EXPERIENCES OF INTIMATE PARTNER VIOLENCE AND THE HEALTH NEEDS OF WOMEN LIVING IN URBAN SLUMS IN KAMPALA, UGANDA

by

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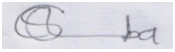
DECLARATION

I declare that **EXPERIENCES OF INTIMATE PARTNER VIOLENCE AND THE HEALTH NEEDS OF WOMEN LIVING IN URBAN SLUMS IN KAMPALA, UGANDA** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other degree at any other institution.



30 November 2015

SIGNATURE **DATE**

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ABSTRACT

Intimate Partner Violence (IPV) is a major problem among women of child-bearing age in Uganda. This study explored the IPV experiences of women living in urban slums and their health needs in order to assist in developing strategies to prevent and respond to IPV. This was a cross-sectional explanatory study using a mixed methods approach among women aged 20-45 years in Kabalagala slums, Kampala, Uganda. The quantitative survey data was collected using a structured questionnaire while qualitative data was collected using in-depth interviews. Quantitative data were collected from a random sample of 372 women and qualitative data from a purposive sample of 48 women with IPV experiences. The quantitative data was analysed using STATA (version 11), and the qualitative data was coded and analysed manually into thematic content.

The study revealed a high overall lifetime prevalence of IPV. The different IPV forms prevalent in the study population included psychological (99.7%), economic (93%), physical (92%) and sexual (88%). Physical violence in the last one year was 91%. The qualitative findings revealed the manifestations of IPV in this context. Furthermore, the physical and psychological health impacts of IPV included but were not limited to injuries; chronic pain and complications; HIV infection; low self-esteem; stress and fear of death, and loss of relationships. The researcher proposed three strategies to prevent and respond to IPV, namely implementing economic empowerment and poverty reduction programmes for women; strengthening the legal and justice system to respond appropriately to the problem of IPV, and improving the social and institutional support including training of health workers to prevent and respond to IPV. The

proposed regulation of substance and alcohol use would also contribute to reducing IPV prevalence and scaling-up the response.

KEY CONCEPTS

Intimate partner violence; violence against women; prevalence of violence; women's experiences; risk factors; perceived causes; impact of violence; women's health needs; urban slums; mixed research methods; prevention strategies; Uganda.

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Indeed, thus far the Lord has taken me − Ebenezer Jehovah.

Dedication

To the most remarkable women I have ever known – my grandmothers, Beaulah and (late) Constancia.

To my parents who believed in me.

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IPV	Intimate Partner Violence
UDHS	Uganda Demographic and Health Survey
UNFPA	United Nations Population Fund
VAW	Violence against women
WHO	World Health Organization

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CHAPTER 1

Orientation to the study

1.1 INTRODUCTION

Violence against women (VAW) is a global phenomenon of grave concern and consequence. This chapter presents the background to the research problem and the significance, aim, objectives and foundations of the study. The research design and methodology, scope and limitations of the study are also outlined.

1.2 BACKGROUND TO THE RESEARCH PROBLEM

Violence against women (VAW) prevents women from assuming any decision-making in their personal lives and in the public sphere which, then, may negatively impact on the economic, social and political landscape (Rico 1997:26). Intimate Partner Violence (IPV) as a form of VAW by a spouse or a life partner, has been proven to have various and serious short- and long-term health consequences (United Nations Population Fund [UNFPA] 2010:13). This type of violence affects women's physical, emotional and social well-being, increasing the risk of illness and disability. IPV has been generally linked to negative emotions and behaviour; for example, depression, anxiety, post-traumatic stress disorders, suicidal tendencies, eating and sleep disorders, shame, guilt, phobias and panic disorders, psychosomatic disorders, smoking, drug and alcohol abuse, suicidal behaviour, self-harm, unsafe sexual behaviour, irritable bowel syndrome, and sexual dysfunction (Murthy, Upadhyay & Nwadinobi 2010:18; UNFPA 2010:13; Liebling-Kalifani, Ojiambo-Ochieng, Marshall, Were-Oguttu, Musisi & Kinyanda 2008:182).

Between 40% and 70% of global homicides are cases of IPV against women. Women experience injuries, bruises, bleeding, burns, and pain (Murthy et al 2010:18). The health consequences of IPV include sexually transmitted infections (STIs), undesirable pregnancy outcomes, urinary tract infection, gastrointestinal disorders, vaginal bleeding and infections, persistent pelvic pain, hypertension, injuries and death (UNFPA 2010:13). These injuries manifest in different forms including fractures, burns, cuts,

wounds, disability and eye injuries. IPV reflects the societal context which underpins and encourages discriminatory attitudes and behaviour against women through negative gender stereotypes. These include the notions that women must be submissive and dependent, and must never question the authority of men who have absolute power to direct their sexuality, movement and expression.

Violence against women is rooted in gender inequality due to the socially constructed perceptions, ideas, rules and cultural beliefs about acceptable and correct male and female behaviour (UNFPA 2010:12). These culturally and socially constructed societies exacerbate discrimination against women. This can often be seen in the differences in power and unequal access to opportunities in all spheres of life. This also hinders women's ability to exercise their autonomy in decision-making, including being able to leave abusive relationships, thereby leading to communities, including women, condoning IPV (UNFPA 2010:12).

1.3 THE RESEARCH PROBLEM

1.3.1 Source of the research problem for interrogation

The researcher has over ten years' experience through engagement in women's health, including sexual and reproductive health rights. This involvement included work in the Kabalagala slums of Kampala where VAW is entrenched in the community, resulting in hopelessness and despair. Secondly, daily reports of IPV in the local media depict the various ways in which this problem impacts the lives of women, families and communities. Thirdly, the *Uganda Demographic and Health Survey, (UDHS* 2012:239) states that in Uganda, 59% of married women reported experiences of IPV. The prevalence was 61% in rural areas and 54% in urban areas thus highlighting that this is a widespread problem. The above reasons led the researcher to investigate women's experiences of IPV in order to generate evidence on effective ways to prevent violence against women.

1.3.2 Background to the problem

1.3.2.1 Uganda

Figure 1.1: Map of Uganda

(Source: United Nations Statistics Division 2013)

Uganda is a landlocked country in East Africa and shares its borders with Tanzania, Rwanda, Kenya, Democratic Republic of Congo and South Sudan (see Figure 1.1). Agriculture is the main economic activity providing 70% of national income and absorbing 80% of the labour force. In Kampala, slums lack running water and electricity (World Vision 2011:2). While there is a free health policy for all, many people do not have access to health facilities. In 2012 the population of Uganda was estimated at 36 million with a life expectancy at birth of 56 years for males and 58 years for women (WHO 2014a:1). The total fertility rate per woman is 6 and the maternal mortality rate is 360 per 100,000 births. The contraceptive prevalence rate is 30% and 48% of the population is below 14 years. The infant mortality rate is 72 per 1000 live births. The population is predominantly rural with only 16% residing in urban areas. The total expenditure on health as a percentage of the Gross Domestic Product (GDP) in 2012 was 8% (WHO 2014a:1). Women are the main contributors to the agricultural labour force at about 80% although only 7% of them own land (World Vision 2011:2).

1.3.2.2 IPV in Uganda

In 2011, 59% of married women in Uganda reported experiencing IPV (UDHS 2012:239). The practice of paying bride price is seen as a means of reinforcing IPV (UDHS 2012:4-6) and this due to the fact that some men feel that they purchased the woman and they are superior in decision-making (Madanda, Ngolobe & Amuriat 2009:7). This situation prevails, despite Uganda's ratification of the *Convention on the Elimination of all forms of Discrimination against Women (CEDAW)* in 1985 without any reservations (Madanda et al 2009:9). The Government of Uganda endorsed the initial National Gender Policy (NGP) in 1997 (Ministry of Gender, Labour and Social Development 1997:1) and the National Plan of Action on Women in 2008 (Government of Uganda 2008:1). These documents spell out gender mainstreaming as a way of addressing gender imbalances and this idea was borne out of the Fourth United Nations International Conference on Women held in Beijing, China in 1995. The premise is that gender concerns must be taken into consideration in designing, implementing, monitoring and evaluating legislation, policies and programmes (Madanda et al 2009:10).

Article 33 (1-5) of the Constitution of Uganda states:

> Women shall be accorded full and equal dignity of the person with men; the state shall provide the facilities and opportunities necessary to enhance the welfare of women to enable them to realise their full potential and advancement; the state shall protect women and their rights, taking into account their unique status and natural maternal functions in society; women shall have the right to equal treatment with men...

Nnadi (2012:48) emphasises that in order to generate evidence on effective ways to prevent VAW, researchers need to understand various forms of violence, including IPV, by using different approaches from a human rights perspective.

1.4 STATEMENT OF THE PROBLEM

A research problem refers to a study topic where there is a knowledge gap (Burns & Grove 2005:70). The problem statement forms the basis of any research (LoBiondo-Wood & Haber 2002:52) and presents the type of evidence gap, context and value of the study phenomenon (Polit & Beck 2004:85).

According to the *Uganda Demographic and Health Survey, 2011* (UDHS), 59% of married women had experienced IPV and 37% had sustained physical injuries as a result (UDHS 2012:239). Furthermore, 16% of women also experienced violence during pregnancy, and this was more common (24%) among women with low income. In spite of the political will to advance women's human rights, VAW in Uganda remains a gross human rights violation and threatens the nation's development. Due to the low regard given to women culturally, violence against women and girls remains a critical challenge in Uganda, especially for those living in abject poverty. VAW is both a cause and consequence of HIV and AIDS and is fuelled by negative cultural values and poverty (Joint United Nations Programme on HIV/AIDS [UNAIDS/UNFPA]/United Nations Development Fund for Women [UNIFEM] 2004:45). This is aggravated by the living conditions of women living in urban slums where there are social, cultural and structural inequalities. Moreover, since they are informal settlements neither government nor non-governmental agencies (NGOs) provide services in slums. Before meaningful interventions are designed, implemented and evaluated, a detailed understanding is needed of the circumstances under which IPV occurs. Less well understood is the IPV prevalence and the different forms in which it manifests itself as well as the health needs of IPV survivors.

The study wished to explore the IPV experiences of women living in urban slums and their health needs and contribute to developing strategies to prevent and respond to IPV.

1.5 AIM OF THE STUDY

1.5.1 Research purpose

The study purpose provides a clear statement showing the aim of the study based on the problem statement (LoBiondo-Wood & Haber 2002:60; Burns & Grove 2005:36, 71). The purpose of the study was to deepen understanding of the occurrence of IPV and the experiences and health needs among women aged 20-45 in Kabalagala urban slums in Kampala, Uganda and contribute to designing practical interventions to reduce IPV.

1.5.2 Research objectives

The specific objectives of a study are the actual achievements the researcher would like to attain at the end of the study (Polit & Hungler 2004:65; Babbie 2007:114). Research objectives are brief declarative statements expressed in the present tense (Burns & Grove 2005:156) and focus on one or more variables indicating clearly if the variables will be identified or described. Study objectives are borne out of the problem statement and study purpose and provide clarity on study variables and population in a quantitative study (Burns & Grove 2005:156). The specific objectives of this study were to

- Determine the nature and prevalence of IPV among women living in Kabalagala slums in Kampala, Uganda.
- Explore experiences of IPV among women living in Kabalagala slums in Kampala, Uganda.
- Explore how IPV experiences influence women's health needs.
- Recommend practical interventions to reduce IPV.

1.5.3 Research questions

A research question is a short interrogative statement that consists of one variable or more (Burns & Grove 2005:158) and is formulated to fill a knowledge gap (Rubin & Babbie 2007:22). It is one of the initial steps in the research process based on the problem statement that gives rise to the research hypotheses (LoBiondo-Wood & Haber

2002:499). Research questions help to identify key study variables, relationships between variables and the study population in quantitative studies (Polit & Hungler 2004:65). De Vos, Strydom, Fouché & Delport (2001:116) state that research questions are useful in qualitative research while hypotheses are relevant for quantitative research. This implies that quantitative research has to derive testable hypotheses from the research questions. This integrated (mixed methods) study sought to answer the following research questions:

- What are the prevalent forms of IPV among women in this study setting?
- What are the IPV experiences of women in the Kabalagala urban slums in Kampala?
- How does the IPV experience influence women's health needs?
- What factors influence women's experiences and responses to IPV?
- What practical interventions can be used to reduce IPV?

1.6 SIGNIFICANCE OF THE STUDY

The findings of this study will be used to make recommendations for the implementation of IPV prevention programmes and address the root causes of IPV in urban poor communities. The findings can also be used in developing training curriculum for capacity building of all service providers working with women at risk of violence and survivors of IPV. In addition, the findings can be used to implement behaviour change programmes in communities by emphasising the benefits of IPV prevention. This study will contribute to the evidence base on the health of urban poor women thereby facilitating the development of appropriate and effective policies and programmes. The findings should guide advocacy efforts for this target group at national, regional and global levels thus fostering improved and sustained political commitment to women's health. Finally, the study will provide indications for improving access to quality health and other supportive services to promote women's health rights in Uganda.

1.7 THEORETICAL FOUNDATIONS OF THE STUDY

A researcher uses a theoretical framework to guide and structure a study. Research knowledge is a product of the researcher's theoretic lenses that guides data collection and analysis. Accordingly, researchers must clearly recognise their epistemological

approach and theoretical assumptions so that this evidence can be considered by others in the right context and perspective (Green & Thorogood 2009:12).

1.7.1 Research paradigm

The mixed methods approach is a triangulation of different methods and enhances the rigour of the study results (Creswell 2013:4) and ensures that methods are mutually informative (Woolley 2009:7). The merits of combining different designs and methods are that they are complementary and allow for generation of new evidence (Polit & Beck 2006:285). In this study the use of mixed methods increased the understanding of perceptions of VAW and substantiation (Johnson, Onwuegbuzie & Turner 2007:123). Using mixed methods enhanced the potential for fully addressing the research questions thereby allowing the researcher to discover new viewpoints. A sequential explanatory design was chosen for the study and involved both quantitative and qualitative phases. In the sequential mixed method design one type of data provides a basis for the collection of another type of data; that is, one after the other. In this study the qualitative phase was preceded by the quantitative survey. This design was chosen to ensure a strong link between content and context of research instruments (Creswell 2013:14).

1.7.2 Theoretical grounding

Bailey (1997:18) maintains that every process of formal inquiry is based on some basic beliefs. Positivism, phenomenological/interpretivist and critical theory are influential paradigms linked to social science research methods (Babbie & Mouton 2001:20; Mouton 2006:140). Positivism is based on the premise that social and natural phenomena are the same (Babbie & Mouton 2001:21; Creswell 2013:7). Positivist methodologies are quantitative and involve experimentation and hypothesis testing while phenomenological/interpretivist methodology is qualitative. Critical theory/ constructionism involves discourse analysis and textual analysis methodology (Terre Blanche & Durrheim 2002:6; Mouton 2006:141).

The study adopted a pragmatic approach with a fusion of positivism and anti-positivism with both quantitative and qualitative methodology leading the researcher to obtain objective and subjective data (Creswell 2013:4). Positivism is rooted in the belief that

reality exists and is driven by natural laws and can be quantified through quantitative research methods, such as surveys (Mouton 2001:21). Positivism is based on the premise that social and natural phenomena are the same (Babbie & Mouton 2001:21). The quantitative survey was based on a positivist view (Creswell 2013:7) to understand the prevalent forms of IPV among women and the modifying variables most associated with IPV with the view of generalising the findings. The aim of the survey was to measure the social world objectively (De Vos et al 2001:241) by testing theory that comprised variables and subjecting these to statistical analysis. The quantitative survey was the first step to determine the nature and prevalence of IPV following which a naturalistic approach was taken to understand the women's experiences of IPV.

Additionally, through the social constructionist view, the researcher recognised the participants' realities that consist of their lived experiences and interactions with their environment (Creswell 2013:8). The qualitative component of the study sought to understand the phenomenon of IPV from the perspectives of women thus the "interpretive approach" was used (Green & Thorogood 2009:14; Tuli 2010:100). In contrast to positivism, this viewpoint suggests that there is no sole truth that must be revealed on the causes, experiences and strategies to prevent IPV. Therefore, perceptions and IPV knowledge are a result of lived experiences of women who have experienced IPV, based on their understanding and interpretations of their reality. Since the focus was on women, the study also took a feminist theoretical view, uncovering the power relations that determine women's health and well-being (Casselman 2008:72).

1.7.3 Conceptual framework

A conceptual framework deepens understanding of the phenomenon under study and is crucial for the construction of knowledge regarding the phenomenon (LoBiondo-Wood & Haber 2002:490; Polit & Beck 2004:116; Burns & Grove 2005:128; Miles & Huberman 1994:18). Miles and Huberman (1994:18) describe a conceptual framework as a map which could be "rudimentary or elaborate, theory-driven or commonsensical, descriptive or causal". By contrast, theory explains a set of relationships giving insight into a phenomenon (Kitson, Rycroft-Malone, Harvey, McCormack, Seers & Titchen 2008:8).

A conceptual framework is a less formal presentation than a theory (Polit & Hungler 2004:114). Theory is a set of defined and interrelated concepts about a phenomenon

(Burns & Grove 2005:9; LoBiondo-Wood & Haber 2002:109; Polit & Hungler 2004:114) and is developed from abstract thought processes, findings and lived experiences (Burns & Grove 2005:9). In positivism, hypotheses are developed based on theory and theory forms the basis of hypothesis testing. This study's conceptual framework (see figure 1.2) was the Integrated Ecologically Nested Model (Heise 1998:265; Finkel & Eckhardt 2011:12). As data was collected and analysed, the researcher gained a deeper understanding of the IPV experiences of women living in slums and developed a framework defining the experiences and health needs identified by the participants. The conceptual framework describes the researcher's reasons for undertaking the research in a particular way and was guided by the literature review, which identified the independent variables affecting VAW perceptions. The dependent variable in this study was IPV. Figure 1.2 depicts the conceptual frame for the study.

Figure 1.2 Integrative Ecologically Nested model

The integrated ecologically nested model was first employed to examine child abuse and neglect causes taking into account the four distinct but interconnected levels of analysis, namely (1) individual characteristics, including their personal history prior to the relationship; (2) close context where the abuse occurs (micro system); (3) establishments and collective structures that encompass the micro system (exosystem), and (4) the macro system, which includes the broader societal beliefs (macro system) (Finkel & Eckhardt 2011:12). The macrosystem included the cultural values and beliefs that influence the ontogenic, microsystem and exosystem including male dominance, hyper-masculinity and rigid gender roles which affect decision-making in intimate relationships (Heise 1998:277). The integrated ecologically nested model was preferred because it offers a more holistic view of the different multi-level factors that influence IPV experiences. As shown in figure 1.2, the model encompasses individual, family, community and broader socio-cultural factors. The model was also crucial in guiding identification and distinction of factors that lead to commission of IPV and those that influence IPV experience. In this study, the model enabled the researcher to understand the reasons male partners perpetrate IPV and why women are commonly targeted and subjected to IPV. In this sense, using the integrated ecologically nested model allowed the researcher to concurrently examine the various IPV-related factors.

