners.

Although IPV is widely recognized as a global problem, most of the risk factor research and intervention research has been conducted in the U.S. or other Western countries. There are no systematic reviews, for example, of IPV research in non-Western countries, and thus it is not clear whether risk factors are similar or different in Western and non-Western countries. This

Thesis will provide a comprehensive review of risk factor research and interventions conducted in African countries. The goals of this thesis are to (1) identify and describe risk factors for IPV perpetration and victimization in African populations, and (2) to describe intervention approaches used in Africa. By analyzing both the risk factors and the interventions available, it is possible to elucidate gaps in IPV research and prevention and provide a comprehensive assessment of the work that still needs to be done.

1.2 Global Prevalence

The National Intimate Partner and Sexual Violence Survey (NISVS) conducted by the CDC found that violence against women is primarily perpetrated by intimate partners, specifically, that "60% of the women who reported being raped, physically assaulted, and/or stalked were victimized by a current or former husband, cohabiting partner, boyfriend, or date" (Black et al., 2011). Prevalence rates can differ by culture as evidenced by research findings that suggest American Indian experience significantly more rape than their white or African-American counterparts, and Hispanic women report a significantly lower rate of IPV than non-Hispanic women (Black et al., 2011). It is unclear as to whether differences in prevalence rates are due to variations in reporting practices or social, environmental, or demographic factors that may intersect with IPV. Reporting rates may be impacted by the woman's willingness to disclose personal information regarding violence, and her perception of what constitutes violence (Tjaden & Thoennes, 1998). For example, when asked why they chose not to report their victimization to the police, most women stated they were afraid their partner would retaliate (Tjaden & Thoennes, 1998). Additionally, women stated the attack was a one-time incident or a minor event, they were too ashamed to report the incident and wanted to keep it private, or they believed the police could not do anything to help them (Tjaden & Thoennes, 1998).

The World Health Organization (WHO) has estimated the global prevalence rate of IPV against women to be between 10% and 52% (Garcia-Moreno et al., 2006). Prevalence rates vary from country to country, and it is difficult to know the exact prevalence across countries because there is no common surveillance system used across countries. Estimates can also be greatly affected by cultural barriers including stigma which can have a substantial affect on reporting rates. IPV rates vary from country to country with a rate of 12% in Morocco to 54% in Ethiopia to 80% in Uganda (Olayanju et al., 2013). In Rwanda, 37% of married women have experienced physical violence since the age of 15 (Verduin, et al., 2013). The continent of Africa contains a wide range of IPV prevalence rates due to differences in religion, literacy rates, and cultural norms present in each country (Uthman et al., 2010). Africa has been chosen as the focus population of this thesis with an understanding that differences exist when comparing one country to the next.

Due to the lack of interventions available regarding IPV and the insurmountable rates of poverty and governmental turmoil, women in Africa experience a disproportionately high prevalence of IPV when compared to other parts of the world (Okenwa et al., 2009). High rates of poverty and governmental turmoil have been associated with IPV as community members experience less control over their lives in conjunction with a decreased efficacy to change their current political climate resulting in possibly violent outcomes (Jewkes et al., 2010). Research suggests that IPV should not solely be viewed as "an expression of male dominance over women but also as male vulnerability stemming from social expectations of manhood that are unattainable due to factors such as poverty experienced by men" (Jewkes 2002).

1.3 Consequences

IPV can lead to both fatal and non-fatal consequences that can have a long lasting impact on the individual, the family, and the community. In the United States out of the 4.8 million intimate partner violence incidents, 2 million will result in injury to the victim (Black et al., 2011). Fatal outcomes include "femicide, suicide, maternal mortality, ante partum hemorrhage, abortion, stillbirth and AIDS" (Joyner et al., 2012). Non-fatal outcomes include "burns, fractures, chronic pain syndromes, mental illnesses, problems with hearing and sight, arthritis, seizures, headaches, STI's, HIV, and pelvic inflammatory disease" (Joyner et al., 2012). Results from the National Violence Against Women Survey (NVAWS) suggest that IPV is chronic in nature as 65% of the women suffering from IPV had been victimized multiple times by the same partner (Saltzman et al., 2002). Therefore several of the consequences of IPV can be chronic in nature or can be developing for several years. The majority of women who participated in the NVAWS experienced relatively minor injuries such as scratches, bruises, and welts (Saltzman et al., 2002). In 1994, "hospital emergency department personnel treated an estimated 243,000 women and men for injuries sustained at the hands of spouses, ex-spouses, boyfriends, and girlfriends" (Saltzman et al., 2002). Research suggests a strong correlation between IPV and poorer physical health outcomes for females including chronic pain, gastrointestinal problems (Burke et al., 2005), disability, arthritis, and headaches or migraines (Coker et al., 2000). Within the male-female relationship, there are interpersonal consequences of IPV including loss of trust and respect between partners and forever altering the balance of power and equality. Additionally, mental health outcomes have been identified as "mental distress, suicidal ideation and attempts (Tadegge 2008), depression (Deyessa et al., 2009), stress and anxiety, and psychosis" (Gessessew & Mesfin, 2004). Thus, IPV is a significant public health problem affecting women

worldwide. While public health interventions are necessary to combat the issue, it is difficult to decipher which consequences are direct results of IPV and which may be confounded by other social ills.

1.4 Risk factors

Risk factors of IPV are present at every level of the socio-ecological model including the individual level, the interpersonal level, the community level, and the larger society level (Dalal et al., 2010). Risk factors embody characteristics that are related to higher levels of IPV but it is important to note that not all risk factors may contribute to IPV equally in all contexts. For example, an individual characteristic may be a risk factor in one community, but a protective factor in another community due to differences in community norms.