1.8 RESEARCH DESIGN AND METHODOLOGY

The study was a cross-sectional sequential explanatory study employing both quantitative and qualitative methods (Creswell 2013:234; Kettle, Creswell & Zhang 2011:538). The sequential explanatory research design involved qualitative and quantitative data collection in phases and enabled the researcher to answer the research questions, generate new ideas and increase understanding of women's experiences of IPV (Leech, Onwuegbuzie & Combs 2011:13; Wisdom, Cavaleri, Onwuegbuzie & Green, 2012:723). This involved three distinct phases, namely quantitative, qualitative, and strategy formulation (Wisdom, Cavaleri, Onwuegbuzie & Green 2012:723).

1.8.1 Quantitative phase

A quantitative cross-sectional descriptive survey was conducted among 372 randomly sampled women aged 20-45 years to identify the nature and prevalence of IPV and

modifying factors in this context. This involved observation, description, examining relationships among variables, and documentation of the participants without applying an intervention (Burns & Grove 2005:71; Polit & Beck 2006:189; Creswell 2013:234). The descriptive survey aimed to depict the participants' actual characteristics and circumstances.

1.8.2 Qualitative phase

The qualitative phase employed purposive sampling to enable the researcher to obtain rich experiences on IPV from the participants (Green & Thorogood, 2009:118; Terre Blanche & Durrheim 2002:44). The researcher used a grand tour question and probing questions to enable participants to share their multiple experiences in detail (Testa, Livingston & VanZile-Tamsen 2011:242; Green & Thorogood 2009:80). The qualitative method provided greater insight into the nature of IPV experiences, their causes, the context, effects on women's health, and coping strategies.

1.8.3 Strategy formulation phase

The last phase of the study involved the development of strategies and a framework to address IPV, based on the study findings. The findings of this study will be used to make recommendations for the implementation of IPV-prevention programmes.

1.9 SCOPE OF THE STUDY

The study was conducted only within the Kabalagala slums of Kampala city. Due to their structural and gendered realities of living in the urban slums, these women have unique experiences negotiating relationships and life in the slums. This is because the majority of the women are the urban poor, who are the main focus of this study. The study therefore excluded middle- and high-income women. There is a possibility that VAW experiences among middle- and low-income women are not similar. Polit and Hungler (2004:653) point out that every study has some limitations. The qualitative results may not be generalised although they might be transferable in similar settings.

1.10 STRUCTURE OF THE STUDY

Chapter 1 briefly describes the background to the research problem; the significance, aim and objectives, conceptual foundations, scope and limitations of the study as well as the research design and methodology.

Chapter 2 presents the literature review and discusses the conceptual framework.

Chapter 3 covers the research design and methodology of the study.

Chapter 4 presents the quantitative data analysis, interpretation, and results.

Chapter 5 discusses the qualitative data analysis, interpretation, and results as well as the research contribution to knowledge on IPV experiences and health impacts.

Chapter 6 presents the qualitative and quantitative data integration as part of the mixed methods approach.

Chapter 7 presents the conclusions, limitations, recommendations, and proposed strategies to prevent IPV, based on the findings.

1.11 DEFINITIONS OF CONCEPTS

A concept describes and ascribes a name to the object/phenomenon in abstract terms, giving it an identity and meaning (Burns & Grove 2005:122,731; LoBiondo-Wood & Haber 2002:113). A conceptual definition supersedes a dictionary definition and is firmly rooted in theoretical literature and helps to standardise use of concepts in a discipline (Burns & Groves 2005:122). In this study the following terms are used as defined below.

- **Violence against women (VAW):** The United Nations' *Declaration on the elimination of violence against women, 1993* states that "violence against women" means any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life (UN 1993, A/RES/48/104).

Wife battering is defined as “violent acts - psychological, sexual and/or physical assault by an assailant of his wife and/or partner made with intent of controlling the partner by inducing fear and pain” (Herbert 1983:2204).

In this study, VAW refers to any harm or threats targeted at women in the public or private sphere that can affect their physical, economic and psychological well-being (WHO 2002a:6).

- **Intimate partner violence (IPV):** IPV is a form of VAW. The WHO (2002:89) defines IPV as any behaviour “within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship”. Acts of violence can take different forms: physical, sexual, psychological and economic deprivation (WHO 2002a:6). While the terms VAW and IPV are used interchangeably in this study, the study focused on violence inflicted by male partners of women.

- **Urban slums:** The study setting is a socially defined context in which events occur with dynamic boundaries (Neuman 2006:385). An urban slum is “a heavily populated urban area characterised by substandard housing and squalor” (UN HABITAT 2003:8). It is estimated that by 2050 the population living in urban areas will have increased to 70% from 50% in 2010 and as of 2010, 33% of the world’s urban population live in slums (WHO 2015:24). Slums are also characterised by lack of sanitation and water supply, uncertain land tenure, and lack of clean household fuels which also impact on the health of residents, especially women and children (WHO 2007:ix). Kabalagala is an urban area with informal settlements. Domestic violence in Uganda is common practice in the towns and rural areas, including informal settlements which are the focus of this study.

- **Experience:** Experience refers to the real, imaginary and symbolic occurrences in one’s life and how they are internalised (Erlich 2003:1127). In this study, experience refers to the acts, processes and end-results of the participants’ life occurrences, their interpretation of the situation in their surrounding and how this is used to guide courses of action in relation to IPV and women’s health needs.

- **Health needs:** Health needs refer to the basic conditions that individuals and populations require to attain a state of holistic well-being as influenced by the wider cultural, social, economic and political context (The Royal College of Physicians & Surgeons of Canada 2012:3). These needs arise from understanding the existing state and the preferred condition. These needs could be subjective or objective and could evolve over time.

- **Operational definitions:** In keeping with the suggestion by Leedy and Ormrod (2005:56) the research presents the operational definitions used in this study. For the quantitative study, the dependent variable was IPV. IPV in this study implies any experience of physical, sexual, economic and emotional violence such as being beaten, verbally abused or deprived of resources by a husband or partner. While the terms VAW and IPV are used interchangeably in this study, the study focuses on violence inflicted by male partners of women. The independent variables/modifying factors are demographic and structural variables that could influence individual perceptions (Glanz, Rimer & Lewis 2002:500) and consequently health behaviours, such as understanding and responses to VAW including age, income, marital status, religion and education level.

1.12 CONCLUSION

This chapter outlined the source of and background to the problem; aims and objectives, theoretical framework, and significance of the study. The chapter described the research design and methodology and defined key terms. The study is a milestone in the field of IPV and contributes to the body of knowledge in this field and context.

CHAPTER 2

Literature review

2.1 INTRODUCTION

This chapter discusses the literature review conducted on Intimate Partner Violence (IPV). The review covered the definition, background, impacts and causes of and theories on IPV. The conceptual framework guided the review.

2.2 PURPOSE OF A LITERATURE REVIEW

A literature review is conducted to establish what is currently known about a topic. Through a literature review a researcher is informed on the available body of knowledge about the topic under investigation thereby preventing duplication. Therefore a literature search demonstrates researchers' familiarity with research in their field, and how the current study contributes to the pool of knowledge (Polit & Beck 2006:107). The literature review assists researchers to comprehend and extend their knowledge of the phenomenon under study and should encompass both positive and negative findings of studies on the topic (Polit & Beck 2006:105). In this study, the researcher reviewed international, national and regional literature about VAW, specifically IPV; causes, impact, modifying and structural factors which influence perceptions of IPV; barriers to IPV prevention; responses and strategies to prevent IPV, and the conceptual model. The literature review improved the researcher's knowledge on the topic and informed the research methodology through critical scrutiny of available literature on the topic (Polit & Hungler 2004:88; Burns & Grove 2005:107; Polit & Beck 2006:503; Terre Blanche & Durrheim 2002:21). Conducting the literature review enabled the researcher to put the subject into perspective, taking into account her own context; identify gaps in evidence; gain insight into contradictory and inconclusive evidence, and consider research designs and methods appropriate to the study (Polit & Hungler 2004:88; Polit & Beck 2006; Burns & Grove 2005:111).

The review included research articles from journals, reports from government ministries and non-governmental agencies (NGOs). The sources were obtained from the

University of South Africa and University of Liverpool online libraries. The researcher focused on key words like ‘violence against women’, ‘gender-based violence’, ‘intimate partner violence’, ‘domestic violence’, ‘Uganda’, ‘Sub-Saharan Africa’, ‘perceptions of violence’ and ‘urban slums’, and articles published in the last fifteen years to increase the possibility of gathering as much evidence on the topic. The search generated many articles relating to IPV and focused on journals and official reports from government and NGOs.

2.3 UNDERSTANDING VIOLENCE

Violence is one of the major causes of death globally for people aged between 15 to 44 years and it has huge economic impact (WHO 2002a:3). Violence is any behaviour that causes pain or injury to people or damages property (Rider 2005:492). It can be anything from slaps, punching, threats or actual harm with dangerous weapons with variable frequency (Hague, Mullender & Aris 2003:19).

WHO (2002a:6) defines violence as:

> The intentional use of physical force or power, threatened or actual, against oneself, another person or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, mal-development or deprivation.

Table 2.1 presents three broad categories of violence (WHO 2002a:6).

Table 2.1 Categories of violence

	Categories of violence			
	1. Self-directed violence	2. Interpersonal violence		3. Collective violence
Sub-categories	-	Family and Intimate partner violence	Community violence	-
Description	This includes suicidal behaviour and self-abuse. Para-suicide is an example of this form of violence	This occurs between family members and intimate partners and would normally take place in the family environment. This includes child abuse, intimate partner violence and abuse of the elderly	This occurs between people who are not related and who may or may not be acquainted and normally takes place outside the home. This includes youth violence, rape or sexual assault by strangers, and violence in institutions such as schools and workplaces	This is committed by large groups of people or the state and can be social, political and economic. War is an example of collective violence

2.3.1 Intimate partner violence (IPV)

Over 90% of the global violence-related deaths occurred in low- and middle-income countries (WHO 2002b:10). In 2013, it was estimated that male partners were responsible for about 38% of female homicides globally (WHO 2014b:10). Women are the main victims of IPV (Tjaden & Thoennes 1998:6, 2000:30; WHO 2002a:1). Women have traditionally played the role of nurturing and care-giving and yet their health and human rights issues have been neglected (Murthy, Upadhyay & Nwadinobi 2010:11). Although limited research has been done on IPV, the review suggests that it is common. It has been found that 10% to 69% of women have experienced IPV at a given point in life (Murthy et al 2010:11; PATH 2002:2). The most common forms of IPV are physical, sexual and emotional. About 12% to 25% of women reported that they had been forced by a partner or former partner to have sex at some point (PATH 2002:2). While VAW occurs in different contexts, there are no significant regional disparities in IPV

prevalence; for example, in Latin America this ranges from 10% to 35% while in Sub Saharan Africa it ranges from 13% to 45% (Murthy et al 2010:11). In the African region, IPV is estimated at 36.6% (WHO 2014b:14). In Pakistan, 44.6% of females reported experiencing physical and emotional violence such as being beaten by their husbands, strangulation, and psychological torture (Humaira 2011:295). Physical and sexual violence are often tied together whereby women who are beaten are also forced to engage in sexual intercourse with the perpetrator and cannot negotiate safe sex (Allsworth, Anand, Redding & Peipert 2009:529). IPV also manifests in the form of marital rape, which is a form of sexual violence (Murthy et al 2010:15). In Uganda the law does not have a provision for marital rape and the issue of conjugal rights is considered a private matter (ActionAid 2015:1).

2.3.2 IPV as a human rights issue

IPV contravenes the principles enshrined in the Universal Declaration of Human Rights and violates the right to life, freedom and personal safety (Rico 1997:14). Due to the indivisibility of rights, all rights must be respected in their entirety. Various covenants uphold the rights and freedom of men and women equally. These include the Universal Declaration of Human Rights; International Covenant on Civil and Political Rights; and the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), its optional Protocol, and the CEDAW Committee's General Recommendations that expand on that Convention, applies specifically to women particularly on violence against women. The International Covenant on Economic, Social and Cultural Rights, is the most authoritative interpretation of the right to health.

Freedom from IPV is part of the human rights agenda in all communities (UNFPA 2010:3). Researchers need to understand various forms of violence including IPV using different approaches from a human rights perspective in order to generate evidence on effective ways to prevent violence against women (Rico 1997:40). Furthermore, a public health approach to violence aims to uncover the causes and risk factors associated with violence and identifying and implementing ways of preventing violence (WHO 2002a:4).

2.4 IVP AS A HEALTH ISSUE

Violence prevents women from assuming any decision-making in their personal lives and in the public sphere thereby impacting negatively on the economic, social and political landscape (Horn, Puffer, Roesch & Lehmann 2014:2). IPV has various and serious short- and long-term health consequences (UNFPA 2010:13). Violence affects the physical, emotional and social well-being increasing the risk of illness and disability. Furthermore, children who witness violence against their mothers experience low self-confidence, anxiety, depression and eating disorders (Murthy et al 2010:18). Fox and Benson (2001:422) emphasise the difficulty of attributing poor health outcomes to poverty or IPV, as women living in such conditions often have a myriad of problems, including financial hardship. This suggests the need to separate the health impacts due to IPV and those as a result of other difficulties.

2.4.1 Mental health

IPV has been linked to depression, anxiety, post-traumatic disorders, self-harm and suicidal tendencies, eating and sleep disorders, shame, guilt, phobia and panic disorders, PTSD, psychosomatic disorders, smoking, drug and alcohol abuse (Ellsberg, 2006 cited in UNFPA 2010:13; Liebling-Kalifani et al 2008:182; Murthy et al 2010:18).

2.4.2 Physical health consequences

Globally, between 40% and 70% of homicides are cases of IPV against women (WHO 2002b:1). Women experience injuries, bruises, bleeding, burns, and pain (Murthy et al 2010:18). Worldwide, about 42% of women who have experienced physical or sexual IPV sustain injuries as a result (WHO, 2014:12). The health consequences include sexually transmitted infections (STIs), injuries (fractures, burns, cuts, wounds, disability, eye injuries), irritable bowel syndrome, undesirable pregnancy outcomes, urinary tract infection, gastrointestinal disorders, vaginal bleeding and infections, persistent pelvic pain, hypertension and death (UNFPA 2010:13) and rectal or urethral fistula (Liebling-Kalifani et al 2008:180).

2.4.3 Sexual and reproductive health consequences

Reproductive health is “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes” (UN 1994:7.2).

This means that people must be able to enjoy and exercise freedom in their sex life, whether or not to have children and the timing of pregnancies and births. This includes the right to obtain information and services on family planning, safe pregnancy and childbirth.

2.4.3.1 Unwanted pregnancies

When women experience IPV, they often lack the ability to exercise their reproductive health rights, including contraceptive use, and are therefore more likely to have unwanted pregnancies (Murthy et al 2010:19; UNFPA 2010:14). They are also likely to have more children as they do not have control on their decisions to use contraception (PATH 2002:3).

2.4.3.2 Unsafe and forced abortions

IPV increases the risk of unsafe and forced abortions with limited access to quality healthcare resulting in death or disability as 13% of pregnancy-related deaths in low-income countries are due to unsafe abortions (Murthy et al 2010:19; PATH 2002:4). Experiences of IPV in pregnancy result in pregnancy complications and cause delay in seeking care. VAW also causes maternal mortality and has been associated with pregnancy termination (UNFPA 2010:14), low birth weight, neonatal mortality, miscarriage, smoking, and alcohol and drug abuse during pregnancy (PATH 2002:4).

2.4.3.3 Pregnancy and foetal complications

The prevalence of violence during pregnancy ranges from 4% to 32% in low-income countries and results in poor pregnancy outcomes, including vaginal infections, miscarriage, low birth weight, premature labour and preterm delivery (Murthy et al 2010:19; Garcia-Moreno & Watts 2011:1; UNFPA 2010:14).

2.4.3.4 STIs and HIV

IPV is both a cause and consequence of HIV (Murthy et al 2010:19). Firstly, it reduces women's ability to negotiate safe sex (UNFPA 2010:14). For instance, in their study among pregnant women, Murthy et al (2010:20) found that those who experience IPV were 1.5 times more likely to acquire HIV infection. In addition, testing positive for HIV increases women's risk of IPV and interferes with access and adherence to anti-retroviral (ARV) therapy (UNFPA 2010:14). Women who disclose their HIV status are at risk of IPV (PATH 2002:3).

Women who suffer IPV are also more likely to practise high-risk sexual behaviours and suffer sexual dysfunction (PATH 2002:4). For female sex workers, the risk of HIV infection is high due to violence associated with the work (UNFPA 2010:15).

2.5 SOCIETAL/SOCIAL EFFECTS OF IPV

2.5.1 Economic and health system consequences

IPV has severe economic costs for communities and health services (UNFPA 2010:13). Women who suffer IPV experience poor health outcomes, access health services more than other women, and are most likely to report their present health status as poor or very poor (PATH 2002:3; Garcia-Moreno et al 2015a:1567). Women who suffer IPV sustain injuries that limit their ability to perform daily activities and suffer from reduced income. They are also frequently absent from work due to the physical and psychological effects of violence (Murthy et al 2010: 20).

2.5.2 Effects of VAW on children

The negative impacts of IPV on children cannot be ignored (Wathen & MacMillan 2013:419). Children of women who experience violence may also have increased levels of infant and child mortality and children who witness this violence suffer from emotional and behavioural challenges and are at risk of being perpetrators or victims of violence themselves (PATH 2002:3). Furthermore, children who witness violence against their mothers are reported to experience low self-confidence, anxiety, depression and eating disorders (Murthy et al 2010:18).

2.6 FACTORS AFFECTING IPV: A THEORETICAL FRAMEWORK

This study was guided by the integrative ecologically nested model which postulates that IPV can be conceptualised at four levels, namely individual, family, community and the macro context (Finkel & Eckhardt 2011:12). The study examined the cultural context as well as the broader macro context which play a significant role in influencing perceptions of VAW.

2.6.1 Individual level

The integrated ecologically nested model considers the ontogenic level which looks at the individual's personal characteristics and how these influence the individual's reaction to micro and exosystem circumstances (Finkel & Eckhardt 2011:12). At the individual level, the focus is also on the cognitive processes that shape the individual women's interpretation of their IPV experiences.

The Interagency Gender Working Group of USAID (2008:7) identified individual risk factors for violence against women such as men's alcohol and drug abuse, women's prior experiences of abuse, and low education and income status of women in communities where men are not sensitised on gender-based violence prevention. Low socio-economic status makes women dependent on men due to lack of economic resources, including land and meaningful employment (PATH 2002:3; Murthy et al 2010:12), placing women in a subservient role and predisposing them to IPV. While IPV affects many women of various walks of life, empirical evidence suggests that this occurs more in women of low socio-economic status (Cunradi, Caetano & Schafer 2002:378) and women who live in disadvantaged areas like urban slums (Fox & Benson 2006:420).