In U.S. and Western sample populations, the risk factors most strongly related to woman's victimization of IPV include female perpetration of violence towards partner (Stith et al., 2003), low education, being unemployed, history of depression, eating disorder, containing personality traits of irritability or hostility, and believing in norms tolerating spousal abuse (Schumacher et al., 2001). The risk factors most strongly related to men's perpetration of IPV were having a past history of being physically abusive (Stith et al., 2003), being young, low education, blue-collar occupations, lower household income, childhood abuse, witnessing interparental aggression, and exhibiting personality traits such as anger, hostility, depression, alcohol, and drug abuse (Schumacher et al., 2001). Additionally, interrelationship factors that can contribute to IPV include marital discord, jealousy, the need for power, and insecurity with partner (Schumacher et al., 2001).

Based on research studies executed in Africa, various risk factors have been ascertained to contribute to IPV. Some are similar to risk factors present in the U.S. and Western populations

while others appear to be indigenous to the African culture. Risk factors at the individual level may include alcohol consumption and abuse (Pitpitan et al., 2013), low levels of literacy, low educational attainment (Jewkes et al., 2011), low self-efficacy, religion, and the woman having witnessed abuse as a child (Guruge et al., 2012). There are caveats to each of these risk factors that make it difficult to state any one of these factors contribute to IPV every time it is seen. The issue of low educational attainment is viewed as a risk factor in some African research studies and as a protective factor in others. In several research studies the data suggests that women with high educational attainment are at a greater risk of being victimized by their partners than women with low educational attainment (Klomegah, 2008). This is hypothesized to be true due to women defying cultural norms by attaining higher education rates. These women may tend to be more assertive, thus threatening the male's power and control resulting in consequent physical abuse (Moore 2008). Risk factors at the interpersonal level include male control of wealth (Dada Ojo, 2013), frequent and habitual marital conflict, unemployment of one or both individuals (Fox et al., 2007), and the financial status of the couple (Guruge et al., 2012). These risk factors illustrate characteristics present within the confines of an intimate relationship. Risk factors at the community level include women isolation and lack of social support from community leaders and elders (Mann et al., 2009), pejorative community attitudes that devalue women and legitimize domestic abuse (Jewkes et al., 2010), and community poverty levels (Eaton et al., 2012). Community level risk factors are significant due to the amount of influence the community has on the lifestyle and health behaviors of community members (Garoma et al., 2012). Risk factors at the society level include pervasive and antiquated gender norms, predominantly patriarchal societies (Archer 2002), inadequate or ineffective laws and policies regarding IPV, and limited education and awareness of IPV issues from law enforcement

officials, health care workers, lawyers, and the government (Guruge et al., 2012). Cultural norms may be a strong risk factor of IPV as illustrated by a particular culture in Zimbabwe known as Shona where, "girls are taught how to please their future husbands as well as to be gentle, submissive, and obedient wives" (Shamu et al., 2012). These types of cultural and gender norms may be difficult to change or modify in communities and could lead to underreporting.

1.5 Cultural norms in Africa

There are several specific factors that may be important determinants of IPV in Africa including cultural beliefs and norms and socioeconomic conditions. Depending on cultural beliefs and norms, some communities believe it is acceptable for a man to hit his wife under certain circumstances. A research study conducted in west Ethiopia found that several community members believed IPV against women was acceptable under particular conditions including failure to give birth, suspicion of infidelity, constantly arguing with her husband or neighbors/community members, disobeying her husband, and circumstances in which a woman attempts to go against the culture and vocalize her thoughts or opinions (Joyner et al., 2012). In contrast, conditions in which IPV are unacceptable to the same community members include male infidelity, drunkenness of the husband, and constantly attacking the wife based on trivial issues (Garoma et al., 2012). One research study found "60% of men and 87% of women believed that beating is justified if the woman was sexually unfaithful" (Garoma et al., 2012). Unfortunately, in order for the community to believe IPV is truly unacceptable it must been proven that the "wife has fulfilled the expectations of the husband and the community including obeying the husband, taking care of the children, giving birth, and not have extra-marital sexual relations" (Garoma et al., 2012). Especially in Africa, cultural norms play a large part in predicting IPV. These cultural norms differ greatly from country to country for reasons including

varying literacy rates, religion, and poverty levels which all influence community and cultural norms. Gross domestic product per capita ranges from US$250 in Ethiopia, Malawi, and Rwanda to US$2000 in Namibia and Swaziland. The adult female literacy rates ranges from 17% in Burkina Faso to 90% in Lesotho. Additionally, the percentage of men with more than one wife ranges from 3% in Liberia to 33% in Nigeria, reflecting differences in societal norms and expectations (Uthman et al., 2010).

1.6 Theories of IPV

Several theories have been formulated in order to explain the occurrence of risk factors of IPV and subsequently the occurrence of IPV in the community. The feminist theory is perhaps the most commonly utilized theory to explain male to female IPV. The feminist theory originates from the belief that patriarchy and oppression are universal facets of society. Culturally oppressive views of women "are not only sanctioned but also embedded in and expressed through all social institutions" (Taylor et al., 2011). Proponents of this theory believe that males abuse their female partners to exert power and control over her. "Violence is one way to create and enforce gender hierarchy and punish transgression" (Burazeri et al., 2005). Additionally, women are consistently at a disadvantage due to male dominance in the work place, in government, and in religious organizations. It can be speculated that in staunchly patriarchal cultures IPV is more prevalent than in less patriarchal cultures (Archer, 2006). The subordination of women tends to be compliant with pervasive gender norms that are inherent to popular culture (Brown 2006). Additionally, feminist theory substantiates that although most attitudes towards women is found on a continuum, typically attitudes can be split into two groups: "very traditional or patriarchal people, who clearly endorse or support male domination of women, and very egalitarian or feminist people, who reject principles of male superiority and domination" (Herzog

2007). These attitudes and beliefs can differ by culture, country, or religion. Critics of the feminist theory argue that it is impossible to split people into two such polar groups based on the socio-political climate found in developed countries. Overt sexism may not be as large a problem as covert or subtle sexism which could include victim blaming or the depiction of women in the media as weak or sexualized (Herzog 2007).

A second approach used to explain IPV the related conflict and interactional perspectives. Both hold that IPV arises during the course of conflicts and interactions, and that communication and interactions between intimate partners is crucial to understanding intimate partner violence. These perspectives hold that it is vital to investigate behaviors and perceptions of behaviors as separate entities. "Interactional models emphasize the importance of person situation interactions in efforts to understand both personality and behavior" (Karin et al., 2008). This perspective goes hand in hand with the conflict perspective which argues that "violence is a non-legitimate tactic individuals employ to settle interpersonal conflict with the perceived intention of causing physical pain or injury to another person" (Straus et al., 1981). The idea of aggression is a complex, multifaceted construct that involves a continuous interaction between people and the situations they face. When a relationship is threatened it can cause one or both partners to respond angrily and if not managed properly can ultimately result in violence (Finkel & Slotter, 2006). Consequences of a harmful intimate partner relationship include low functionality, low self-efficacy, and typically involve damaged partners who are stressed and at a higher risk for developing mental disorders (Lawrence et al., 2012).

1.7 The present study

This thesis will provide a comprehensive review of risk factor research and interventions conducted in African countries. The goals of this thesis are to (1) identify and describe risk

factors for IPV perpetration and victimization in African populations, and (2) to describe intervention approaches used in Africa. By analyzing both the risk factors and the interventions available, it is possible to elucidate gaps in IPV research and prevention and provide a comprehensive assessment of the work that still needs to be done.

Chapter II: Methods and Procedures

2.1 Literature search

A literature search was conducted using PUBMED and EBSCO databases. The key word searches included “intimate partner violence” or “gender based violence” or “domestic” or “dating” plus “violence” or “abuse” or “assault”, “Africa”, and “intervention” or “program”. No restrictions were placed on study date. Restrictions were placed on location as only countries in Africa are being considered for this review. Additional searches were conducted by substituting a specific country name for “Africa”. Countries specifically searched for included Kenya, Uganda, Nigeria, South Africa, Ethiopia, Niger, Egypt, Morocco, Djibouti, Madagascar, Malawi, Mauritius, Mozambique, Rwanda, Somalia, Sudan, Tanzania, Zambia, Zimbabwe, Angola, Cameroon, Chad, Congo, Libya, Tunisia, Botswana, Lesotho, Namibia, Swaziland, Gambia, Cote d’Ivoire, Ghana, Liberia, Mali, Mauritania, and Sierra Leone.

All articles that described risk factor research and interventions or programs were included in the review of the programs available section. All research articles included were required to have empirical data relating some risk factor to either female IPV victimization or male IPV perpetration. All intervention studies included were required to have evaluations conducted on the intervention in order to ascertain results. The reviewed studies will be examined to determine (1) which risk factors have been studied, (2) which ones relate to IPV victimization and perpetration, and (3) what intervention approaches have been utilized and in what contexts.

Chapter III: Results

Table 1: Risk Factor Review

Reference	Country	Sample population	Sample size	Risk Factor for Female (Victimization)	Relation to IPV	Risk factor for Male (Perpetration)	Relation to IPV
Abeya, et al.	Ethiopia	Men and women that had ever been married/cohabited from one urban and four rural districts in East Wollega Zone were recruited. Multiple ethnic groups present (Oromo, Amhara, Gurage, and Tigre)	115	Community attitudes condone IPV	Positive	Community attitudes condone IPV	Positive
Verduin, et al.	Rwanda	Married men and women who were inhabitants of Byumba province	241	Common mental health disorder	Null	Common mental health disorder	Null
				Suicidal ideation	Null	Suicidal ideation	Null
Antai	Nigeria	Women aged 15-49 who were residents or visitors in the community were recruited	2877	Working outside the house	Positive		
				Attitudes justifying IPV	Positive		
				Autonomy in domestic decision making	Negative		
						Controlling behavior	Positive

				Living in a rural area	Positive	Living in a rural area	Positive
Mann & Takyi	Ghana	Married men and women between the ages of 15-49 were randomly selected	2133	Autonomy in domestic decision making Low education Religion	Negative Positive Null	Autonomy in domestic decision making Low education Religion	Positive Positive Null
Pettifor, et al.	South Africa	Sexually active women aged 18-24 were recruited from a family planning, STI, VCT clinic in inner-city Johannesburg	30	Financially dependent on spouse Low education	Positive Positive		
Tumwesigye, et al.	Uganda	Women aged 15-49 were randomly selected based on the Uganda Demographic and Health Survey	1743	Low education Living in a rural area	Positive Positive	Alcohol abuse Living in a rural area	Positive Positive
Townsend, et al.	South Africa	Sexually active men aged 25-55 living in Cape Town were recruited	428			Attitudes justifying IPV Inconsistent condom use Reported at least one symptom of a STI Engaged in transactional sex Alcohol abuse Having multiple sexual partners Sexual HIV risk behaviors	Positive Null Positive Positive Positive Null Positive

Okenwa, et al.	Nigeria	Women aged 15-49 were recruited from the obstetrics and gynecology department of the Lagos University Teaching Hospital	934	Religion	Positive		
				Low education	Positive		
				Low literacy levels	Positive		
				Autonomy in domestic decision making	Positive		
				Young age	Positive		
				Media Viewing	Negative		
						Having multiple sexual partners	Positive
						Smoker	Positive
				Having children	Positive	Having children	Positive
				Household financial difficulties	Positive	Household financial difficulties	Positive
				Alcohol abuse	Positive	Alcohol abuse	Positive
Wong, et al.	South Africa	Men and women over the age of 18 were recruited by advertisements and referrals from community-based organizations within two townships (Langa and Manenberg)	395	Alcohol abuse	Positive		
				Drug abuse	Null		
				Sexual HIV risk behaviors	Null		
				Depression	Positive		
				Exposure to community violence	Null		