Personality traits and disorders have also been attributed to causing IPV. Violence infliction is thought to be the result of childhood abuse, borderline personality disorder, anti-social personality disorder, post-traumatic stress, and low self-esteem (Roberts 2002:26: Howard 2015:1). Radical feminists have historically criticised male dominance and power over women highlighting the strong link with IPV within the family and the broader societal structure (Hutchinson 2006:13). Radical feminists have themselves

been criticised for portraying women as victims and men as villains thereby obscuring the diversity among men and women in relation to violence (Loseke, Gilles & Cavanaugh 2005:20).

For some women, it is unheard of to speak openly about their experiences of violence and in some cases women feel ashamed and blame themselves for the violence. In other instances, there is a lack of confidentiality and women fear further violence from their partners if found to have disclosed and consequently suffer in silence (UNFPA 2010:40). Women often feel uncomfortable discussing their experiences of violence and accept it as part of their lives (PATH 2002:1).

Early marriage of young women before the age of 18 predisposes them to IPV and the risk of IPV is even more elevated for those who get married before the age of 15 (UNFPA 2010:81; Erulkar 2013:11). This is because the young women often marry older men with a mean age difference of up to 14 years who subject them to violence (Clark, Bruce & Dude 2006:79). In Uganda early marriages are common and while the legal age of marriage is 18, 15% of women age 20-49 were married before 18 while almost half (49%) were married by 18 years of age (UDHS 2011:50). The practice of early marriage in Uganda is driven by the cultural norms and poverty (Green, Mukuria & Rubin, 2009:4). They are also disenfranchised as they lack the ability to continue with education which is often protective against violence. Moreover, they are prone to social isolation and lack the ability to exercise the right to freedom of movement.

2.6.2 Family level

The micro system/family level deals with the relational context or situation in which IPV occurs, such as the family structure. The family structure could prevent or facilitate IPV experiences as influenced by their beliefs, attitudes, and practices regarding IPV. They could be a source of social support or hindrance to obtaining support. At the family level in male-dominated societies, men wield more power than women. Dunbar & Burgoon (2005:208) define power as the ability to make others do what they want them to do within the unit of analysis. In terms of IPV, the unit of analysis is the household or man-woman relationship. When men control the resources and decision-making in relationships, women are prone to violence (PATH 2002:3).

In some societies subcultures cultivate norms that condone violence more than the main culture and as such IPV may occur more often in violent societies than those where there is peace (Sana 2001:1). These subcultures include peer networks, formal and informal social networks and history of the family that encourage male control and use of violence in the family. Furthermore, pornography and violent images in the media promote a culture of violence against women in these subcultures.

In South Africa, women experience very high levels of emotional, sexual and physical abuse in intimate relationships (Ludin & Vetten 2005:19; Fiddler & Spence 2000:28). Women's risk of violence in intimate heterosexual relationships is a major concern. Women find themselves in a subservient role in largely patriarchal societies and due to the unequal power dynamics, lack the means to confront the abusive partners (Kendall-Tackett 2004:21). Women in marriage or cohabiting relationships are most at risk of violence (Mooney 2006:3). There are various views on VAW in relation to marital status. One view is that married women are treated with respect by their partners and do not experience as much violence as cohabiting women (Douglas 2004:68; Stadley 2006:25). On the other hand, married women are actually more likely to experience violence as they are objectified/owned by their husbands (Park, Fedler & Dangor 2000:57). In most cases in Africa IPV is shrouded in secrecy and often seen as a family matter (Ludin & Vetten 2005:22). Another cause of IPV is cohabitation, which refers to a woman and man living together as in a marital relationship without any recognised cultural or legal union (Dries & Rowthon 2002:19). Cohabitation is viewed as an informal marriage (Coltrane & Collins 2001:590).

2.6.3 Community level

The community level or exosystem is concerned with social structures and how these influence IPV. Social structures include the community's demographic characteristics, infrastructure and the community norms which may contribute to shaping IPV experiences. Among the community risk factors for VAW, the Interagency Gender Working Group of USAID (2008:7) identified traditional roles and norms that reinforce male superiority, and societal norms and beliefs that lead to condoning of violence against women. Furthermore, impunity and lack of access to legal redress, low socio-economic standing and increased levels of crime and conflict were also identified as community-level risk factors.

Violence against women is rooted in gender inequality due to the socially constructed perceptions and rules and cultural beliefs about acceptable male and female behaviour ideas and rules about correct male and female behaviour (UNFPA 2010:12). These culturally and socially constructed societies exacerbate discrimination against women. This is frequently seen in the differences in power and the unequal access to opportunities in all spheres of life (UNFPA 2010:12). In addition, it hinders women's ability to exercise their autonomy in decision-making, including condoning VAW and not being able to leave abusive relationships.

Gender inequality and inequity where women do not have access to the same resources as men have adverse outcomes such as lower educational attainment for women (Murthy et al 2010:12). One of the causes of VAW is the socially constructed and sanctioned societal inequalities that give rise to conflict (Gul, Zeb & Faiz 2013:334; Greiff 2010:3). This is found particularly in male-dominated societies where the risk of violence is much higher because men have more power than women and in societies where women are looked upon as the weaker sex (PATH 2002:3; Murthy et al 2010:12).

IPV reflects the societal context which underpins and encourages discriminatory attitudes and behaviour against women through negative gender stereotypes. These include the notions that women must be submissive, dependent, and never question the authority of the men who have absolute power to direct their sexuality, movement and expression (Nanda et al 2014:37). In this regard IPV is seen as a tool to reinforce male domination and forcing women to comply (Ellis, Stuckless & Smith 2015:73).

Women and society cover up IPV thus leading to underreporting of the problem. Underreporting of violence is common because women experience fear, shame and often blame themselves for the violence. Widespread acceptance of male dominance and superiority in all spheres of life perpetuates IPV (Murthy et al 2010:11). Under-reporting is due to economic dependence on men, fear, self-blame and lack of confidence in the justice system (Payne and Wermeling, 2009:180).

In some cultures, wife battering is considered acceptable in certain instances, such as if a wife turned down the husband's sexual advances or failed to prepare food on time. For example, in a study in Nigeria, Murthy et al (2010:16) found that 66% of Nigerian

women felt that it was right to do so and 61% of Nigerian men believed in wife-beating. This confirms that IPV is an acceptable and deeply entrenched cultural norm in some societies.

2.6.4 Macro level

The macro system explores culture, norms and beliefs related to IPV. This includes availability of programmes and interventions to address IPV and a policy environment that is enabling in terms of instruments and processes that address women's health and underlying determinants such as poverty and urbanisation.

At the macro level factors perpetuating IPV include the absence of gender mainstreaming in all sectors to cater for women's needs and inadequate political will and representation of women in key decision-making positions (Murthy et al 2010:13).

Failure to establish and implement gender equality frameworks to improve women's status and the lack of effective women's human rights movements to advocate for the rights of women also preserve IPV (Murthy et al 2010:13). IPV perpetuates the subordinate role of women and is reinforced by social, economic, cultural and political factors.

2.6.4.1 Characteristics of slums

With the growing rate of urbanisation, emergence or expansion of urban slums presents a different set of public health problems including IPV. For example, diarrheal diseases, malnutrition, injuries, cancer, and diabetes among others are common in groups of low socio-economic status including residents of slums (WHO 2007:7). Informal settlements do not have access to water, sanitation and drainage and house mostly poor migrants from rural areas. In addition, neither government nor non-governmental agencies provide services in slums (Rashid 2011:1). In Bangladesh, the urban slums are characterised by gang violence, drug abuse and organised crime with 93% of residents reporting that they had been affected by crime (Rashid 2011:2). Gambling and domestic violence are also two of the major problems identified in the slums. This is exacerbated by the fact that since they are informal settlements neither government nor NGOs provide services in slums.

2.6.4.2 Slums and IPV

Due to their structural and gendered realities of living in urban slums, young women have unique experiences negotiating relationships and life in general in the slums. These experiences provide a starting pointing of defining their world view. Women living in these conditions of deprivation are vulnerable to emotional, physical and sexual violence and lack access to health care (Winton 2004:166). Rashid (2011:4) found that early marriages were commonly sanctioned in slums due to poverty and insecurity as a result of violence which predisposes young women to rape and sexual harassment. Many early marriages resulted in young women experiencing violence as their husbands and in-laws demanded dowry payment from them which refers to cash or goods payments made to the groom upon marriage (Rashid 2011:5). The study found that though the dowry payments were illegal, it was common practice that grooms and their families insist on this even after the marriage and yet many parents preferred to marry off their daughters early because then they would pay less dowry to the groom. In contrast, in Uganda some parents marry off their daughters early in order to obtain wealth in the form of bride price which is cash or payment paid to the girl's family by the groom (Rubin, Green, & Mukuria 2009:5). On account of the social and cultural context and structural inequalities, married adolescent women in urban slums had limited understanding and lived experience of their rights including autonomy over their bodies and lives. There is therefore a greater need for more interventions that would change community norms, beliefs and stereotypes that support, justify and reinforce IPV. Nevertheless, there is little knowledge of what these interventions specifically are in the context of women living in urban slums. The researcher found no research on the qualitative intimate partner violence experiences of young women living in Kampala slums. This necessitated and led the researcher to undertake this study.

2.6.5 Summary of the conceptual framework

The main assumption in the study's conceptual framework is that women's IPV experiences are directly or indirectly shaped by several individual, family, community and macro level factors. This framework enabled the researcher to deepen her understanding of the participants' own interpretation of these experiences from a public health perspective while bearing in mind the influence of the different factors occurring

within a broader environmental and socio-economic context (Heise 1998:274). This included understanding IPV within the context of urbanisation, specifically slum settings characterised by poverty and deprivation in order to identify appropriate interventions. Urbanisation as a phenomenon has been identified as being responsible for the shifting disease burden to non-communicable diseases and injuries (Campbell & Campbell 2007:55).

2.7 IPV THEORIES

Various theories explain the reasons why IPV is perpetrated at different levels. Theory helps to guide the inquiry into the study phenomena (Rubin & Babbie 2007: 38). These theories delve deeper into explaining factors from the individual to the macro level. Most IPV studies have focused on the sociological perspectives of general family stress and resource theory and the feminist perspective (Gage & Hutchinson 2006:13). Three theoretical perspectives commonly applied in IPV studies are family stress and resource, feminist, and social learning theory.

2.7.1 Family stress and resource theory

This theory attributes IPV to the accrual of stress related to poverty. Poverty and economic stress have been linked to increased IPV rates (Fox & Benson, 2006:420; PATH 2002:3; Murthy et al 2010:12; Nanda et al 2014). The resource theory emphasises the link between the varying levels of resources within a relationship and IPV and how this affects the decision-making power. The theory postulates that in cases where the men have more resources than the women, they tend to have more control, dominance and power thereby resulting in IPV (Gage & Hutchinson 2006:14). Women who rely on their partners economically tend to be at high risk of IPV. However, men who have female partners with more resources can also use IPV to control women (Gage & Hutchinson 2006:14).

2.7.2 Radical or Dominance Feminist theory

In advocating for women's rights, feminists have historically criticised male dominance and power over women by highlighting the strong link with VAW within the family and

the broader societal structure (Mitra 2011:62). According to radical or dominance feminist theory, IPV is the consequence of patriarchy where male dominance is common and in which women are the victims while men are the perpetrators (Jones 2003:94; Dutton & Nicholls 2005:683; Gage & Hutchinson 2006:13). This power imbalance between men and women is often explained as a product of historical male socialisation whereby men kept women in a subservient role through different means, including IPV. In order to address IPV, the radical or dominance feminist theory recommends the promotion of gender equality and addressing gender dynamics in ways that favour women. These power inequalities are often rooted in socio-economic class and factors such as education (Clowes et al 2009: 22). A criticism against feminist theory is that violence between men is even more common than male violence against women hence it offers a narrow view in terms of explaining violence as a phenomenon and solely focuses on violence against women perpetrated by men. Nonetheless, violence against women especially IPV is frequently committed by men (Hester, Westmarland, Gangoli, Wilkinson, O'Kelly, Kent, and Diamond, 2006:3; WHO, 2012:1) and the radical or dominance feminist perspective still dominates IPV research and advocacy for women. Feminists argue further that the way in which the media portray IPV is associated strongly with cultural acceptance of IPV (Ryan, Anastario & DaCunha 2006:226; Nanda et al 2014:50).

2.7.3 Burgess-Akers Social learning theory

According to Burgess-Akers social learning theory, IPV is learned and results from a number of circumstantial and situational influences (Sana 2001:1; Akers 2011:50). The circumstantial influences comprise individual attributes and aggressive disposition, couple characteristics, constant worry, experiences of violence in the family and peer associations. Situational influences encompass alcohol and drug abuse and economic hardship.

In the qualitative research phase of this study, the focus was on how women who have experienced violence interpret their experiences (Rathus & Feindler 2004:22) allowing them to describe their experiences from their own view. Qualitative inquiry emphasises understanding the world view of those under study (Neuman 2006:160). Furthermore the study also examined the circumstantial and situational influences of IPV and explored how resources affect decision-making and influence IPV. In this way the

researcher applied all the threes theories namely the Family Stress and Resource theory; Radical or Dominance Feminist theory and Burgess-Akers Social Learning. These theories helped to contextualize and explain the experiences of IPV and health needs of women.

2.8 IPV STUDIES IN UGANDA

In a cross-sectional study among women living with HIV in rural Uganda, Osinde, Kaye and Kakaire (2011:6) found that one third (n=317) of the participants had suffered IPV in the previous year. Of these, women taking anti-retroviral therapy were more likely to experience IPV. The mean age of the women was 29.7 years; 6.9% were adolescents; 73.5% were married and the lifetime prevalence of IPV was 36.6%. Furthermore, women with spouses with a higher level of education were less likely to report psychological or sexual violence.

In a study of IPV against women in eastern Uganda and the implications for HIV prevention, Karamagi, Tumwine, Tylleskar and Heggenhougen (2006:4) found a lifetime prevalence of IPV of 54%. Physical violence and sexual coercion were the most common forms of IPV while women's higher education and satisfaction with marriage was associated with lower IPV risk. Residing in a rural area had a four-fold risk of IPV; being in a relationship with a husband who had another partner posed a higher IPV risk, and 35% of the women were in polygamous union. Low socio-economic status was also cited as a major cause of IPV due to men's failure to provide for their families, which led to stress and tensions.

In their study among 942 women seeking post-abortion care in Mulago Hospital, Kampala, Kaye, Mirembe, Bantebya, Johansson and Ekstrom (2006:97) found that domestic violence was strongly associated with unwanted pregnancy and induced abortion. Violence was assessed using an abuse assessment screening tool. Bride price payment, pregnancy, socio-economic changes and poor conflict resolution skills were found to be factors associated with domestic violence. In addition, living with the extended family unit was also associated with domestic violence (Kaye et al 2006:99).

In rural Uganda, a study on domestic violence and behavioural risk factors found that 30% of women had experienced physical violence threats or physical abuse from their

current partners (Kitson, Rycroft-Malone, Harvey, McCormack, Seers, Koenig, Lutalo, Zhao, Nalugoda, Wabwire-Mangen, & Kiwanuka 2003:56). Violence was viewed as justifiable in some instance by most of the men and women. As reasons for IPV, the men cited failure of the women to complete household chores; disobedience to the husband or older relatives; refusal of sex; arguments over finances, and suspected infidelity of the women. More than one fifth of the women who had experienced violence were in need of medical attention for their injuries.

The researcher found limited qualitative literature about the personal experiences of women regarding IPV in Uganda, especially in urban slums. Most of the available literature focused on the prevalence and impact of this violence on specific health outcomes, such as pregnancy and psychological well-being. Accordingly, the study went beyond ascertaining the prevalence and gave women the liberty to share their distinctive experiences, with the view of informing policy and practice. When examining the IPV experiences of women in adulthood, the researcher considered the circumstances of the women that predisposed them to relationships in which they experienced IPV. The adverse health outcomes and widespread prevalence of IPV underscore the need for urgent attention and responses in Uganda.

2.9 STRATEGIES TO PREVENT AND REDUCE IPV

There is strong evidence that suggests that IPV can be prevented through the reduction of alcohol abuse and implementing intervention for problem drinkers (UNFPA 2010:35). In addition, programs implemented in schools to promote gender equality have also been demonstrated to be effective as well as advocacy support programs (UNFPA 2010:35). Emerging evidence also suggests that economic empowerment coupled with gender equity training, life skills training and modification of social norms through social marketing can reduce IPV (Murthy et al 2010:21; UNFPA 2010:35).

IPV screening is “asking women about experiences of violence/abuse, whether or not they have any signs or symptoms” (Bott, Guedes, Claramunt & Guezmes 2010:109). Moreover, it is important to increase health workers’ ability to identify and support women experiencing VAW (Murthy et al 2010:21; WHO 2002a:131). According to García-Moreno (2002:1509-1510):

> Although there might be general agreement that health services have an important role in addressing intimate partner violence, and that asking women about abuse is generally a good thing, there needs to be greater clarity on who should ask the questions, of whom, in which settings, and after what training. Ensuring women's safety during and after disclosure is of paramount importance.

Other strategies to prevent and reduce IPV include empowerment of women to understand that IPV is unacceptable and educating men and communities about preventing VAW and respecting/protecting women's human rights (Murthy et al 2010:21). It is also important to increase male participation in IPV prevention; improve legal, psychosocial support and empowerment programmes for survivors of violence, and increase cross-sectoral collaboration to prevent IPV. Policy to support primary prevention of IPV must be developed and implemented (Murthy et al 2010:21).

2.10 CONCLUSION

IPV is a historical problem that is deeply entrenched in the cultural background of patriarchal societies. This chapter discussed the literature review conducted for the study. The review identified IPV as a sub-set of interpersonal violence that occurs between intimate partners and is generally a major problem with an estimated prevalence of 37% in the African region. Overall, most IPV is perpetrated by men against women and indeed the Radical or Dominance Feminist theory attributes this gender asymmetry of IPV to patriarchal values which promote control of women by their male partners. Although it is clear that men are the majority of perpetrators in this context not much is known however, about women's experiences of IPV. A closer interrogation of these experiences among women residing in the urban slums is needed prior to drawing conclusions based on research conducted among other populations particularly those in rural areas. Various health impacts of IPV have also been identified, mainly related to three categories: mental, physical and sexual and reproductive health. There is also evidence that the practice of early marriage as a social norm increases the risk of IPV. Thus it is important to note that examining women's experiences of IPV merits research attention. More so, conducting the research in a low-income urban setting illuminates the differences and similarities with other findings from rural Uganda where the influences of traditional norms may vary. The dynamics of IPV within the rural

patriarchal context are relatively well-documented in the literature, however, little is known about this in the low-income urban setting.

The review shaped the researcher's thinking about IPV within the study context as guided by the Integrated Ecologically Nested Model which posits that IPV experiences are influenced by the interaction of factors operating at the individual, family, community and macro levels that affect human behaviour. By conducting the research at all levels of the conceptual framework instead of solely focusing on individual or family level of analysis, the researcher broadened the explanatory basis of IPV in this context to also include the structural and situational factors that shape the nature of IPV. Individual and relational factors were thus woven within this framework and situated with the broader social context. The study filled a gap in IPV scholarship in Uganda and contributed to a holistic public health approach to IPV response and prevention.

The review revealed that there are various theoretical contributions to IPV but virtually no studies on IPV among women living in the urban slums in Kampala. Family Stress and Resource theory, Radical or Dominance Feminist theory and the Burgess-Aker Social Learning theory inform the examination of the different factors that contribute to IPV based on the women's experiences. The feminist perspective attributes IPV to male dominance while sociological perspectives attribute it to social determinants such as poverty and stress. The theoretical and empirical evidence logically assisted the researcher to contextualize IPV and inform the study's methodology to generate evidence for policy and practice.

There is a lack of evidence on the responses to IPV and the systems of support for survivors. This paucity of evidence on IPV experiences among women from the urban slums lends support to the assertion that they are a segment of the population often left behind in development programs. Therefore, it was necessary to identify their experiences and mechanisms of support and how they work to design useful interventions to curb IPV. Methodologically, most of the evidence on IPV is based on quantitative studies. Clearly, more mixed methods research such as the one used in this study was needed to understand the lived experiences of women in relation to IPV. Chapter 3 discusses the research design and methodology of the study.

CHAPTER 3

Research design and methodology

3.1 INTRODUCTION

This chapter describes the research design and methodology used in the study. This includes the population, sampling, data collection and analysis; measures for ensuring validity, reliability, credibility, transferability, dependability and confirmability of the results, and ethical considerations.

3.2 PURPOSE OF THE STUDY

The purpose of the study was to deepen understanding of the occurrence of IPV and the experiences and health needs among women aged 20-45 in Kabalagala urban slums in Kampala, Uganda and contribute to designing practical interventions to reduce IPV. In order to achieve the objectives, the study answered the following research questions:

- What are the prevalent forms of IPV among women in this study setting?
- What are the IPV experiences of women in the Kabalagala urban slums in Kampala?
- How does the IPV experience influence women's health needs?
- What factors influence women's experiences and responses to IPV?
- What practical interventions can be used to reduce IPV?

3.3 RESEARCH DESIGN

A research design is an overall plan for obtaining answers to research questions and the "skeletal backbone of the study" (Polit & Beck 2013:72). According to Burns and Grove (2007:236), a research design is the blueprint for conducting a study that maximises control over factors that could interfere with the credibility of the findings and gives greater control and improves the trustworthiness of a study. The research design guides the researcher to answer the uncertainties associated with the study (De Vaus

2001:9). The research problem determines whether a quantitative or qualitative approach should be used (Babbie & Mouton 2001:271). The approach to the study informs the design which, in turn, determines the type of information to be collected and the data-gathering instruments to be used (Babbie & Mouton 2001:271).

The study was a cross-sectional sequential explanatory study employing quantitative and qualitative methods (Creswell 2013:234; Kettle, Creswell & Zhang 2011:538). The sequential explanatory research design involved quantitative and qualitative data collection in phases and enabled the researcher to answer the research questions, generate new ideas and increase understanding of women's experiences of IPV (Leech, Onwuegbuzie & Combs 2011:13; Wisdom, Cavaleri, Onwuegbuzie & Green 2012:723). This involved three phases, namely quantitative, qualitative and strategy formulation (Wisdom, Cavaleri, Onwuegbuzie & Green 2012:723).

3.3.1 Quantitative phase

A quantitative cross-sectional descriptive survey was conducted among 372 randomly sampled women aged 20-45 years to identify the nature and prevalence of IPV and modifying factors in this context. This involved observation, description, examining relationships among variables and documentation of the participants without applying an intervention (Burns & Grove 2005:71; Polit & Beck 2006:189; Creswell 2013:234). The descriptive study aimed to depict the actual characteristics and circumstances of the women. The underlying goal of this portrayal was to identify problems, understand and determine actions. This type of study does not establish causality but can generate insights into the study phenomenon. In this study design data was obtained from a cross-sectional sample and data was collected over a single data-collection period (Polit & Beck 2006: 239). The survey enabled the researcher to determine the frequency of event occurrence (Burns & Grove 2005:26).

3.3.2 Qualitative phase

Since IPV usually occurs in the private sphere, understanding these experiences relies heavily on the subjective meaning that the participants attach to it and can therefore not be quantified (Testa, Livingston & VanZile-Tamsen 2011:237). The qualitative study

employed purposive sampling to enable the researcher to obtain data-rich experiences of IPV from the participants (Green & Thorogood 2009:118; Terre Blanche & Durrheim 2002:44). The researcher used a grand tour question, *"What are your experiences of intimate partner violence and how has this affected you?"*, and probing questions in order to enable participants to share their experiences in detail (Testa, Livingston & VanZile-Tamsen 2011:242; Green & Thorogood 2009:80). The researcher explored the participants' experiences, perceived influences of IPV, causes, impacts and responses.

The qualitative approach enhanced the rigour of the study results (Creswell 2013:4) and ensured that the methods were mutually informative (Woolley 2009:7). The merit of using mixed methods was that it complemented the existing quantitative data and allowed for generation of new evidence (Creswell 2013:4). In this study the use of the qualitative method increased understanding of perceptions of VAW and substantiation in the natural setting without manipulation and generated theories from the participants' perspective (Testa, Livingston & VanZile-Tamsen 2011:237; Wisdom, Cavaleri, Onwuegbuzie & Green 2012:723). The researcher obtained rich descriptions and explanations of participants' IPV experiences (Swift & Tischler 2010:562) using a qualitative method which acknowledged the existence of multiple realities (Lincoln & Guba 1985:294). The qualitative method provided greater insight into the nature of IPV experiences, their causes, the context, effects on women's health and coping strategies (Testa, Livingston & VanZile-Tamsen 2011:239).

3.3.3 Strategy formulation phase

The last phase developed strategies to address IPV based on the findings as a contribution to the body of IPV interventions. The findings were used to make recommendations for the implementation of IPV prevention programmes.

The researcher collected and analysed quantitative data to gain a general understanding of the nature and prevalence of IPV and the modifying factors among the participants. In this study, the quantitative and qualitative aspects were of equal importance to the researcher and this was reflected in the study questions, data collection, analysis and interpretation. The qualitative phase enabled the researcher to elaborate on the quantitative results and explore the participants' views in greater depth (Creswell 20013:9; Kettle, Creswell & Zhang 2011:538). The quantitative and qualitative

phases were connected in the study's intermediate stage. Figure 3.1 illustrates the sequential explanatory research design.

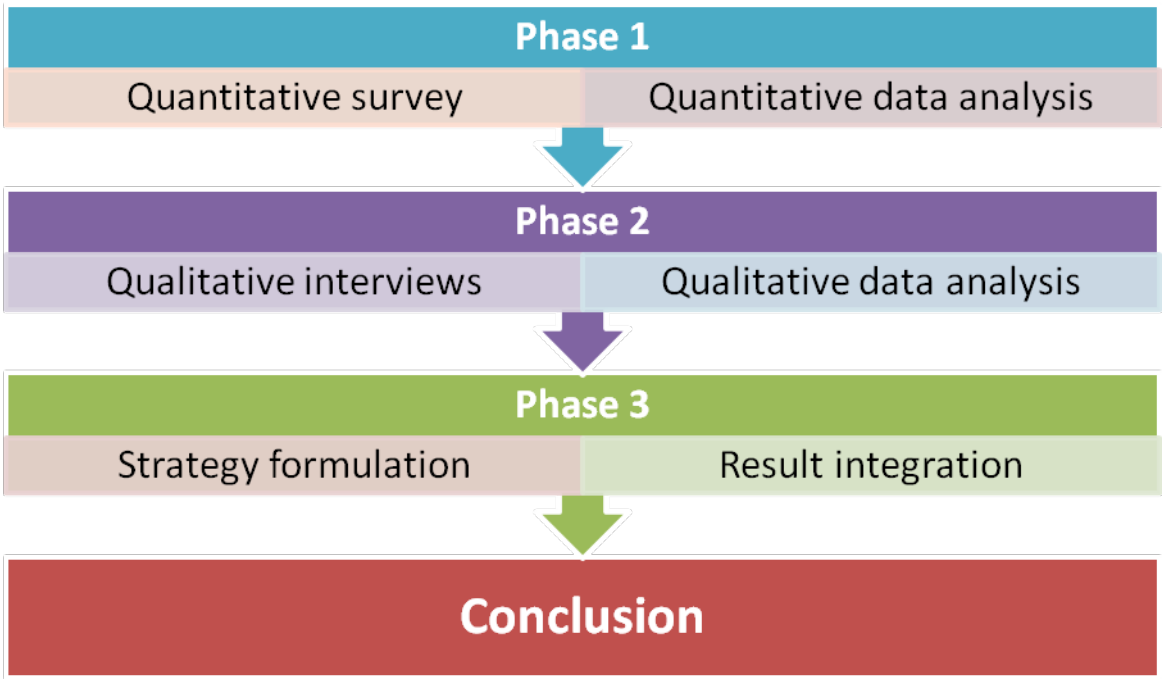

Figure 3.1 Sequential explanatory research design

3.4 RESEARCH METHODOLOGY

Research methods address the development, validation and evaluation of research tools and methods to be used to collect and analyse the information obtained during the study (Polit & Beck 2008:328). Burns and Grove (2001:223) describe research methodology as the "entire plan of the study" which includes the steps of the research process from problem identification to data collection.

The researcher followed a mixed methods approach in order to obtain a thorough understanding of IPV. The quantitative survey described the extent of the IPV problem while the qualitative interviews provided more details about the IPV experiences thus substantiating the quantitative findings. The research methodology included the population, sample and sampling, and data collection and analysis.

3.4.1 Population

A research population refers to all the elements from which data can be potentially collected, and could be "units, individuals, organisations, events or artifacts" (Polit & Beck 2008:339). The target population in this study consisted of women aged 20 to 45 living in Kamwanyi and Kikubamutwe slums in the Kabalagala area in Kampala, Uganda. The total size of the population was not known but was estimated at 2 500. Hence the sample frame was an estimated 2 500 women in the 20 to 45 years age group living in the two slums. This age group was selected because according to UDHS (2012:239), these women are at greatest risk of violence (55%-59%). This is also the age range where they are most likely to be in intimate partner relationships thus increasing vulnerability (Tjaden and Thoennes, 1998:2). Participants with rich IPV experiences were identified through a community agency that runs a non-paying clinic that treats vulnerable children and assists women reporting health problems due to IPV.

The accessible population refers to the portion of the entire population to which the researcher has access (Polit & Beck 2008:339). In the quantitative study, the accessible population was women aged 20 to 45 years from the two slums. The researcher used simple random sampling to select participants until a desirable sample size was reached (Creswell 2013:233). Random sampling ensured that all women in the study population had an equal chance of being selected to participate in the study. Households were selected randomly and in cases with more than one eligible woman in the household, the researcher assigned numbers to all the eligible women and randomly selected one to participate. The use of a random sample meant that findings could be generalised to the population of women aged 20 to 45 years living in urban slums in Uganda (Creswell 2013:233). To be included in the study, the women had to give consent to participate. Women were excluded from the study if participating posed a threat in terms of violence from their partners.

3.4.2 Sample and sampling

A study sample is a subset of elements that is a representative of the entire population (Polit & Beck 2008:338). Sampling refers to the practice of selecting a proportion of the population in order to describe and analyse the characteristics of the phenomenon under study (Polit & Beck 2008:339).

3.4.2.1 Site sampling

The site target population refers to all the eligible cases that could potentially participate in the study and from which the researcher accesses the study participants known as the accessible population (Burns & Grove 2005:341; Polit & Beck 2006:511). The site target population was the slums in Kampala and purposive sampling was used to select the Kamwanyi and Kikubamutwe slums.

The area comprises low income residents from various cultural backgrounds and is two kilometres from Kampala City centre. These slums have an estimated population of over 10,000 based on the municipal data. Residents live in makeshift homes made of mud and pole and some of brick. Most of the people are engaged in petty trades, such as hawking, and some work as unskilled casual labourers. Kabalagala is popular for its bars and commercial sex work is common among young women.

3.4.2.2 Participant sampling

It is not always possible for researchers to study the entire population due to economic, time and other constraints (Burns & Grove 2005:351). A sample of the population is then chosen to represent the population (Polit & Hungler 2004:289). Hence, in cases where the sample size is representative, findings are generalised to the accessible population and then to other populations with similar context and characteristics (Polit & Beck 2006:260).

A sample is considered representative if it has the same characteristics as the target population. The researcher used simple random sampling to select participants until the desirable sample size was reached (Creswell 2013:233). Random sampling ensured that all women in the population had an equal chance of being selected to participate. Households were selected randomly and in cases with more than one eligible woman in a household, the researcher assigned numbers to all the eligible women and randomly selected one to participate in the study. The use of a random sample meant that findings could be generalised to the population of women aged 20 to 45 years living in urban slums in Uganda (Creswell 2013:233).

3.4.2.3 Sample size determination

In quantitative research, sample size determination can be done through statistical computation if the data is available. This data includes total population size from where the sample is drawn from (Saunders, Thornhill & Lewis 2003:173). Additionally, one needs an effective size, power and standard error to compute the sample size (Burns & Grove 2005:354-355). The total size of the population of women aged 20-45 living in the slums was not known but was estimated at 2500. The study wished to explore women's experiences of IPV and the quantitative survey sample size was determined as shown below:

$$n = \frac{z^2 \times pq}{d^2}$$

Where n = minimum sample size required in each study setting

z = Standard normal deviation or z-score (based on z-score of 1.96 corresponding to 95% confidence interval. This is based on recommended standard deviation and error levels in social science research (Frankfort-Nachmias & Leon-Guerrero 2011:243). 95% CI =est+-1.96 x Standard error

$$\text{Standard error} = \frac{sd}{\checkmark n}$$

$$\text{Sd of a proportion} = \checkmark p(1-p)$$

$$\text{Se} = \frac{\checkmark p(1-p)}{\checkmark n}$$

d = the acceptable error level. In this study being 5% (0.05).

$$\text{Margin of error} = 1.96 \times se$$

$$\text{Margin of error (m)} = \frac{1.96\checkmark p(1-p)}{N}$$

p = proportion of sample with outcome measure: women with experiences of IPV.

q = proportion of women who do not have experiences of IPV (q =1-p). The expected proportion of women with experiences of IPV based on the national statistics 59% (UDHS 2012:239).

$\checkmark n = \frac{1.96 \times \checkmark p(1-p)}{m}$

Sample size (n) = $\frac{1.96^2 \times p(1-p)}{m^2}$

Thus $n = \frac{1.96^2 \times 0.41 \times 0.59}{0.05^2}$

$= \frac{1.96 \times 1.96 \times 0.59 \times 0.41}{0.05 \times 0.05}$

$= \frac{0.929283}{0.0025}$

= 371.7

That is, approximately **372** participants required for the survey.

Regarding the site sample size, the study sampled two slums, Kamwanyi and Kikubamutwe, in Kabalagala area in Kampala, Uganda with an estimated population of 10,000.

3.4.3 Data collection

Data collection is “the precise, systematic gathering of information relevant to the research purpose or specific objectives, questions or hypothesis of a study” (Polit & Beck 2008:67, 367).

3.4.3.1 Data-collection approach

In the quantitative phase, primary data was collected through a survey questionnaire with face-to-face interaction between the researcher and the participants (Family Health International 2005:30; Pope & Mays 1995:43). A self-designed questionnaire was used for quantitative data collection (Polit & Beck 2006:22). The researcher developed the instrument, based on the literature review. The questionnaire consisted of a 31-item scale to assess the prevalence of physical, psychological, sexual and economic violence (see Annexure E for a copy of the survey questionnaire). The researcher sent the questionnaire to a language expert for translation, for participants who did not speak

English. The researcher trained and supervised two fieldworkers to assist in data collection.

In the qualitative phase, the researcher used one grand tour question (Creswell 2013:227), followed by probing questions, to obtain rich data on multiple realities and allow the participants to adequately describe their own experiences of VAW (Green & Thorogood 2009:80). The researcher explored the participants' experiences, perceptions of IPV, causes, impacts and responses. This enabled the researcher to understand and obtain in-depth information and explore new issues (Family Health International 2005:30; Pope & Mays 1995:43). The qualitative interviews were conducted personally by the researcher assisted by the two fieldworkers in order to understand the participants' realities. In order to collect accurate data on the participants' realities, the researcher used tape recorders to record the interviews, took field notes and recorded observations on non-verbal cues.

The qualitative approach enhanced the rigour of the study results (Creswell 2013:4) and ensured that methods were mutually informative (Woolley 2009:7). The merit of using this method was that it complemented the existing quantitative data and allowed for generation of new evidence (Polit & Beck 2006:285). The interviews were conducted until data saturation was achieved whereby no new themes emerged as the researcher constructed their theory.

3.4.3.2 Pre-testing of the questionnaire

A pre-test or pilot study is a small-scale trial with participants who are not included in the final study (Polit & Hungler 2000:320). A pre-test is a trial run to determine whether the instrument is clearly worded and free from major biases and whether it solicits the desired information (Brink & Wood 2001:94). According to LoBiondo-Wood and Haber (2002:305), pre-testing of a data-collection instrument identifies problems in the design and sequencing of questions or procedures for recording responses, and determines its reliability and validity.

The researcher pre-tested the questionnaire with five participants who did not participate in the main study (Hardon, Boonmongkon, Streefland & Tan 2001:301; Polit & Beck 2006:296, 507). The pre-test was done to

- Identify and correct possible problems such as ambiguity, vague or difficult language or confusing statements.
- Determine any weakness in the organisation and administration of the interview schedule.
- Establish the reliability and validity of the questionnaire, how long it took for the participants to complete, and whether they understood all the questions.

3.4.3.3 Validity and reliability

The quality of research and a data-collection instrument is determined by its validity and reliability (De Vos et al 2005:110). A data-collection instrument needs to be validated before it can be used to collect data. Validity of a research instrument is determined by its ability to accurately measure what it is supposed to measure (LoBiondo-Wood & Haber 2006:338). It is the measure of the truth or accuracy of what it claims, thus validity serves as verification that the instrument measures the concept in question and the concept is measured accurately (Polit & Hungler 2000:308; De Vos, Strydom, Fouche & Delport 2002:166).

Validity is the extent to which the research tool measures what it is meant to measure and ensures that the results appropriately reflect study variables (Creswell 2013:235; Burns & Grove 2005:755; Polit & Beck 2006:571; Terre Blanche & Durrheim 2002:90). A valid research tool reflects the real meaning of the concept under consideration (Babbie & Mouton 2001:122; LoBiondo-Wood & Haber 2006:338). In this study, internal validity and external validity were important.