Zacarias, et al.	Mozambique	Women aged 15-49 were recruited from the forensic services department at the Maputo Central Hospital	1442	Low education	Null		
				Alcohol abuse	Positive		
				Unmarried	Positive		
				Smoker	Positive		
				Having children	Positive	Having children	Positive
				Controlling behavior	Positive	Controlling behavior	Positive
Shamu, et al.	Zimbabwe	Pregnant or nursing women were recruited from public primary health facilities in low-income high density residential suburbs in Harare	64			Sexual HIV risk behaviors	Positive
				Community attitudes condone IPV	Positive	Community attitudes condone IPV	Positive
Gass, et al.	South Africa	Men and women older than 18 years living in households and hospital-based hostels were sampled from the South Africa Stress and Health Study	1715	Physically abused as a child	Positive	Physically abused as a child	Positive
				Witnessing domestic abuse during childhood	Positive	Witnessing domestic abuse during childhood	Positive
				Unmarried	Negative	Unmarried	Positive
				Alcohol abuse	Positive	Alcohol abuse	Positive
				Household financial difficulties	Positive	Household financial difficulties	Positive

Peltzer, et al.	South Africa	Couples were recruited from community health centers in Nkangala and Gert Sibande health districts. Women were pregnant women aged 18 and older at the antenatal care clinic and men were aged 18 and older with an enrolled pregnant partner	239			Having multiple sexual partners	Positive
				Sexual HIV risk behaviors	Positive	Sexual HIV risk behaviors	Positive
Eaton, et al.	South Africa	Men and women who attend alcohol serving venues in Cape Town were recruited	2120	Being pregnant	Positive	Spouse is pregnant	Positive
				Alcohol abuse	Positive	Alcohol abuse	Positive
Klomegah	Zambia	Married women aged 15-49 who participated in the Zambia Demographic and Health Survey were selected	4731			Young age	Positive
				Attitudes justifying IPV	Positive	Attitudes justifying IPV	Positive
				Living in a rural area	Negative	Living in a rural area	Negative
				Religion	Null	Religion	Null
Moore	Togo	Women aged 15 years and older were sampled from a representative survey of Togolese families and households	2759	Women with multiple children	Negative		
				Low education	Negative		
				Living in a rural area	Negative	Living in a rural area	Negative
				Religion (Islam)	Positive	Religion (Islam)	Positive

Jewkes, et al.	South Africa	Women aged 15-25 were recruited from schools in a rural community	1099	Sexual HIV risk behaviors	Positive		
McCloskey, et al.	Tanzania	Women aged 20-44 who were in a relationship were randomly selected in the Moshi Urban District	1444	Low education	Positive		
				Experienced problems conceiving	Positive		
				Young age	Null		
				Freedom to choose a marriage partner	Null		
				Unmarried	Null		
						Having multiple sexual partners	Positive
						Household financial difficulties	Positive
				Religion (Christianity & Islam)	Null	Religion (Christianity & Islam)	Null
Abrahams, et al.	South Africa	Men in heterosexual relationships were recruited from three divisions of work including civil engineering, water and cleansing, and parks and recreation in Cape Town	1368			Witnessing domestic abuse during childhood	Positive
						Engaging in violent behavior at work or in the community	Positive
Stockl, et al.	Tanzania	Women aged 15-49 were randomly selected in the cities of Dar es Salaam and	1721	Uptake of antenatal and post-natal care	Null		

		Mbeya					
				Ever having a miscarriage	Null		
				Low birth weight of the last born child	Null		
				Bride price	Null		
				Unmarried	Positive		
				Unintended pregnancy	Positive		
						Alcohol abuse	Positive
						Refusal to use condoms	Positive
						Having multiple sexual partners	Positive
				Low education	Positive	Low education	Positive
				Young age	Null	Young age	Null
Dada Ojo	Nigeria	Adult men and women were randomly selected from the city of Agege in Lagos	120	Infidelity	Positive		
						Alcohol abuse	Positive
				Household financial difficulties	Positive	Household financial difficulties	Positive
Oladepo	Nigeria	Men and women who had ever been in an intimate relationship were randomly recruited from three states (Kaduna, Enugu, and Oyo)	3000	Unmarried	Negative		
				Young age	Positive		
						Alcohol abuse	Positive
						Smoker	Positive

Table2

	Risk Factor for Female (Victimization)	Number of Studies that had the risk factor present	Number of studies that confirmed risk factor contributes to IPV	Percentage
Individual level Risk Factors	Attitudes justifying IPV	2	2 out of 2	100.00%
	Alcohol abuse	5	5 out of 5	100.00%
	Low education	8	6 out of 8	75.00%
	Sexual HIV risk behaviors	3	2 out of 3	67.00%
	Young age	4	2 out of 4	50.00%
	Unmarried	5	2 out of 5	40.00%
Interpersonal Level Risk Factors	Having children	2	2 out of 2	100.00%
	Household financial difficulties	3	3 out of 3	100.00%
	Autonomy in domestic decision making	3	2 out of 3	67.00%
Community level risk factors	Community attitudes condone IPV	2	2 out of 2	100.00%
	Living in a rural area	4	2 out of 4	50.00%
	Religion	5	2 out of 5	40.00%

Table3

	Risk factor for Male (Perpetration)	Number of Studies that had the risk factor present	Number of studies that confirmed risk factor contributes to IPV	Percentage
Individual level Risk Factors	Controlling behavior	2	2 out of 2	100.00%
	Low education	2	2 out of 2	100.00%
	Alcohol abuse	8	8 out of 8	100.00%
	Attitudes justifying IPV	2	2 out of 2	100.00%
	Smoker	2	2 out of 2	100.00%
	Sexual HIV risk behaviors	3	3 out of 3	100.00%
	Witnessing domestic abuse during childhood	2	2 out of 2	100.00%
	Young age	2	1 out of 2	50.00%
Interpersonal Level Risk Factors	Having children	2	2 out of 2	100.00%
	Household financial difficulties	4	4 out of 4	100.00%
	Having multiple sexual partners	5	4 out of 5	80.00%
Community level risk factors	Community attitudes condone IPV	2	2 out of 2	100.00%
	Living in a rural area	4	2 out of 4	50.00%
	Religion	4	1 out of 4	25.00%

Table4

Reference	Country	Sample Population	Intervention Details	Strategies	Results
Mankuta, et al	Democratic Republic of Congo	Women were recruited from three primary care clinics focusing on sexual assaults. The clinics chosen were remote so service could be provided to populations that typically have limited access to medical and psychological services.	The four components of the intervention involved training the local staff on primary care gynecology and the psychological aspects of sexual assault, a clinical and medical evaluation of the victims, a psychological evaluation of the victims, and transport of the victims to a central hospital for further surgery.	Provide access to medical aid, enhance self-efficacy, raise awareness of treatment and psychological effects	Health conditions improved, self efficacy of the women increased, psychological effects were treated
Kalichman, et al	South Africa	475 men living in two townships in Cape Town were recruited by chain recruitment in order to reach men in their social networks.	Men examined the personal and community consequences of gender violence and HIV/AIDS, participated in activities geared toward addressing gender roles and reducing adversarial attitudes toward women, training men to become vocal advocates for risk reduction behavior change with other men in the community, communication skills for initiating conversation within relationships	Targeting men who are essential agents of change due to power imbalance, addressing HIV prevention by tackling gender-based violence, utilized Social Cognitive Theory	Reductions in negative attitudes towards women, reduced propensity to act violently against women, and increased testing for HIV

Njuki, et al	Kenya	Women were recruited from reproductive health facilities in five provinces of Kenya (Kisumu, Kitui, Kiambu, Kilifi, and Korogocho)	The gender based violence recovery service vouchers are freely available to women at the facility and provide access to medical exams, hospitalizations, lab testing, HIV counseling, links to support groups, family planning methods, and maternal and newborn services	Increase the participation in gender-based violence recovery services by utilizing a reproductive health voucher program	Increase in family planning methods, increased skilled birth attendance, no increase in GBVRS program due to lack of understanding and stigma of GBV
Jewkes, et al	South Africa	Men and women aged 16-23 were recruited from schools in 70 villages around the town of Mthatha	The intervention included critical reflection, role play and drama, single-sex workshops and dual-sex workshops. The themes of the intervention included sex and love, conception and contraception, taking risks and sexual problems, gender-based violence, communication skills, STDs/HIV, and motivations for sexual behavior.	Tackle gender based violence by concurrently preventing the spread of HIV	Increased communication skills between partners, enhanced self-efficacy
Usdin, et al	South Africa	Community members were recruited through advertisements on the radio, television, and print	At the socio-political level, an advocacy campaign was conducted to ensure implementation of the Domestic Violence Act. The television and radio were utilized to gain public support and reach a wide audience. At the community level, collective efficacy was enhanced through mass media, pamphlets, posters, and community events. At the individual level, a toll-free helpline was available to impact knowledge and raise awareness.	Reduce domestic violence by targeting the individual, the community, and the socio-political environment. By mobilizing the community and mediating shifts in cultural norms, it is possible to create an enabling legal environment to stop domestic violence.	Increased knowledge of abuse, shift in attitudes towards domestic abuse, and increased collective efficacy

Wechsberg, et al	South Africa	Women aged 18 and older who reported use of alcohol, were an active sex worker, living in Gauteng Province, and reported South African citizenship were recruited to participate in the intervention	Women complete a personalized action plan to address their individual risk behaviors and develop goals to reduce sex risk, substance abuse, and gender based violence. The intervention aimed to increase knowledge about risky behavior, role-playing to teach proper condom use, and active referrals to counseling services.	Utilize the intersectionality between HIV risk, substance abuse, and gender based violence to improve the overall health of the community	Increased self efficacy and collective efficacy for women, reduced risk levels for HIV
Warren, et al	Kenya, Swaziland	Women are recruited from public health facilities in Central and Eastern provinces in Kenya and three regions in Swaziland	Intervention includes mother/baby physical exams, infant feeding counseling, postpartum counseling and provision, HIV counseling and testing, screening for cervical cancer, and HIV treatment	Utilize the intersectionality between HIV services and sexual and reproductive health to improve the overall health of the community	No results yet
Abramsky, et al	Uganda	Community members are recruited by the Centre for Domestic Violence Prevention in Kampala who work voluntarily to facilitate and promote intervention activities	Community activists, community leaders, health care professionals, police officers, and institutional leaders work together to mobilize the community by conducting community dramas, small group activities, facilitating discussion, increase access to health services, influence policy change.	The intervention uses a community mobilization approach to try to change the community attitudes and norms and behaviors that underlie power imbalances including risky HIV behavior and the perpetration of violence against women. A holistic approach operating at the individual, community, and societal level.	No results yet

Joyner, et al	South Africa	Adult women were recruited from three rural primary care facilities	Two nurse practitioners taught a session on the history of abuse specifying emotional, sexual, financial, and physical abuse. The women were offered comprehensive medical exams, HIV tests, and psychiatric assessments.	The interventionists aimed to reduce IPV by increasing access to healthcare services and giving women a safe space to discuss issues of abuse.	Increased seeking out protection orders, increase in social worker visits, women felt better after talking to someone and explaining their situation
Kim, et al	South Africa	Women aged 18 and older from the poorest households in each village were identified and recruited by community leaders	Women attended training on issues including gender roles, communication, cultural beliefs, power relations, self-esteem, domestic violence, and HIV. The women were also given loans to support a range of small businesses.	This intervention utilizes the intersection between poverty, gender inequalities, and health by implementing a program that combines microfinance with gender and HIV training.	Improvements in economic well being, enhanced women's empowerment, lowered IPV risk
Krishnan, et al	Tanzania	Men and women aged 18-30 living in 10 villages in Kilombero/Ulanga were randomly selected from the Ifakara Demographic and Health Surveillance System database.	Participants underwent STI/HIV counseling and testing. They received cash payments for every 4 monthly negative STI laboratory test result. All individuals were invited to group counseling sessions that focused on relationship and life skills training.	These researchers employed a financial incentive program to keep participants from engaging in risky sexual behavior.	Men and women expressed more gender equitable behavior, reduction of reported IPV, increased shared decision making power