- **Internal validity**

The researcher ensured that other competing factors that could potentially affect the research results were ruled out as explanations for any observed association between the dependent and independent variables. For example, the researcher ensured that all the participants came from the accessible population where they were likely to have similar demographic characteristics. The participants were randomly selected which meant that every eligible woman in the accessible population had an equal chance of being selected and thus counterbalanced any unforeseen factors.

- **External validity**

External validity is achieved when results can be generalized to situations outside the specific research setting (Polit & Hungler 1997:277). By using a random sample representative of the target population, the researcher ensured that the study findings are accurate and could be generalised to the population at large.

Reliability refers to the consistency with which an instrument measures attributes or variables relevant to the study (Creswell 2013:233). Reliability is associated with a measure's stability, consistency or dependability (Polit & Beck 2008:452). According to LoBiondo-Wood and Haber (2001:192, 317), reliability refers to coherence, precision, stability, equivalence and homogeneity of the instrument's content. Reliability is a measure that can produce the same results if the behaviour is measured repeatedly by means of the same scale. It is the level at which the instrument produces the same results over repeated measurements. A tool with high reliability has minimal variation in repeated measurements with the same or a similar population at different times (Polit & Beck 2006:324-326). Reliability of the questionnaire was enhanced through pre-testing (Brink & Wood 2001:184).

3.4.3.4 Credibility, dependability, confirmability and transferability

The truth and accuracy of the findings are determined by their credibility, dependability, confirmability and transferability.

- **Credibility**

Credibility is the extent to which the findings of the study are true or accurate (Lincoln & Guba 1985:290; Polit & Beck 2008:539). The researcher improved the credibility of the data, by using qualitative research techniques due to the sensitivity of issues of VAW. The researcher allowed the participants to reflect on their personal lives and experiences privately without fear or embarrassment. Member checking ensured credibility of the findings (Polit & Beck 2008:314). Furthermore, all translations were cross-checked by the researcher to ensure that the data was credible and trustworthy. A

rich description of the context also enhanced the credibility of the study (Drew, Hardman & Hart 1996:169-71).

- **Dependability**

Dependability refers to the consistency or stability of the findings and ability to be repeated (Lincoln & Guba 1985:290; Polit & Beck 2008:539). The researcher ensured that the research processes were consistent in the study design, data collection, interpretation, and reporting. All processes were explained and presented clearly taking into account the dynamic study context and how it affected the research processes.

- **Confirmability**

Confirmability is the extent to which the study's results reflect the participants' views instead of the researcher's interests (Lincoln & Guba 1985:285; Polit & Beck 2008:539). The researcher ensured that the results of this study could be confirmed or verified by others by documenting the procedures for checking and re-checking the data throughout the study. The researcher had an increased awareness of any undesirable negative occurrences that dispute previous observations. In addition, at the end of the data collection and analysis, the researcher reviewed the research processes and established any potential bias.

- **Transferability**

Transferability refers to the ability to ensure that the findings can also be relevant to similar settings (Lincoln & Guba 1985:290; Polit & Beck 2008:539). To ensure transferability of the results, the researcher provided a thick description of the research context and key research assumptions. This would enable others who desire to transfer to make judgment about the study findings.

3.4.3.5 Data-collection process

The fieldworkers who assisted the researcher were qualified social workers who were given two days training on how to collect quantitative and qualitative data. The researcher collected and supervised the data-collection process to ensure that the data

collected was of high quality. The questions were asked in a clear and unambiguous manner and the responses recorded verbatim. Probes helped the researcher to explore new insights that were previously not considered (Gray 2011:217). The researcher acknowledged that a word or phrase in another language may have a different meaning in another context thus where the lexical equivalent could not be obtained, conceptual equivalence were sought (Kirkpatrick & Van Teijlingen 2009:26). Data was collected over a period of six months from July 2014 to January 2015 (Annexure F shows the research timelines).

3.4.4 Data analysis

Data analysis is the process of bringing order, structure and meaning to collected data. Data analysis is conducted to reduce, organise and give meaning to the data.

3.4.4.1 Quantitative

The quantitative survey data collected was entered into the MS access (version 10) database, then exported to Stata (version 11) for data cleaning and analysis. Descriptive statistics were used to summarise and describe the data in the form of numbers, charts, frequency distribution tables, percentages and proportions. To test the association between variables under study, the odds ratios and confidence intervals were calculated. Odds ratios are a measure of the association between an exposure and an outcome. In this study, IPV as the outcome and odds ratio indicated the likelihood that IPV would occur given the presence of certain exposures particularly demographic and socio-economic characteristics (Szumilas 2010:1). The 95% confidence interval was used to estimate the level of precision of the odds ratios with wide confidence intervals indicating low precision and small confidence intervals representing high precision of the odds ratios (Du Prel et al 2009:336; Szumilas 2010:1).

3.4.4.2 Qualitative

The interviews were recorded on a digital audio recorder and notes were taken. The researcher transcribed and translated the recordings within a day of the interview thus ensuring that the data was ready for analysis. This was crucial in familiarising the

researcher with key ideas that emerged from the data, and overall impressions about the participants during the interviews. The researcher was able to verify the quality of the data by identifying and writing key ideas, impressions of participants down (Terre Blanche & Durrheim 2002:48). The data analysis methods were congruent with the study's epistemological underpinnings and position (Terre Blanche & Durrheim 2002:86). The tools and techniques used in the data collection were also considered in choosing the methods. The qualitative data was subjected to thematic content analysis, which involved coding of transcripts to classify the data (Green & Thorogood 2009:198; Terre Blanche & Durrheim 2002:324). Each interview was structured into an individual table highlighting key themes. The researcher then developed a theme codebook consisting of the themes and sub themes with numerical codes attached to each theme and sub-theme. The researcher checked for authenticity of codes, divergent cases and confirmed the emergent themes by categorising the data tables in order to find patterns and processes (Gifford 1998:547; Mason 2010:1).

3.4.4.3 Qualitative data coding

A code refers to "the most basic segment or element of the raw data … that can be assessed in a meaningful way" (Braun & Clarke 2006:88). Coding leads you "from the data to the idea and from the idea to all the data pertaining to that idea" (Richards & Morse 2007:137). The researcher used descriptive, analytical and hierarchical coding (Saldana 2012:88). Descriptive coding provided a summary of the text in relation to the objectives (Richards & Morse 2007:138). Analytical coding involved the researcher explaining the phenomenon (Taylor & Gibbs 2010:1). Then the researcher used hierarchical coding to identify key themes, based on the study objectives. This involved classifying the themes and sub-themes in tabulated transcripts.

3.5 ETHICAL CONSIDERATIONS

Ethics refer to "a system of moral values concerned with the degree to which research procedures adhere to professional, legal and social obligations of the participants" (Polit & Beck 2008:553). Ethical principles in research are essential in generating sound knowledge for practice; should sustain fairness and honesty; protect from discomfort and harm, and maximise benefits. The main ethical principles include respect for

persons, beneficence and justice (Polit & Beck 2010:553). In this study the researcher upheld the ethical principles of the rights of the institution and the participants.

3.5.1 Permission

The researcher obtained ethical approval and permission to conduct the study from the Research and Ethics Committee of the Department of Health Studies, University of South Africa (see Annexure A). Ethical approval and permission was also obtained from the Uganda National Council of Science and Technology (UNCST) and Office of the President (see Annexure B).

3.5.2 Access to community and records

Meetings were held with local leaders as gatekeepers to gain entry into the communities. The researcher obtained information on possible participants for the qualitative study through the review of clinic records from the community agency that ran the clinic. The community agency had an established relationship with and extensive knowledge of the community and therefore an increased understanding of the local realities. This made it easier for the researcher to get the trust and build rapport with the communities. The community agency itself also offered a safe space for women experiencing distress or violence through support groups and allowed ease of access in identifying participants with experiences of IPV.

3.5.3 Self-determination

The right to self-determination is based on the ethical principle of respect for persons and indicates that people are capable of controlling their own destiny. The participants were accorded fair and equitable treatment; confidentiality, privacy and anonymity (Burns & Grove 2005:157-158; Polit & Hungler 2004:143; Terre Blanche & Durrheim 2002:68). Pseudonyms were used to protect their identities and maintain confidentiality and anonymity by ensuring the data could not be traced back to any participant (Polit & Hungler 2004:141; Creswell 2007:141; Rubin & Babbie 2007:25). The researcher ensured that there was non-manipulation of the participants (Babbie & Mouton 2001:563).

3.5.4 Informed consent

The researcher explained the purpose and significance of the study; risks and benefits of participation; emphasised that participation was free and voluntary, and treated the participants with respect (Holosko 2001:263; Babbie 2005:61; Polit & Beck 2004:141). This information enabled the participants to make an informed decision about participating and seek any clarification about the study. If the participants agreed to take part, they were asked to sign an informed consent form before commencing (see Annexure D). The researcher arranged convenient times at the clinic for the qualitative interviews. The participants were informed of their right to withdraw at any stage of the study (see Annexure C). Participation in the research was voluntary and the identities of all participants were kept anonymous and the research results were only used for aims related to the study (Polit & Hungler 2004:141).

3.5.5 Confidentiality

The researcher assured the participants of confidentiality and anonymity. The identities of all participants were kept anonymous and the research results were only used for aims related to the study (Polit & Hungler 2004:150). Since they may not have been able to talk freely about the topic at their homes, the participants were given the option of participating at a nearby centre where they could sit and talk freely without interruption. The researcher felt it was important to conduct the interviews at the centre because it offered a safe and friendly environment for the women where they could speak freely without feeling intimidated (Polit & Beck 2004:37). The interview setting influences the data collected and privacy is very important (Green & Thorogood 2009:95). The tapes and all documents were de-identified and rendered anonymous and will be kept securely in a remote location for up to five years after study completion after which they will be destroyed. The researcher used pseudonyms to protect the identities and maintain confidentiality of the participants. The raw data obtained from the study was accessed by the researcher and the promoters only.

3.5.6 Risks

There could have been some psychological discomfort due to the sensitive nature of the topic. This invoked undesired memories and psychological distress for some of the

women but participants were made to feel comfortable through good rapport and assured of maximum confidentiality and respect of all responses. None of the participants needed further support. There was minimal risk of loss of confidentiality therefore the researcher used pseudonyms to protect their identities and maintain confidentiality. The data obtained from the study was accessed by the researcher, the supervisory committee and ethics committees only as necessary.

The women may have felt that the researcher was more knowledgeable than them but this power imbalance was reduced through good rapport with participants (Green & Thorogood 2009:80).

3.5.7 Adverse events

While there were no adverse events, the researcher had adequately prepared so that if any participants needed further support, they would be referred to a qualified counsellor and social worker from the community agency. The researcher did not have to inform the ethics committees about any adverse events and therefore no new information about the study's risks was obtained to revise information on the risks during the consenting process.

3.6 CONCLUSION

This chapter described the research design and methodology used in this study. A sequential explanatory study was conducted, using quantitative and qualitative methods. The methodology included the population, sampling and sampling, data collection and analysis, and strategies to enhance validity, reliability, transferability, dependability, confirmability and credibility of the data. Finally the ethical considerations were briefly discussed.

Chapter 4 covers the quantitative data analysis, interpretation and results.

CHAPTER 4

Quantitative data analysis and interpretation, and results

4.1 INTRODUCTION

This chapter presents the quantitative data analysis, interpretation and results. The quantitative survey wished to determine the types of IPV prevalent among the participants.

4.2 QUANTITATIVE DATA MANAGEMENT AND ANALYSIS

A structured questionnaire was used to collect information on IPV from the participants. Intimate partner violence was grouped as physical, psychological, economic and sexual. A sample size of 372 was obtained to attain half width of the 95% confidence interval for the prevalence of IPV based on previous studies at 59% (UDHS 2012:239). Psychological violence was assessed by 24 variables; economic violence by three variables namely money, stop and deprive money; sexual violence was assessed by one variable on forced sex while physical abuse was assessed by nine variables (see Annexure E).

The different forms of IPV were also taken as the outcome dichotomous variables. One dependent variable was created as presence of physical or psychological form of violence defined as the participant being subjected to any or both forms of violence. The socio-demographic factors were considered as independent variables. Age was divided into the following categories: =20, 21-29, 30-39, and 40-45 years. Education was grouped into none, primary, secondary, higher secondary, tertiary and university. Occupation was grouped into none, unskilled labour and small business owner. Income was grouped into <58,000; 58,000-100,000 and >100,000. Marital status was grouped into single, cohabiting, married, divorced and widowed. Religion was grouped into Catholic, Anglican, Seventh Day Adventist, Pentecostal, Moslem and Traditional. The participants' number of children was grouped into none, 1-2 and >=3 children. Figure 4.1 shows the dependent and independent variables.

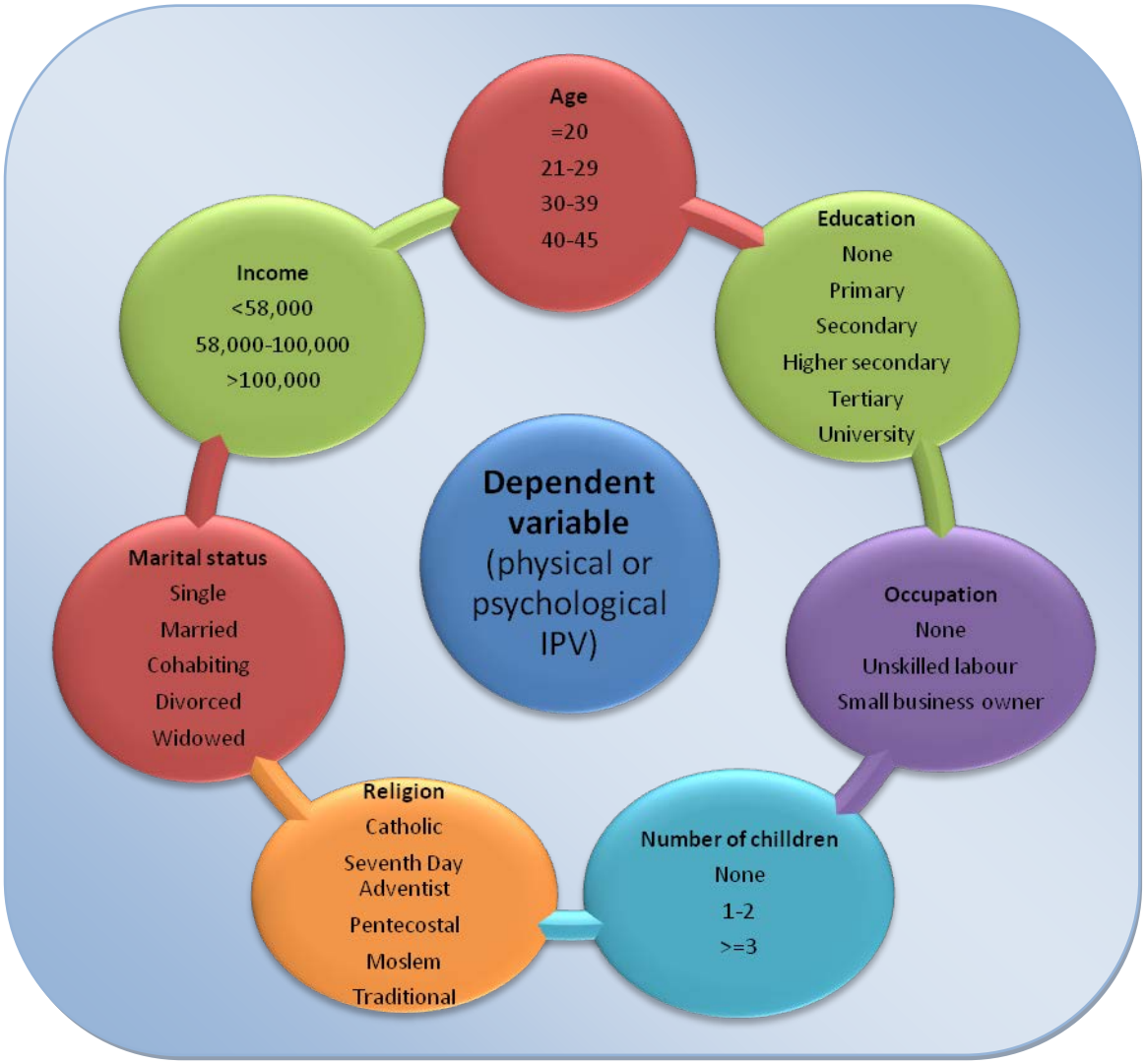

Figure 4.1 Dependent and independent variables

For bi-variate and multi-variate analysis, the dependent variable was dichotomised into experience of a form of violence and not experiencing any form of violence. Descriptive statistics on socio-demographic characteristics were used to summarise the data. The results were summarised and presented in tables and charts to clarify the findings. The data collected was entered into the MS access (version 10) database, exported to Stata (version 11) for data cleaning and analysis.

4.3 RESEARCH RESULTS

4.3.1 Sample characteristics

The study explored the participants' socio-demographic characteristics including age, marital status, educational level and religion. For example, the participants' (100%; N= 372) mean age was 29 years with a standard deviation of +-7.8 years; 53.24% (n=197) had no education; 46.51% (n=173) indicated business as occupation; 47.58% (n=177) had a monthly income of 21 USD, and 55.26% (n=205) were cohabiting. Table 4.1 presents the participants' detailed socio-demographic information. The individual characteristics are discussed in detail.

Table 4.1 Participants' socio-demographic characteristics

Variables	**N=372**	**%**
Participants		
1 Age groups		
20 years	20	5.38
21-29 years	201	54.03
30-39 years	115	30.91
40-45 years	27	7.26
2 Education		
None	197	53.24
Primary	114	30.81
Secondary	46	12.43
High Secondary	8	2.16
Tertiary	2	0.54
University	3	0.81
3 Occupation		
Semi-Skilled	82	22.04
Business	173	46.51
None	117	31.45
4 Income		
<58,000 UGX (21usd)	177	47.58
58,000-100,000 UGX (21-37usd)	49	13.17
>100,000 UGX (37usd)	146	39.25
5 Marital status		
Single	41	11.05
Married	93	25.07
Cohabiting	205	55.26
Divorced	14	3.77
Widowed	18	4.85
6 Religion		
Catholic	139	38.40
Anglican	88	24.31
Seventh Day Adventist	16	4.42
Pentecostal	43	11.88
Moslem	33	9.12
Traditional	43	11.88

Variables	N=372	%
Participants		
7 Number of Children		
No children	35	9.41
(From) 1-2 Children	182	48.92
(From) 3 Children	155	41.67

4.3.1.1 Age

The participants' age ranged from 20 to 45 years. Of the participants, 54% (n=201) were aged 21-29; 31% (n=115) were aged 30-39, and 7% (n=27) were aged 40-45. The participants' mean age was 29, the median age was 26, and the standard deviation (sd) was 7.8 years. Figure 4.2 presents the participants' ages.