Rijsdijk, et al	Uganda	Adolescents were recruited to participate in over 150 schools throughout Uganda	This school-based intervention aimed to empower and support young people in making their own, informed decisions about sex. The computer-based program develops computer skills and creative expression. Virtual peer educators guide students in learning about self-esteem and decision making, the social environment, sexuality, HIV/AIDS, and goal setting.	These researchers utilize teachers to act as non-judgmental facilitators and role models throughout implementation.	Students were able to detect wrong beliefs about pregnancy prevention, more likely to delay first time sex, more positive attitudes towards condom use, and higher intention to use condoms
Mohlala et al	South Africa	Women were recruited from the midwife and obstetrician unit in Khayelitsha, Cape Town	All participants were offered antenatal care, HIV group education, and individual counseling. Additionally, pregnancy counseling was offered. HIV education included risk behavior, risk assessment, serodisclosure, coping with results, and benefits of testing.	The researchers attempted to engage men to participate in the intervention by asking pregnant women to solicit their male sex partners to join them. Additionally the men were offered counseling, rather than simply pregnancy HIV prevention as an incentive.	The use of the counseling letter increased male attendance compared with the pregnancy prevention letter

3.1 Risk factor studies results

Twenty two research studies were found that examined risk factors for intimate partner violence and included in this review. Those studies were conducted in several different African countries including Ethiopia, Rwanda, Nigeria, Ghana, Mozambique, Zimbabwe, South Africa, Zambia, Togo, Tanzania, Botswana, and Uganda. Table 1 shows all of the studies including sections of reference, country, sample population, sample size, risk factor for females IPV victimization (n = 20), risk factor for male IPV perpetration (n = 19) and the relation between the risk factor and its contribution to IPV. Regarding the risk factor studies, two of the studies targeted only males, 11 studies targeted only females, and 9 studies targeted both males and females. The sample size ranged from 30 to 4731 with a median of 1405. The mean and standard deviation of the sample sizes were mean = 1396.27, sd = 1214.38. On average, the studies examined 4.23 risk factors with a standard deviation of 2.88.

A variety of risk factors were examined. Several were more common than others. Table 2 shows the risk factors for female victimization that were present in at least two studies, organized by a social ecological model with individual, interpersonal, and community level risk factors. Wherever possible, risk factors were assigned levels according to the conceptualization used by Schumaker. On an individual level, these risk factors include: attitudes justifying IPV, alcohol abuse, low education, sexual HIV risk behaviors, young age, and being unmarried. On an interpersonal level, risk factors included having children, household financial difficulties, and autonomy in domestic decision making. On the community level, risk factors included community attitudes that condone IPV, living in a rural area, and religion. The four risk factors most commonly studies were alcohol abuse, education, marital status, and religion. Alcohol abuse was tested in five studies and all five found a relationship between alcohol abuse and

female victimization. Education level was tested in eight studies and six out of eight found a negative relationship; less educated women were more likely to be victims of IPV. Marital status was examined in five studies; two found that single women were more likely to be a victim of IPV. Two studies found that being unmarried was a protective factor to IPV, and one found no relation. Religion was also examined in five studies, two of which found that women who were more highly religious had a greater chance of being a IPV victim. The other three studies found no relation between religion and IPV.

In regards to female victimization, several variables were examined in only one study and found to have a relationship to IPV including working outside the home, low literacy, depression, smoking, controlling behaviors, being pregnant, experiencing problems conceiving, unintended pregnancy, woman's infidelity, experiencing physical abuse as a child, and witnessing domestic violence as a child. Other factors were examined in only one study and found to have a negative relationship with IPV including media viewing (i.e. exposure to newspapers, radio, and television) and having multiple children. Risk factors that were found to have no relationship with IPV include exposure to community violence, having a mental health disorder, suicidal ideation, having more freedom to choose a marriage partner, receipt of ante natal and post natal care, ever having had a miscarriage, low birth weight of the last born child, bride price (i.e. dowry), and unintended pregnancy

Table 3 shows the risk factors for male perpetration that were present in at least two studies. On an individual level, risk factors included: controlling behavior, low education, alcohol abuse, attitudes justifying IPV, being a smoker, sexual HIV risk behaviors, and witnessing domestic abuse during childhood, and young age. On an interpersonal level, risk factors included having children, household financial difficulties, and having multiple sexual

partners. On the community level, risk factors included community attitudes that condone IPV, living in a rural area, and religion. The five risk factors most tested for were alcohol abuse, household financial difficulties, having multiple sexual partners, living in a rural area, and religion. Alcohol abuse was examined in eight studies and all found a relationship between alcohol abuse and perpetration of IPV. Household financial difficulties was tested in four studies and all found a relationship with IPV perpetration. Having multiple sexual partners was tested in five studies and four out of five found a relationship, the remaining study found no relationship. Living in a rural area was tested in four studies and two out of four found that living in a rural area was related to perpetration of IPV; the remaining two found a negative relationship. Religion was tested in four studies and only one out of four found a relationship; the remaining three found no relationship.

In regards to male perpetration, several variables were examined in only one study and found to have a relationship to IPV including autonomy in domestic decision making, reporting at least one symptom of an STI, engaging in transactional sex, being physically abused as a child, being unmarried, having a spouse who is pregnant, refusal to use condoms, and engaging in violent behavior at work or in the community. Risk factors examined in one study that found no relationship with male perpetration of IPV included common mental health disorder, suicidal ideation and inconsistent condom use.