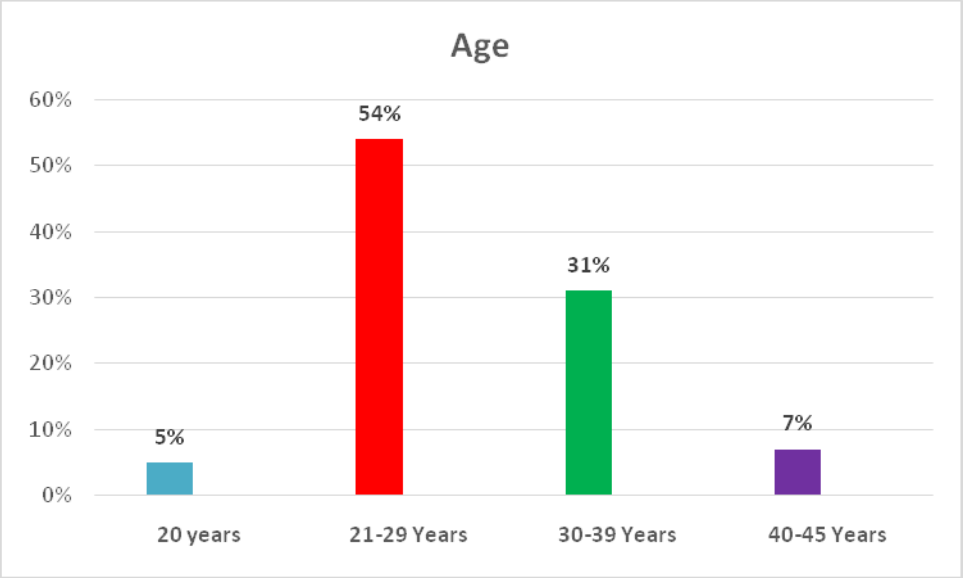

Figure 4.2 Participants' age (n=372)

4.3.1.2 Education level

Regarding the participants' educational level, 53% (n=197) had no formal education; 31% (n=114) had primary education; 12% (n=46) had secondary education; 2% (n=8) had high school education, 0.54% had tertiary education and 0.8% (n=3) had attained university level (see figure 4.3).

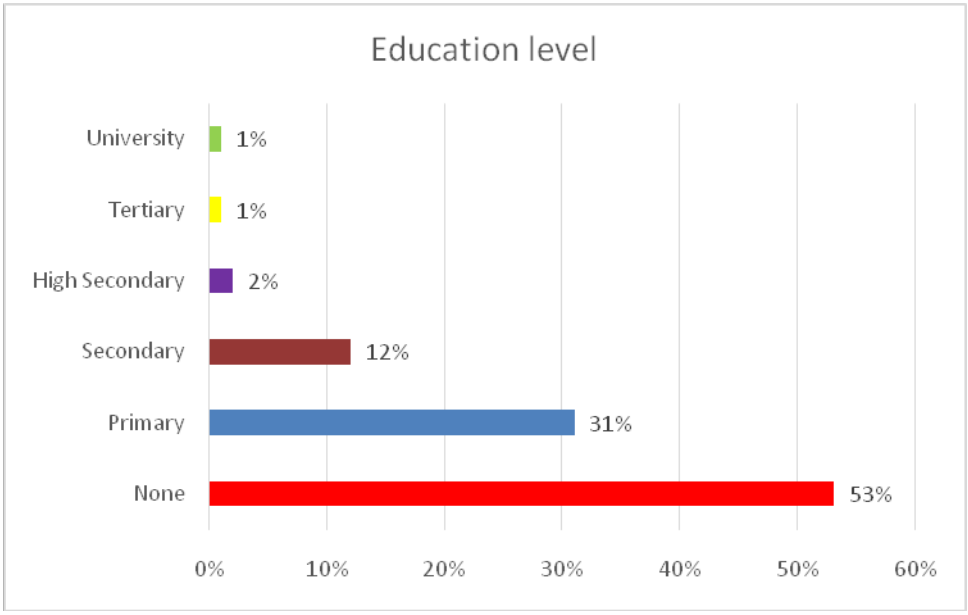

Figure 4.3 Participants' education level (n=372)

In contrast, the Uganda Demographic and Health Survey (UDHS 2012:30) found that only 13% of women aged 15-49 years had no formal education while the majority (59%) had primary education. This could indicate that a significant proportion of women in the urban slums have no formal education. Low educational level has been associated with IPV experiences (The Interagency Gender Working Group of USAID 2008:7; Cunradi, Caetano & Schafer 2002:378) and poor health outcomes (WHO 2015:11). In India, women who were less educated and younger were found to be more susceptible to IPV due to their inability to look after themselves and a decreased ability to handle spousal stress (Nanda et al 2014:47).

4.3.1.3 Occupation

Of the participants, 47% (n=173) were engaged in small business-related activities such as hawking clothes, selling food and running a hair salon; 32% (n=117) were not engaged in any work, and 22% (n=82) were employed in unskilled jobs such as washing clothes for other people and cleaning homes, selling charcoal, and working in bars (see figure 4.4).

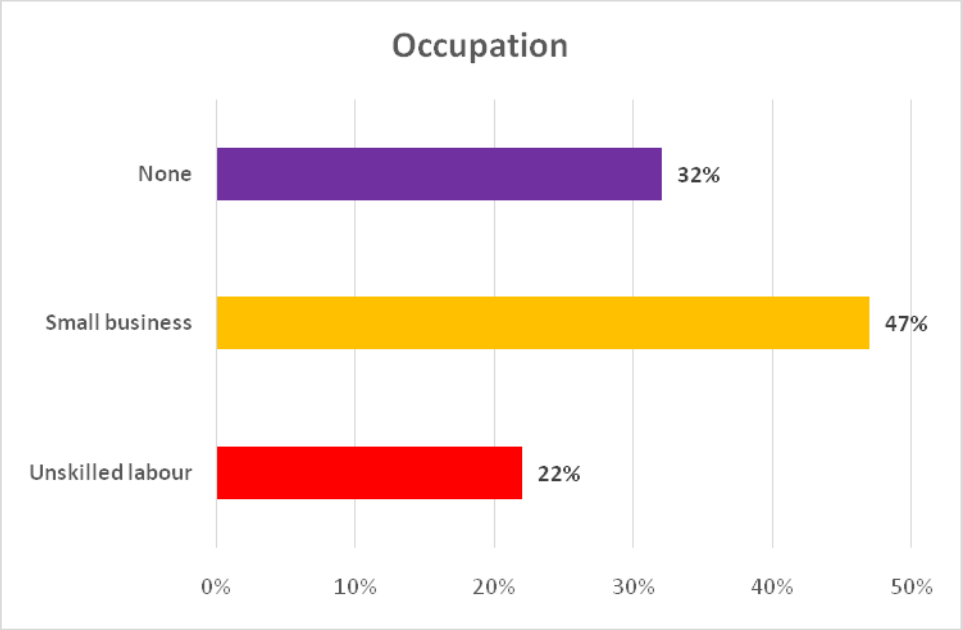

Figure 4.4 Participants' occupation (n=372)

4.3.1.4 Income

Of the participants, 48% (n=177) earned below 58,000 Uganda shillings (21 USD) per month; 13% (n=49) earned 58,000 to 100,000 Uganda shillings (21-37 USD) per month while 39% (n=146 earned more than 100,000 Uganda shillings (see figure 4.5). According to the Bank of Uganda on 10 November 2014, the exchange rate was 1 USD to 2717 Uganda shillings.

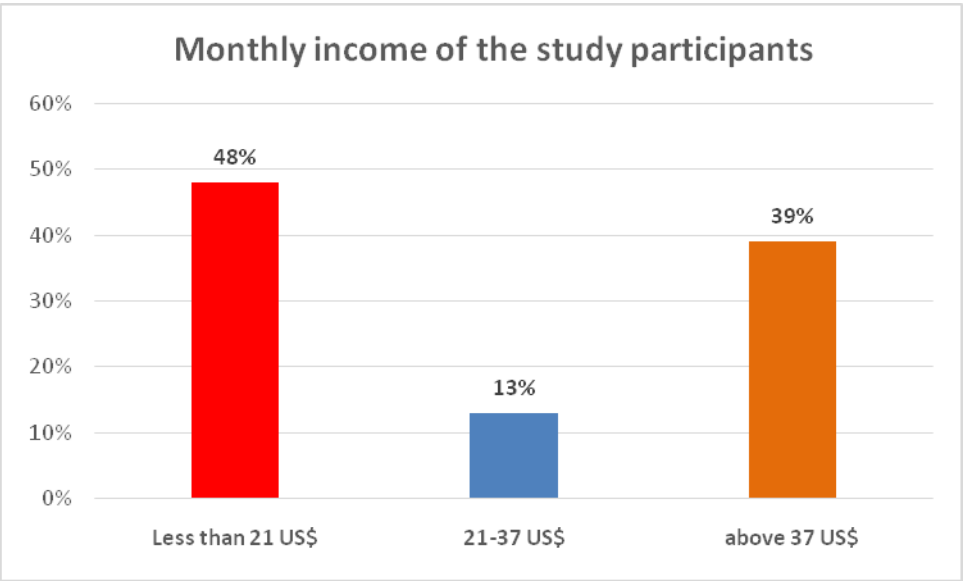

Figure 4.5 Participants' monthly income (n=372)

4.3.1.5 Marital status

Of the participants, 55.3% (n=205) were cohabiting; 25.1% (n=93) were married, 11.1% (n=41) were single; 4.9% (n=18) were widowed, and 3.8% (n=14) were divorced (see figure 4.6). According to the Uganda Demographic and Health Survey (UDHS 2012:47), 24% of women had never married, 36% were married; 27% were cohabiting; 9% were divorced/separated, and 4% were widowed.

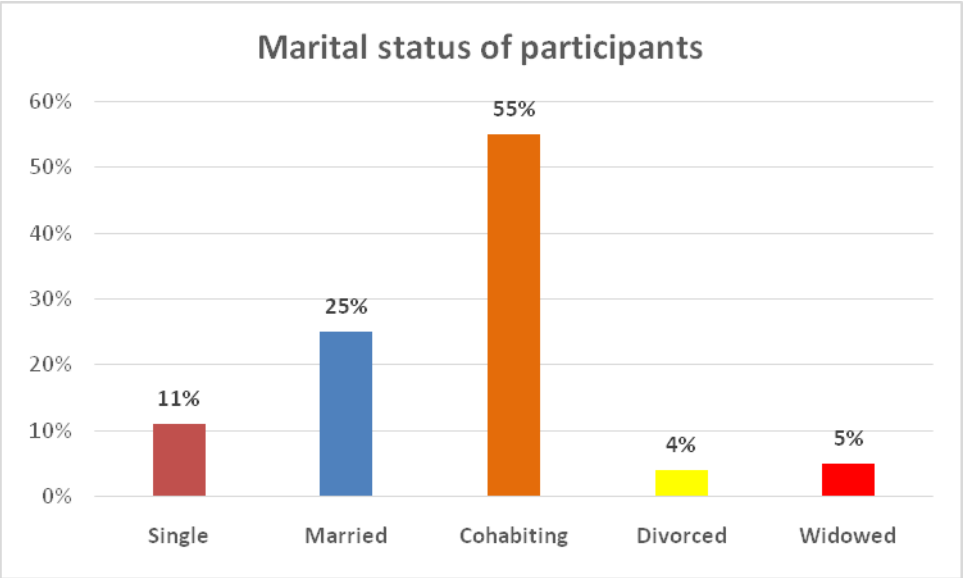

Figure 4.6 Participants' marital status (n=372)

4.3.1.6 Religion

Of the participants, 38% (n=139) were Catholic; 24% (n=88) were Anglican; 12% (n=43) each were Pentecostals and Traditional religion; 9% (n=33) were Moslems, and 4% (n=16) were Seventh Day Adventists (see figure 4.7.). The Uganda Demographic and Health Survey (UDHS 2012:29) found that 41% of women in Uganda were Catholic, 13% were Muslim, 2% were Seventh Day Adventists and 13% were Pentecostal.

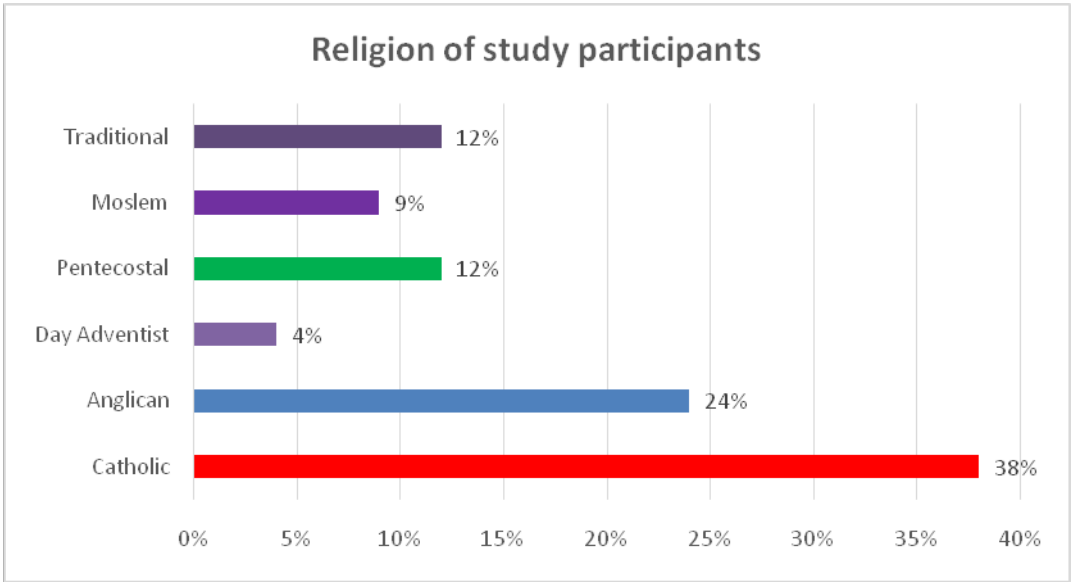

Figure 4.7 Participants' religion (n=372)

4.3.1.7 Number of children

Of the participants, 49% (n=182) had 1-2 children; 42% (n=155) had three or more children, and 9% (n=35) had no children. The number of children per woman (mean) was 2 with a minimum of 0 and maximum of 7 (see figure 4.8). According to the Uganda Demographic and Health Survey (UDHS 2012:59), the average number of children per woman in Kampala is 3.3 while the national total Fertility Rate is 6.2.

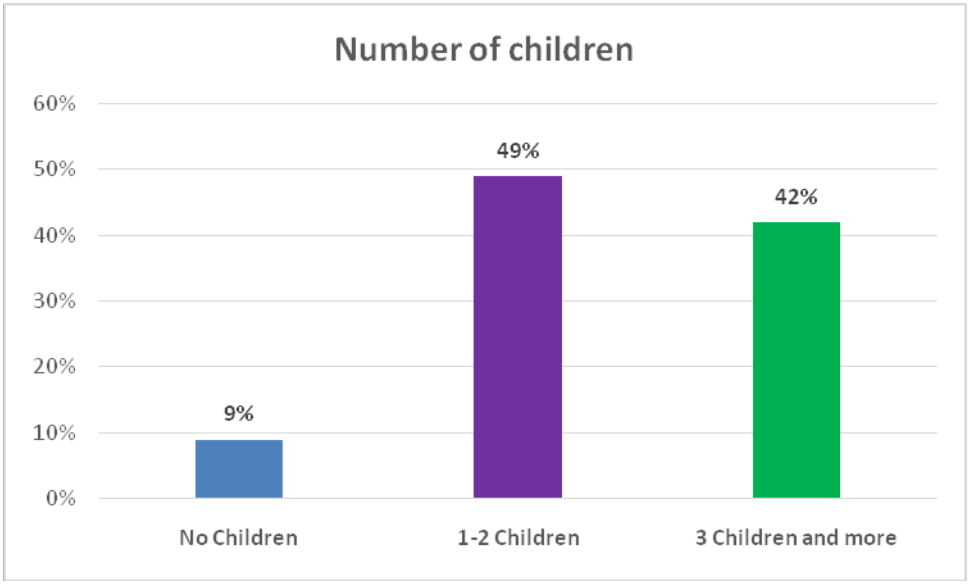

Figure 4.8 Participants' number of children (n=372)

4.3.2 IPV prevalence among women

Almost all the participants reported IPV prevalence (99.73%; n=371). The IPV prevalence by type was also very high with the highest being psychological and the least prevalent being sexual (88.44%; n=329).

Table 4.2 Participants' prevalent forms of IPV

Prevalence of different forms of violence among participants (n=372)	
Form of violence	%(n)
Physical violence	91.67 (341)
(hit when angry, damage, locked, weapons)	
Physical violence in the last one year	91.40 (340)
(slapped, arm twist, slammed, kicked, choke, push, burned)	
Sexual violence	88.44 (329)
(forced sex, suspect partner)	
Psychological violence	99.73 (371)
(upset,forbid,insult,angry,afraid,harm,threaten,monitor,prisoner,unsafe,ashamed ,power,hide,harass,abusive,angry,contact,hurt,punish,take,relationship,force,sui cide)	
Economic violence	93.01 (346)
(money, stop, deprive money)	

Figure 4.9 depicts the participants' prevalent forms of IPV.

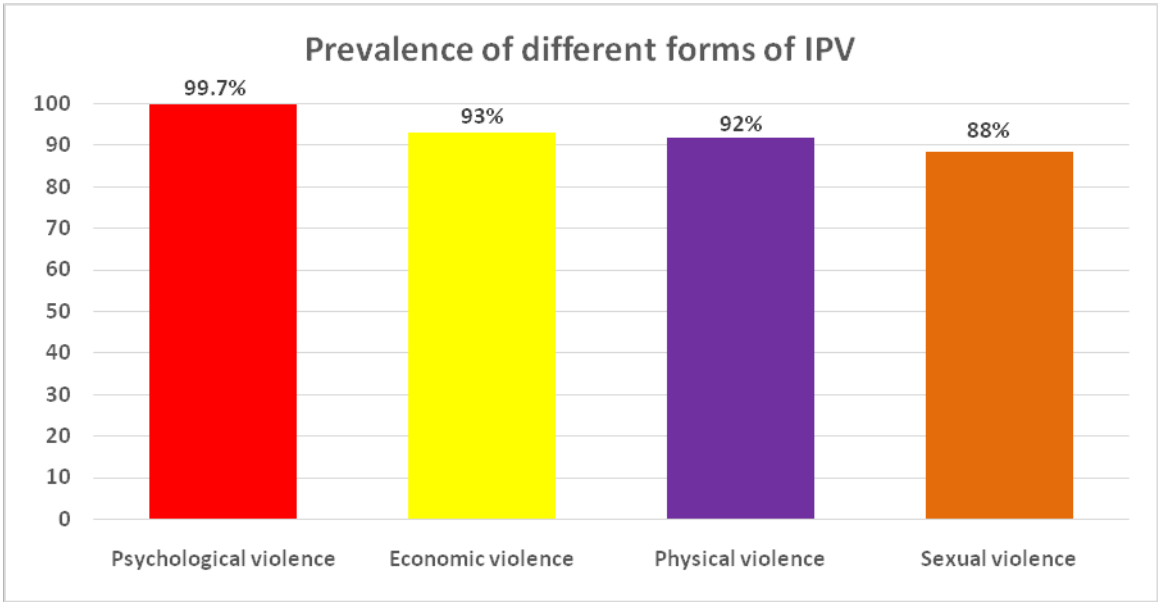

Figure 4.9 Participants' prevalent forms of IPV (n=372)

4.3.3 Prevalence of psychological violence

Table 4.3 lists the participants' psychological violence as assessed by 24 constructs.

Table 4.3 Prevalence of psychological violence

Psychological violence variable		Yes	No
1	Does your partner forbid you from having any friends and socialising with them	258 (70.1%)	110 (29.9%)
2	Does your partner insult you in front of others?	290 (78.8%)	78 (21.2%)
3	Does your partner get angry if you disagree with his point of view?	290 (78.8%)	78 (21.2%)
4	Are you afraid of your partner?	290 (78.8%)	78 (21.2%)
5	Does your partner cause damage to your property when angry?	294 (79.9%)	74 (20.1%)
6	Is your partner jealous and does he suspect you of cheating without reason/cause?	297 (80.7%)	71 (19.3%)
7	Does your partner steal from you (money or other valuables) leaving you stranded?	292 (79.6%)	75 (20.4%)
8	Does your partner discourage your contact with family?	263 (71.5%)	105 (28.5%)
9	Has he threatened to hurt your family or friends?	254 (69.4%)	112 (30.6%)
10	Does he punish or deprive the children when he was angry at you?	219 (59.0%)	152 (41.0%)
11	Does he threaten to take the children if you leave him?	212 (57.1%)	159 (42.9%)
12	Has he ever locked you outside or inside the house?	254 (68.5%)	117 (31.5%)
13	Does he threaten to end the relationship if you do not do what he wants?	281 (76.0%)	89 (24.0%)
14	Has he tried to force you to leave your home?	279 (75.2%)	92 (24.8%)
15	Does he threaten to commit suicide when he is angry at you?	268 (72.2%)	103 (27.8%)
16	Does your partner threaten to harm/kill you?	236 (63.6%)	135 (36.4%)
17	Does your partner threaten to kill/harm your children?	228 (61.6%)	142 (38.4%)
18	Does your partner follow you or hang around the house to monitor your movements?	261 (70.3%	110 (29.7%)
19	Does your partner make you feel like a prisoner?	263 (71.5%)	105 (28.5%)
20	Does he make you feel unsafe even in your own home?	296 (79.8%)	75 (20.2%)
21	Do you feel ashamed of the things he does to you?	314 (84.6%)	57 (15.4%)
22	Does he make you feel like you have no control over your life and no power?	291 (78.9%)	78 (21.1%)
23	Do you hide the truth from others because you are afraid?	299 (81.2%)	69 (18.8%)
24	Does your partner harass you at work?	228 (61.6%)	142 (38.4%)

Of the participants, 81% (n=297) reported that their partners were jealous and suspected them of cheating without reason/cause; 85% (n=314) felt ashamed of the things that their partners did to them, and 81% (n=299) hid the truth from others

because they were afraid. Guruge, Bender, Aga, Hyman, Tamiru, Hailemariam, Kassa & Refaie-Shirpak (2012:4) and Nanda et al (2014:48) found that women hid the truth about occurrences of IPV due to shame and Tjaden and Thoennes (2000:50) found that some women were afraid that the male partners may seek revenge for doing so.

4.3.4 Prevalence of economic violence

Table 4.4 lists the participants' prevalence of economic violence as assessed by three variables.

Table 4.4 Prevalence of economic violence

Economic violence variable		Yes	No
1	Does your partner use money or make important financial decisions without talking to you about it?	261 (71.1%)	106 (28.9%)
2	Does your partner deliberately deprive you of money?	305 (82.9%)	63 (17.1%)
3	Does your partner stop you from working?	281 (76.4%)	87 (23.6%)

Of the participants, 82.9% (n=305) stated out that their partners deliberately deprived them of money; 76.4% (n=281) stated that their partners stopped them from working, and 71.1% (n=261) stated that the partners took important financial decisions without engaging them. In India, Nanda et al (2014:26) found that two-thirds of the men thought that they had a greater say in important decisions than their partners.

4.3.5 Prevalence of sexual violence

Of the participants, 83.4% (n=306) stated that their partners forced them to have sex without their consent (see table 4.5).

Table 4.5 Prevalence of sexual violence

Sexual violence variable		Yes	No
1	Does your partner force you to have sex when you do not want?	306 (83.4%)	61 (16.6%)

4.3.6 Prevalence of physical violence

Physical violence was the most common form of IPV reported by the participants (see table 4.6).

Table 4.6 Prevalence of physical violence

Physical violence variable	Yes	No
1 Has your partner in the last one year:		
a. Slapped you	320 (86.5%)	50 (13.5%)
b. Physically twisted your arm	310 (83.8%)	60 (16.2%)
c. Slammed you or held me against a wall	299 (80.8%)	71 (19.2%)
d. Kicked you	296 (80.0%)	74 (20.0%)
e. Tried to choke you	288 (78.0%)	81 (22.0%)
f. Pushed or grabbed you	325 (88.3%)	43 (11.7%)
g. Burned you	275 (74.3%)	95 (25.7%)
h. Hit you with a fist (punching)	285 (77.0%)	85 (23.0%)
i. Stabbed you with a knife	235 (63.5%)	135 (36.5%)

The participants reported the following most common forms of physical violence: 88.3% (n=325) being pushed or grabbed; 86.5% (n=320) were slapped; 83.8% (n=310) had their arms twisted; 80.8% (n=299) were slammed or held against a wall; 80% (n=296) were kicked; 78% (n=288) were choked; 77% (n=285) were punched, hit with a fist; 74.3% (n=275) were burned, and 63.5% (n=235) were stabbed. Archer (2002:317) found that physical violence includes throwing objects at the partner; kicking, pushing, choking, shoving and threatening with a weapon. The use of weapons depends on the cultural setting and in the American region firearms are most used in perpetrating violence although most physical violence in general is often inflicted by fists and feet through punching and kicking (WHO 2014b:12).

4.3.7 Partner characteristics

Table 4.7 Partner characteristics

Partner characteristics		Yes	No
1	Does your partner use drugs and/or alcohol?	315 (84.5%)	58 (15.5%)
2	If yes, how does he act when he is drinking or on drugs? Is he ever verbally or physically abusive?	313 (99.4%)	2 (0.6%)
3	Do you have weapons in your home?	218 (58.5%)	153 (41.5%
4	Has your partner ever threatened to use them when he was angry?	218 (58.5%)	153 (41.5%)

Of the participants, 84.5% (n=315) indicated that their partners used alcohol or drugs. Of these, 99.4% (n=313) stated that their partners were verbally or physically abusive when drunk. Women whose partners drink have a far higher risk of violence compared to those whose partners do not (Jewkes 2002:1425; Abramsky et al 2012:2; Sambisa et al 2010:165; McIlwaine 2013:69; WHO 2014b:ix). Alcohol abuse affects the cognitive function resulting in decreased self-control, with consequences such as violence (WHO 2014b:34). Uganda has a high consumption of alcohol and is ranked among countries with the highest per capita alcohol consumption globally of 9.8 litres of pure alcohol in comparison to the WHO African region average of 6.0 (WHO 2014c:1). In this study, 58.5% (n=218) of the participants stated that their partners had weapons in their homes and had threatened to use when they were angry. Easy access to weapons and alcohol abuse have been strongly linked to IPV (WHO 2014b:ix).

4.3.8 IPV interventions in community

The participants were asked about IPV interventions in the community. Table 4.8 indicates the responses.

Table 4.8 IPV interventions in the community

IPV intervention variable	Yes	No
1 Do you have anyone you can talk to about issues of violence?	46 (12.7%)	315 (87.3%)
2 Have you ever attended talks on violence against women?	44 (12.2%)	317 (87.8%)
3 Do your health workers advise you on ways of preventing and managing violence?	32 (8.9%)	329 (91.1%)
4 Are there any agencies in your community involved in the dissemination of information on violence against women?	36 (10.0%)	325 (90.0%)

Of the participants, 12.7% (n=46) had someone they discussed issues of violence with; 12.2% (n=44) had ever attended talks on VAW; 8.9% (n=32) were advised by their health workers on preventing and managing violence, and 10% (n=36) stated that there were agencies in their community that disseminated information on VAW. IPV experiences tend to be reduced where women have someone to confide in but increased isolation and low social support networks due to urbanisation makes it difficult to seek help (McIlwaine 2013:72). Non-reporting and limited care seeking contribute to underreporting of the problem of IPV; most women have not shared their problems of violence with anyone, and many do not seek any institutional support (WHO 2014b:13).

4.4 ASSOCIATION BETWEEN SOCIO-DEMOGRAPHIC FACTORS AND IPV

The dependent variable was IPV defined as having experienced any form of physical, economic, sexual and psychological violence and the independent variables were age in years, educational level, occupation, income level, marital status and religion. Logistic regression was used to determine the contribution of the socio-demographic factors with IPV as the outcome variables. The covariates were selected if the confidence interval of the odd ratios did not contain the value of 1.The variables considered significant across all forms of IPV were identified.

Table 4.9 Association between demographic characteristics and all forms of IPV

Variables	% (n) with violence	OR (95% CI)
Participants		
1 Age groups		
20 years	5.9 (19)	1
21-29 years	58.8 (190)	0.91 (0.11-7.43)
30-39 years	26.0 (84)	0.15 (0.02-1.15)
40-49 years	6.8 (22)	0.23 (0.02-2.16)
2 Education		
None	55.1 (177)	1
Primary	30.5 (98)	1.07 (0.41-2.76)
Secondary	11.5 (37)	0.47 (0.17-1.31)
High secondary	2.5 (8)	
University	0.3 (1)	
3 Occupation		
Semi-skilled	22.9 (74)	1
Business	43.7 (141)	0.07 (0.01-0.57)
None	33.4 (108)	1.4 (0.09-22.75)
4 Income		
<58,000 UGX	50.8 (164)	1
58,000-100,000 UGX	10.5 (34)	0.17 (0.07-0.39)
>100,000 UGX	38.7 (125)	0.42 (0.2-0.87)
5 Marital status		
Single	10.9 (35)	1
Married	25.8 (83)	1.58 (0.52-4.78)
Cohabiting	60.0 (193)	2.76 (0.97-7.83)
Divorced	0.9 (3)	0.05 (0.01-0.22)
Widowed	2.5 (8)	0.14 (0.04-0.49)
6 Religion		
Catholic	40.6 (127)	1
Anglican	24.0 (75)	0.50 (0.21-1.17)
Day Adventist	4.8 (15)	1.3 (0.16-10.78)
Pentecostal	10.5 (33)	0.29 (0.11-0.73)
Moslem	09.0 (28)	0.61 (0.18-2.04)
Traditional	11.2 (35)	0.38 (0.14-1.01)

The participants in the 21-29 years age group were more exposed to IPV than their counterparts in other age categories. Age is a life course factor in IPV as younger women have a greater risk of IPV compared to older women (McIlwaine 2013:69; Speizer 2011:5; Jewkes, Flood & Lang 2015:1581). Of the participants, those who had no education (55.1%; n=177) and those who had no occupation (33.4%; n=108) were

more exposed to IPV. Nanda et al (2014:49) found that women who did not have an active job outside their homes or who did not earn cash had the highest prevalence of IPV while age above 35 was more protective of IPV experience. In addition, low educational levels among women are a strong risk factor for IPV (Ali & Gavino 2007:1423; Jewkes et al 2002:1426). Of the participants, 50.8% (n=164) with an income of <58,000 Uganda shillings and 40.6% (n=127).

Table 4.10 Association between psychological violence and risk factors

Variables	% (n) with violence	OR (95% CI)
Participants		
1 Age groups		
20 years	5.4 (20)	0
21-29 years	54.2 (201)	
30-39 years	30.5 (113)	
40-49 years	7.3 (27)	
2 Education		
None	53.5 (197)	0
Primary	30.7 (113)	
Secondary	12.2 (45)	
High secondary	2.2 (8)	
University	1.36 (5)	
3 Occupation		
Semi-skilled	22.4 (83)	0
Business	46.4 (172)	
None	31.3 (116)	
4 Income		
<58,000 UGX	47.4 (176)	0
58,000-100,000 UGX	13.2 (49)	
>100,000 UGX	39.4 (146)	
5 Marital status		
Single	11.1 (41)	0
Married	24.7 (91)	
Cohabiting	55.6 (205)	
Divorced	3.8 (14)	
Widowed	4.9 (18)	
6 Religion		
Catholic	38.4 (138)	0
Anglican	24.5 (88)	
Day Adventist	4.5 (16)	
Pentecostal	11.7 (42)	
Moslem	8.9 (32)	
Traditional	12.0 (43)	

There was no significant factor associated with psychological violence. However, in five low socio-economic communities in urban Karachi, Pakistan, Ali and Gavino (2007:1423) found that risk factors for psychological violence included low socio-economic status of the family and low level of education as well as alcohol use.

Table 4.11 Association between economic violence and risk factors

Variables	% (n) with violence	OR (95% CI)
Participants		
1 Age groups		
20 years	5.8 (20)	
21-29 years	57.2 (198)	
30-39 years	27.8 (96)	
40-49 years	6.4 (22)	
2 Education		
None	53.6 (184)	1
Primary	30.9 (106)	1.07 (0.41-2.76)
Secondary	11.7 (40)	0.47 (0.17-1.31)
High Secondary	2.3 (8)	
University	1.5 (5)	
3 Occupation		
Semi-skilled	23.7 (82)	1
Business	43.1 (149)	0.1 (0.01-0.57)
None	33.2 (115)	1.4 (0.86-22.75)
4 Income		
<58,000 UGX	48.8 (169)	1
58,000-100,000 UGX	11.6 (40)	0.18 (0.06-0.52)
>100,000 UGX	39.6 (137)	0.57 (0.21-1.53)
5 Marital status		
Single	11.3 (39)	1
Married	25.3 (87)	0.89 (1.68-4.8)
Cohabiting	59.6 (205)	
Divorced	1.2 (4)	0.02 (0.0-0.13)
Widowed	2.6 (9)	0.05 (0.0-0.28)
6 Religion		
Catholic	39.1 (131)	1
Anglican	24.5 (82)	0.73 (0.24-2.25)
Day Adventist	4.5 (15)	0.8 (0.09-6.97)

Variables	% (n) with violence	OR (95% CI)
Participants		
Pentecostal	11.6 (39)	0.52 (0.15-1.87)
Moslem	9.3 (31)	1.66 (0.2-13.96)
Traditional	11.0 (37)	0.33 (0.1-1.04)

Of the participants, 43.1% (n=149) indicated 'business'; 33.2% (n=115) indicated 'none', and 23.7% (n=82) indicated 'semi-skilled' as occupation. Regarding income, 39.6% (n=137) indicated more than 100,000 Ugandan shillings, and 11.6% (n=40) indicated 58,000 to 100,000 Ugandan shillings.

Of the participants, 59.6% (n=205) were cohabiting; 35.3% (n=87) were married, and 11.3% (n=39) were single.

Of the participants, 40.6% (n=127) were Catholics; 24.5% (n=82) were Anglicans; 11.6% (n=39) were Pentecostals, and 11.0% (n=37) were Traditionalists.

These findings were significantly associated with economic violence (CI does not include 1).

Business, income of 58,000-100,000, divorced and widowed were significantly associated with economic forms of violence (CI does not include 1).

Table 4.12 Association between physical violence and risk factors

Variables	% (n) with violence	OR (95% CI)
Participants		
1 Age groups		
20 years	5.9 (20)	
21-29 years	57.9 (197)	
30-39 years	27.1 (92)	
40-49 years	6.5 (22)	
2 Education		
None	54.3 (183)	1
Primary	30.9 (104)	0.88 (0.37-2.11)
Secondary	11.6 (39)	0.43 (0.16-1.13)
High Secondary	2.4 (8)	
University	0.9 (3)	0.38 (0.0-0.45)

Variables	% (n) with violence	OR (95% CI)
Participants		
3 Occupation		
Semi-Skilled	23.5 (80)	1
Business	42.9 (146)	0.2 (0.06-0.69)
None	33.5 (114)	2.14 (0.35-13.09)
4 Income		
<58,000 UGX	49.1 (167)	1
58,000-100,000 UGX	11.2 (38)	0.19 (0.07-0.48)
>100,000 UGX	39.7 (135)	0.61 (0.25-1.48)
5 Marital status		
Single	11.2 (38)	1
Married	25.1 (85)	0.96 (0.24-3.91)
Cohabiting	60.4 (204)	16.10 (1.63-158.96)
Divorced	0.9 (3)	0.21 (0.0-1.22)
Widowed	2.4 (8)	0.63 (0.01-0.28)
6 Religion		
Catholic	39.5 (130)	1
Anglican	24.3 (80)	0.61 (0.22-1.7)
Day Adventist	4.6 (15)	0.92 (0.11-7.9)
Pentecostal	10.9 (36)	0.32 (0.11-0.93)
Moslem	9.1 (30)	0.92 (0.19-4.57)
Traditional	11.6 (38)	0.47 (0.14-1.51)

Having completed university, business, earning 58,000-100,000, being widowed, and being Pentecostal were significantly associated with physical forms of violence (CI does not include 1). Similarly, Ogland, Xu, Bartkowski and Ogland (2014:8) found that women with high education faced greater risk of IPV than their counterparts with lower education as they tended to be assertive, which could be construed as defying male dominance. While those with Pentecostal religion where more likely to have experienced physical violence in this study, Nanda et al (2014:47) found no significant relationship between religion and violence in India in the twelve months preceding the study. In the urban slums of Bangladesh, risk factors for IPV physical violence included low socio-economic status (Sambisa et al 2010:176). In their study in Bangladesh, VanderEnde, Sibley, Cheong, Naved and Yount (2015:686) reported that women with a higher economic status had a lower risk of IPV.