3.2 Intervention results

Thirteen intervention studies were included in this thesis. The studies were conducted in six different African countries including South Africa, the Democratic Republic of Congo, Kenya, Swaziland, Uganda, and Tanzania. Target populations of the interventions varied across the countries. Five intervention studies recruited community samples, two recruited participants

from schools, four recruited from health facilities, one targeted female sex workers, and one targeted community members recruited by local domestic violence prevention agencies.

The interventions used a variety of strategies to combat the issue of intimate partner violence. Four of the programs addressed IPV with other related issues, most notably HIV prevention, in order to increase visibility and raise awareness of the problem. HIV may receive greater funding in Africa relative to IPV prevention as it is seen as a higher priority than IPV. Consequently, IPV programmers must utilize HIV prevention efforts to deal with IPV as the two issues may be correlated through common risk factors, or directly via negotiation of safe sex behaviors or HIV testing. One program (Kalichman et al., 2009) targeted men as agents of change and combined HIV prevention effort aimed at increasing testing for HIV with efforts aimed at reducing negative attitudes towards women. Men were taught to examine the consequences of gender violence and HIV/AIDS and participated in activities that trained them to become vocal advocates for risk reduction behavior change with other men in the community. The study found reductions in negative attitudes towards women, a reduced propensity to act violently against women, and increased testing for HIV. Another program (Jewkes et al., 2006) that utilized the intersection between HIV and IPV included workshops that focused on themes such as sex and love, conception and contraception, taking risks and sexual problems, gender-based violence, communication skills, STDs/HIV, and motivations for sexual behavior. A third program (Wechsberg et al., 2011) targeted high risk female sex workers and addressed their individual risk behaviors by developing goals to reduce risky sexual practices, substance abuse, and gender based violence. The intervention employed role-playing to teach proper condom use and active referrals to counseling services. These interventions found increased communication between partners, enhanced self-efficacy of women, and reduced HIV risk behaviors. The fourth

program (Warren et al., 2012) targeted women attending public health facilities. The intervention included mother/baby physical exams, infant feeding counseling, postpartum counseling and provision, HIV counseling and testing, screening for cervical cancer, and HIV treatment. No evaluation of this program was reported.

Two interventions employed community mobilization strategies to reduce IPV. One intervention (Usdin et al., 2005) conducted an advocacy campaign to ensure implementation of the Domestic Violence Act. The television and radio were utilized to gain public support in conjunction with distribution of pamphlets and posters at community sponsored events. The results included increased knowledge of abuse, shift in attitudes towards domestic abuse, and increased collective efficacy of the community. The second intervention (Abramsky et al., 2012) employed community activists, leaders, health care professionals, and law enforcement officers to mobilize the community by conducting community dramas, small group activities, and increasing access to health services. The intervention was not evaluated.

Four interventions recruited clients from health service settings to increase access to medical aid and decrease incidence of IPV. The first intervention (Mankuta et al., 2012) trained the staff at local primary care clinics in the gynecology and psychological aspects of sexual assault. They provided access to victims in need of medical attention and counseling. The results found health conditions improved, self efficacy of the women increased, and psychological effects were treated. The second intervention (Njuki et al., 2012) utilized a gender-based violence recovery service voucher program to provide access to medical exams, HIV counseling, links to support groups, and family planning methods. Results found an increase in family planning methods and skilled birth attendance but no increase in participation in gender-based violence recovery services, which was attributed to a lack of understanding and stigma

associated with gender-based violence. The third intervention (Joyner et al, 2012) employed nurse practitioners to teach women about the history of abuse including emotional, sexual, financial, and physical abuse. Women were offered medical exams, HIV tests, and psychiatric assessments. Results found an increase in seeking out protection orders, an increase in social worker visits, and an increase in healthy interpersonal discussion surrounding IPV. The fourth intervention (Mohlala et al., 2011) offered antenatal care, HIV group education, and individual counseling to couples recruited from the midwife and obstetrician unit. The intervention attempted to engage men to participate by asking pregnant women to solicit their partners to join them. The results found an increase in male participation after being offered counseling sessions.

Two interventions addressed issues of poverty as they relate to HIV and IPV. The first intervention (Kim et al., 2009) trained women on issues including gender roles, communication, cultural beliefs, power relations, self-esteem, domestic violence, and HIV, and women were given loans to support a range of small businesses. Results included improvements in economic well being, enhanced women's empowerment, and lowered IPV risk. The second intervention (Krishnan et al., 2012) implemented STI/HIV counseling and testing and incentivized participants by giving them cash payments for every four monthly negative STI laboratory test results. Participants were followed for 12 months and interviewed to gather data on issues including attitudes about IPV and relationship power, as well as experiences of victimization and perpetration. The results of the study included men and women expressed more gender equitable behavior, reduction in reported IPV, and increased shared decision making power.

One intervention (Rijsdijk et al, 2011) implemented in a school aimed to empower and support young people to make their own, informed decisions regarding sex. This computer-based program guided students in learning about self-esteem, decision making, the social environment,

sexuality, HIV/AIDS, and goal setting. Results included students were able to detect wrong beliefs about pregnancy prevention, were more likely to delay first time sex, had positive attitudes towards condom use, and a higher intention to use condoms.

Chapter IV
Discussion and Conclusion

4.1 Risk factors

The risk factors for female victimization of IPV in Africa most commonly identified are low education, history of depression, and believing in norms tolerating spousal abuse. The risk factors most strongly related to men's perpetration of IPV that are the same in African research studies include being young, low education, household financial difficulties, childhood abuse, witnessing interparental aggression, and alcohol abuse.

It is clear from the literature that several risk factors for IPV among African populations have been studied to a greater extent than others. Alcohol abuse and religion are the two risk factors that appear to be the most tested risk factors to intimate partner violence perpetration and victimization. While religion was not found to have a relationship with IPV perpetration or victimization, alcohol abuse was significantly correlated. In order to truly combat IPV, it is vital to address this pervasive factor. Alcohol consumption and abuse may reduce self-control and "affects cognitive and physical functioning which reduces the ability of an individual to negotiate non-violent conflict resolution" (Tumwesigye et al., 2012). By providing the community with alcohol prevention and cessation training, it may be possible to reduce the prevalence of IPV. By implementing policies that reduce drinking hours at bars or reduce consumption of alcohol during working hours, it is possible to make a sustainable change. Several U.S. studies have shown that reductions in alcohol use are associated with reductions in partner violence (O'Farrell et al., 2003).

In regards to HIV, young men and women in Africa experience a very high risk of contracting HIV due to the prevalence of HIV in Africa combined with a lack of condom use,

lack of awareness of HIV risk reduction methods, and lack of HIV testing. In some African cultures within a relationship, "requesting condom use or refusing sexual advances is not acceptable and may result in suspicions of infidelity and carry the risk of violent outcomes" (Pettifor et al., 2012). Consequently, IPV and HIV risk can have a bidirectional relationship, with each affecting the other. The results of this review show that HIV risk factors are a risk factor for IPV victimization and perpetration as well. As these risk factors are related to each other, it may be necessary to create interventions that address both IPV and HIV together.

4.2 Interventions

A total of 13 interventions were reviewed. Several of the interventions attempted to reduce IPV by targeting men as potential perpetrators and agents of change due to cultural and gender norms present in African culture. Additionally, "high normative acceptance among men may make it difficult for them to realize the abuse they perpetuate" (Rani et al., 2004). The results suggest that attitudes justifying IPV is a risk factor for male perpetration of IPV; by gearing interventions towards men, they may be more likely to stop violent behavior towards women.

A number of the interventions utilize the intersection of IPV and HIV to deliver their agenda by including messages surrounding IPV in HIV counseling and prevention programs. A clinic-based study found "young women reported that fear of violence was one major reason for not discussing HIV/AIDS and for not using condoms" (Erulkar 2004). By raising awareness of HIV transmission and raising self-efficacy surrounding condom use, women are given a voice to demand their right to sexual freedom. As a result, they are less likely to believe IPV is simply a part of the culture. By pushing back on one issue the women are more likely able to push back on several other issues as well.

The results showed that community attitudes that condone IPV is a risk factor for victimization and perpetration. These results have been reflected in the literature review when describing the infrastructure of law enforcement. The role of law enforcement needs to be augmented in order to help abused and victimized women, as inconsistencies in the way IPV is handled may deter woman from reporting. For example, Garoma and colleagues (2012) describe a situation in which a woman experiencing IPV went to the police for help, but local elders were sent to handle the problem. This was not helpful as the elders saw the problem as one that should be mediated between the husband and wife. The issue seems to be not one of policy, but one of implementation of those policies. By mobilizing the community, it is possible to create an enabling legal environment that will put an end to IPV. Often times, despite police presence, enforcement of policies may not occur due to cultural norms that affect day to day behavior.

The intersection of poverty and culture may have deleterious outcomes as one research study found "date rape with the intention of impregnating a girl was carried out if the girl refused a marriage offer, and was generally perpetrated by poorer men who lacked the money for bride wealth" (Shamu et al., 2012). As some African cultures maintain the use of dowry to essentially transfer a woman from her father to her husband, men who cannot afford dowry may turn to violent behaviors to get what they desire.

In addition, it would be beneficial to consistently tailor interventions to each specific country or culture within Africa. As evidenced by the literature review, there are a wide range of cultural norms present across the continent of Africa and it would be advantageous to researchers and community members to implement a program that caters to specific cultures. It would also be beneficial to implement healthy dating programs to adolescents and teenagers before they engage in sexual activity or begin to cohabit with a partner in order to foster health community

norms surrounding intimate relationships. Such programs have been shown to reduce dating violence in Western populations (Foshee et al., 2005) Alcohol prevention and cessation programs can be implemented in order to decrease the amount of alcohol abuse in high risk populations. "In 2004, Uganda had the highest per capita alcohol consumption in the world" (Tumwesigye et al., 2012). Therefore, specific countries in Africa that suffer disproportionately from alcohol abuse are in need of appropriate and effective interventions.

4.3 Limitations

This research study had several limitations. The first is that, as with any review, only published works were included and analyzed. There may be many more IPV prevention efforts occurring in Africa that did not appear in the literature and could this not be included.

A second limitation is that this thesis is a qualitative review, not a quantitative review which includes a computation of effect sizes for each risk factor to determine the strength of the relationship between risk factors and outcomes. Because there were relatively few studies with very diverse methods, it was not possible to conduct a quantitative review.

4.4 Future research

Recommendations for further research includes the need for more studies based on strong theoretical models, more studies that examine the effects of breaking up and repartnering, and more studies regarding same-sex couples in order to better understand the prevalence rates and risk factors of the gay community (Capaldi et al., 2012). One of the biggest problems when dealing with IPV in Africa is the fact that women have not yet accepted that IPV is inherently wrong. In addition, women face bigger problems like lack of resources, avoiding infectious diseases, and acquiring clean drinking water. It may be necessary to research intersecting issues including poverty in order to further understand IPV in Africa.

Additional research needs to be conducted on teen dating violence as it may be possible to prevent future IPV by preventing teen dating violence. The relationship between child abuse and witnessing domestic abuse as a child and IPV must also be researched further. A small number of research studies looked at these issues and it would be beneficial to dissect the issue further.

4.5 Conclusion

Violence against women is a global public health concern that affects millions of men and women every day. The majority of women who experience violence are victims of intimate partner violence perpetrated by a boyfriend, spouse, or partner. Intimate partner violence within a community results in severe consequences on the health of woman, their children, and the larger community. The children of mothers who experience IPV "generally experience ongoing trauma as they often witness the violence committed against their mothers and are frequently the victims of abuse themselves" (Pretorius 2009). By reducing the incidence of IPV, it is conceivable to improve the health of both current and future generations of African children. This review provides insight for policymakers, public health interventionists, and researchers who are attempting to tackle the issue of global IPV.

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