Table 4.13 Association between sexual violence and risk factors

Variables	% (n) with violence	OR (95% CI)
Participants		
1 Age groups		
20 years	5.8 (19)	1
21-29 years	58.5 (192)	1.12 (0.13-9.34)
30-39 years	26.2 (86)	0.16 (0.02-1.26)
40-49 years	6.7 (22)	0.23 (0.25-2.16)
2 Education		
None	54.3 (177)	1
Primary	30.4 (99)	0.8 (0.39-1.65)
Secondary	12.0 (39)	0.6 (0.25-1.59)
High Secondary	2.5 (8)	
University	0.9 (3)	
3 Occupation		
Semi-skilled	23.2 (176)	1
Business	43.6 (143)	0.44 (0.18-1.05)
None	33.2 (109)	1.43 (0.48-4.26)
4 Income		
<58,000 UGX	50 (164)	1
58,000-100,000 UGX	11 (36)	0.2 (0.09-0.48)
>100,000 UGX	39 (128)	0.49 (0.23-1.05)
5 Marital status		
Single	10.7 (35)	1
Married	26.3 (86)	2.46 (0.74-8.14)
Cohabiting	59.3 (194)	3.02 (1.05-8.71)
Divorced	1.2 (4)	0.07 (0.02-0.29)
Widowed	2.5 (8)	0.14 (0.04-0.49)
6 Religion		
Catholic	40.3 (128)	1
Anglican	23.9 (76)	0.49 (0.2-1.2)
Day Adventist	4.7 (15)	1.17 (0.14-9.8)
Pentecostal	11.3 (36)	0.4 (0.14-1.13)
Moslem	8.8 (28)	0.55 (0.16-1.87)
Traditional	11.0 (35)	0.34 (0.13-0.93)

Sexual violence was associated with Traditional religion, being widowed or divorced and income of 58,000-100,000 (confidence intervals do not contain 1). The odds of sexual violence were 0.34 times among the Traditionals than the Catholics. Having a low income, was also significantly associated with sexual violence in this study. This concurs with findings in Karachi, Pakistan, where Ali and Gavino (2011:1423) found that risk factors for sexual violence included low socio-economic status of the family, the women's low educational attainment, and being in a large household with five or more family members.

4.5 OVERVIEW OF RESEARCH FINDINGS

Of the 372 participants, 92% (n=341) had suffered physical violence in their lifetime, and 91% (n=340) in the past year; 99.7% (n=371) had suffered psychological violence; 93% (n=346) had suffered economic violence, and 88% (n=329) had suffered sexual violence. The most common form of IPV was psychological followed by economic, physical and lastly, sexual violence. Many of the participants had suffered more than one form of IPV, which concurred with Kouyoumdjian, Calzavara, Bondy, O'Campo, Serwadda, Nalugoda, Kagaayi, Kigozi, Wawer and Gray's (2013:1333) findings in Rakai, Uganda that IPV forms were experienced concurrently. In Karachi, Pakistan, Ali and Gavino (2007:1421) found that 98.5% of women reported experiences of stress as a result of marital conflict while 80% reported physical violence from their husbands. Olayanju et al (2013:107) found a lifetime prevalence of IPV of 80% in Uganda while Nanda et al (2014:72) found a high lifetime prevalence of IPV of 75% in Odisha State, India. O'Leary and Maiuro (2000:xiii) state that in some cases psychological abuse does not result in physical violence although physical violence is intricately linked to psychological violence. This aspect was not explored in this study.

In Cape Town, South Africa, Pitpitan, Kalichman, Eaton, Cain, Sikkema, Skinner and Pieterse (2013:302) found that in low-income settings, many poor women engaged in transactional sex and alcohol use which might predispose them to IPV. Heavy drinking was found among 20% of Ugandan women and is a significant risk factor for HIV infection (Tumwesigye and & Kasirye 2005:206; Martinez, Roislien, Naidoo & Clausen 2011:1).

This study found a high prevalence of IPV, particularly psychological violence, among the participants aged 21-39 years living in the Kabalagala slums in Kampala. Those in the 21-29 years age group had the highest prevalence of IPV (58.8%; n=190) followed by those in the 30-39 years age group (26%; n=84).

Economic, physical and sexual violence were also found to be very high at 93%, 92% and 88%, respectively. Apart from psychological violence, the findings indicate that across all forms of IPV having an income of 58,000- 100,000 Uganda shillings and being widowed was associated with high sexual, physical and economic violence. Having business as an occupation, was associated with high physical and economic violence. Additionally being divorced was associated with both sexual and economic violence. Traditional religion was associated with sexual violence while Pentecostal religion was associated with physical violence. In addition, university education was also associated with physical violence.

4.6 CONCLUSION

This chapter presented the quantitative data analysis and results on the prevalence of IPV in the study population and setting. The participants' socio-biological characteristics and the prevalence of different forms of IPV were described. The factors associated with each form of IPV were elucidated and provided some direction in explaining IPV among the women in this and similar settings.

Chapter 5 discusses the qualitative data analysis, interpretation and results.

CHAPTER 5

Qualitative data analysis and interpretation, and results

5.1 INTRODUCTION

This chapter presents the qualitative findings according to the main themes and juxtaposing the participants' experiences of IPV. For qualitative data collection, the researcher used a grand tour question, *"What are your experiences of intimate partner violence and how has this affected you?"* and probes to enable the participants to adequately describe their experiences of VAW (Green & Thorogood 2009:80). The objectives were to describe the nature and experiences of IPV; explore how the participants' health needs were influenced by their IPV experiences, and recommend practical interventions to reduce IPV.

5.2 QUALITATIVE DATA MANAGEMENT AND ANALYSIS

The qualitative data was collected over a period of four months from August to December 2014 and data saturation was reached at interview 48. The interviews were recorded on a digital audio recorder and notes were taken. The researcher listened to, transcribed and translated the recordings within a day of the interview thus ensuring that the data was ready for analysis. This was crucial in familiarising the researcher with key ideas that emerged and overall impressions about the participants' responses during the interviews. The researcher was able to verify the quality of the data by identifying and writing down key ideas and impressions of participants (Terre Blanche & Durrheim 2002:48). The data analysis methods selected were congruent with the epistemological underpinnings and position of the study (Terre Blanche & Durrheim 2002:86). The tool and techniques used in the data collection were also considered in choosing the methods. The qualitative data was subjected to a thematic content analysis (Green & Thorogood 2009:198). This involved coding of transcripts in order to classify the data (Terre Blanche & Durrheim 2002:324). Each interview was structured into an individual table highlighting key themes. A theme codebook was then developed consisting of the themes and sub-themes with numerical codes attached to each theme and sub-theme.

The researcher checked for authenticity of codes and divergent cases, and confirmed the emergent themes by categorising the data tables in order to find patterns and processes (Gifford 1998:547; Mason 2010:1). Braun and Clarke (2006:88) define a code as “the most basic segment or element of the raw data … that can be assessed in a meaningful way”. Richards and Morse (2007:137) state that coding “leads you from the data to the idea and from the idea to all the data pertaining to that idea”. Data was analysed using descriptive, analytical and hierarchical coding (Saldana 2012:88). Descriptive coding provided a summary of the text in relation to the objectives (Richards & Morse 2007:138). Analytical coding involved explaining the phenomenon (Taylor & Gibbs 2010:1). Hierarchical coding identified key themes based on the study objectives. This involved classifying the themes and sub-themes in tabulated transcripts.

5.3 RESEARCH RESULTS

The participants’ socio-demographic characteristics included age, marital status, number of children, occupation, duration at current residence and duration with violent partner (see table 5.1).

5.3.1 Participants’ socio-demographic characteristics

5.3.1.1 Age

The average age of the participants was 31.75 years and the minimum age was 20 with a maximum of 45 years.

5.3.1.2 Marital status

Of the participants, 65% (n=31) were married; 19% (n=9) were single; and 17% (n=8) were widowed.

5.3.1.3 Number of children

All the participants had children, with an average of 4 children and a maximum of 7 children. Of the participants, 4.2% (n=2) had one child; 27.1% (n=13) had two children; 27.1% (n=13) had 3 children, 25% (n=12) had 3 children, 12.5% (n=6) had 4 children, 10.4% (n=5) had 5 children, 8.3% (n=4) had 6 children and 12.5% (n=6) had 7 children.

5.3.1.4 Occupation

Of the participants, 45.8% (n=22) reported hawking as their work (mainly food, tea and clothing); 12.5% (n=6) reported cleaning; 6.3% (n=3) indicated shop-keeping; and 4.2% (n=2) owned a salon.

Table 5.1 Participants' socio-demographic characteristics

Characteristic	**N=48**	**%**
Average age	**(31.75) years**	
Mean number of children (maximum)	**4 (7) children**	
Marital status		
Married	31	64.6
Single	9	18.7
Widowed	8	16.7
Occupation		
Hawker	22	(45.8)
Housewife	10	(20.8)
Cleaner	6	(12.5)
Shop owner	3	(6.3)
Salon owner	2	(4.2)
Other	5	(10.4)
Mean duration at current residence (minimum-maximum)	**6.2 (2-20) years**	
Mean duration with violent partner (minimum-maximum)	**7.95 (0.5-30) years**	

5.3.1.5 Duration at current residence

The participants' average stay at their current residence was 6.2 years with a minimum of 2 years and maximum of 20 years.

5.3.1.6 Duration with violent partner

Most of the participants (64.6%; n=31) reported that they were still living with their violent partners. The average duration of stay with the violent partner was 7.95 years with a minimum of half a year and a maximum of 30 years.

5.3.2 Themes and categories

The researcher read and re-read the transcripts of the interviews and identified themes and sub-themes (see table 5.2). Manual coding of the data was done and cross-checked over a period of ten months. The findings are therefore presented in relation to the themes and sub-themes that emerged from the data. The major themes that emerged from the data were forms of IPV and how these manifested themselves; women's health needs resulting from IPV experiences, and strategies to reduce IPV based on the participants' suggestions. Direct quotes from the participants provide a thick description of the findings with some literature support. Pseudonyms were used to protect the participants' identities and confidentiality.

Table 5.2 Theme codebook

Themes	Sub-themes	Categories
1 Nature and experiences of IPV	1.1 Physical violence	1.1.1 Physical harm
	1.2 Psychological violence	1.2.1 Neglect
		1.2.2 Use of threats
		1.2.3 Verbal insults
		1.2.4 Unfaithfulness
	1.3 Sexual violence	1.3.1 Marital rape
		1.3.2 Non-marital rape
	1.4 Economic violence	1.4.1 Stealing and selling off women's resources leading to economic disempowerment
		1.4.2 Role reversal
		1.4.3 Prohibition from paid work
2 Health needs of women survivors of IPV	2.1 Physical care and treatment	2.1.1 Physical Injuries, pain and health complications
		2.1.2 HIV infection
	2.2 Psychosocial health care and support	2.2.1 Stress and fear of death
		2.2.2 Shame and embarrassment
		2.2.3 Lack of access to education
		2.2.4 Poverty and loss due to IPV
3 Perceived causes of IPV	3.1 Women's perceptions on IPV causes	3.1.1 Drug abuse
		3.1.2 Increased responsibility associated with birth of children
		3.1.3 Peer influence
		3.1.4 Jealousy
		3.1.5 Young age
		3.1.6 Infertility
4 Strategies to reduce IPV	4.1 Economic support	4.1.1 Access to capital for small businesses
	4.2 Legal and justice system	4.2.1 Strengthen legal and justice system
	4.3 Social and institutional support	4.3.1 Establish support groups and shelters for IPV survivors
		4.3.2 Improve access to sexual and reproductive health services

5.3.3 Types and experiences of intimate partner violence

The participants in the qualitative component shared a wide range of IPV experiences. The shared experiences revealed that the participants' had experienced IPV in different forms and in many instances more than one form of violence. The interconnectedness of these forms was vivid. Table 5.3 presents the participants' experiences under the themes/categorisation of the forms of IPV identified. The participants' narratives highlighted that no single factor resulted in IPV, but that a number of factors were often at play.

Table 5.3 Nature and experiences of IPV

Themes	Sub-themes	Categories
1 Nature and experiences of IPV	1.1 Physical violence	1.1.1 Physical harm
	1.2 Psychological violence	1.2.1 Neglect
		1.2.2 Use of threats
		1.2.3 Verbal insults
		1.2.4 Unfaithfulness
	1.3 Sexual violence	1.3.1 Marital rape
		1.3.2 Non-marital rape
	1.4 Economic violence	1.4.1 Stealing and selling off women's resources leading to economic disempowerment
		1.4.2 Role reversal
		1.4.3 Prohibition from paid work

All the participants (100%; n=48) reported experiencing physical, psychological, economic and sexual forms of IPV. This was against the understanding that urbanisation created opportunities for women to participate more in the workforce. However, in slums like Kabalagala, urbanisation also exposes them to increased vulnerability to violence, particularly in urban slums (McIlwaine 2013:71).

> "He comes home very late in the night and I have to keep awake until he comes home. When you give him food, he pours it on you if he does not like it. Sometimes I sleep outside.'' (Hawa, aged 31)

> ''The man beats me all the time. He goes and gets very drunk with his friends and then comes home. My life is pure hell but there is nothing I can do about it.'' (Birungi, aged 23)

5.3.3.1 Sub-theme 1: Physical violence

The lived experiences of the women played a crucial role in interpreting the physical violence and this was a common thread in the narratives of the women.

5.3.3.1.1 Physical harm

The participants described experiences of physical violence from their partners who beat, slapped, kicked, boxed, stabbed them with knives, and mutilated them. Grace described how her partner used to pull her braids off her head in addition to kicking her. Her partner would close the door when he beat her because he did not want her to escape or seek help. Such actions by a partner show that the violence is intentional and the perpetrator is conscious of that. He closes the door while he beats her and when he feels that he has beaten her enough, he opens the door for her to run.

> "I used to plait my hair and he would pull it and it all gets out. That's why I gave up on the braids. Now, I don't grow my hair. So when someone meets me they say why you don't grow hair, I say I don't want it. But for me, I know the reason. Then the kicking and boxing, he finds you there and he starts beating you, even when you try to run he has closed. Then when he opens you run because you know when you stay he may even kill you." (Grace, 27 years old)

Meron, a mother of three, described how her partner physically hurt her through beatings especially when he had consumed alcohol:

> "… whenever he would drink he would beat me, so I would be there wondering whether I will sleep or not. Sometimes he would just come and disturb the children but with an intention of provoking me." (Meron, 41 years old)

5.3.3.2 Sub-theme 2: Psychological violence experiences

The study took psychological violence to encompass trauma to the women as caused by certain acts, threats of acts or coercion tactics. The participants reported that they experienced psychological violence that would most often be followed by physical violence. The participants described neglect, threats and verbal insults as psychological

torture as they adversely affected their mental wellbeing. The narratives showed a pattern of psychological violence whose cause was actually economic violence. This indicates that the psychological violence came about as a result of hardships associated with the women's partners not looking after the families when the women perceived that the men had the means to do so.

5.3.3.2.1 Neglect

The participants described the trauma and emotional torment they go through because of their partners' neglecting the responsibility of taking care of the family. A mother of six, described she finds difficulty in taking care of her six children and this has left her with "no life" because the man does not assist her to take care of the children but spends his money on other women and alcohol. This issue would escalate into a verbal argument and result in a physical fight but what is evident is that the economic hardship as a result of the man's failure to provide for the family was the main problem. When women complain and remind men of their responsibilities, they are subjected to physical violence:

> "For me, sincerely I don't have a life... The man abandoned me with the children…the man would sleep outside the home, he would not give children what to eat nor pay house rent, he got other women and spent all the money in the bar…Whenever he would come I would ask where the money is, the children are dying of hunger, not even soap. Then instead of saying, let me go buy for the children what to eat, he would just abuse me, so we would have a fight, he would beat me and assure me that he has other women…." (Jackline, 43 years old)

A common feature in the participants' reports was the perception that their men had found other women whom they spent the money on as well as that the men had the money but would instead buy alcohol:

> "He comes drunk, beats me and tells me I don't have this, I don't have money, and he would go out and buy people alcohol… He does not care, he can't give me money. As for the rent of the house, sometimes he brings half and yet he has the money!" (Sharon, 39 years old)

One participant described the situation that she has been in for the 11 years with her partner. The man does not want to be asked for money nor for her to answer him and even when she keeps quiet, he beats her for keeping silent. This could be explained by the fact that culturally, the men are not supposed to be questioned by their women as Grace explained:

> "… so you tell him give us some money like Shs.1000 so that I cook tea, but there is no sugar or we could also buy some scones so that children can take it with tea so he starts abusing you, when you reply him he says 'how do you reply me?". So he starts from there and he beats you and he says you have ill-treated him… (Grace, 27 years old)

The participants resorted to physically demanding unskilled casual work to take care of their children exposing the economic vulnerability of their households in case they fell ill and were unable to work. Furthermore, the unskilled casual work did not earn them a decent wage to take care of their families as presently in Uganda there is no prescribed minimum wage indicating the dire socio-economic conditions in which the participants live together with their children.

> "If I am lucky and I make Shs.2000 [about 60 US cents], then I use Shs.1000 for eating supper, and Shs.500 for packing for children and the Shs.500 I try and get them *posho* [maize meal]. Then, you know, the day is done. Now what I do is I wash someone's plates or I get someone to give me some little and I go and feed the children." (Natasha, 34 years old)

The participants explained further that as a consequence of their partners neglecting the families they were the sole breadwinners and bringing up children as single parents required them to work hard in order to meet their personal and educational needs:

> ''I had to bring up the children alone. I have to work a lot to put food on the table.'' (Subira, 42 years old)

In addition to the economic deprivation resulting in hardship and poverty, the participants told how they spent sleepless, cold nights outside or at the neighbours' homes because their husbands had thrown them out of the house. Uganda has few

public temporary shelters where such women can run to and the women did not know about them, so they have to endure the cold nights and mosquitoes:

> "Now the violence is one of spending a night outside, when he comes drunk and beats me, locks me outside. Then I go to the bush, the mosquitoes bite me and my baby because when he throws me out, with the baby that 'I don't want you to make noise for me'. And then I tell him the baby is sick and he says 'me, I don't have money, don't familiarise me and I don't want you to make noise with your baby for me. I am tired I want to sleep', so I would go and sleep outside…" (Audrey, 30 years old)

This economic neglect also affected families that have people living with HIV, who need good nutrition to improve adherence to antiretroviral therapy (ART). Lack of good nutrition among people living with HIV has been significantly associated with non-adherence to ART, improved immunity and mitigation of side effects (Berhe, Tegabu & Alemayehu 2013:7: de Pee and Semba 2010:313). One participant explained that her partner did not care enough for their HIV-infected child by ensuring that there was enough food to take when given the strong antiretroviral therapy. The participants regarded the presence of a man who did not take care of the children and wife as a 'torturing' experience:

> "But the problem I found with the child of four years, is that he has the HIV virus. But the man doesn't help, like this child who is taking Antiretroviral drugs (ARVs), he has to eat on time…he says 'sort yourself with your child', and yet he is the one that infected us. When you tell him to bring something for the child to eat, he can't, he just says 'for me ever since I got the disease have I died? He will also be there and survive'. So the boy has to take ARVs with some tea but he goes to school without any packed food. This man has tortured me most, because when you ask him for anything, he says that I also have hands and legs like he has so I can also work. So I get stuck. " (Grace, 27 years old)

Generally, for a traditional man in a Ugandan perspective, the gender roles are specified and men are ideally expected to be the breadwinners and heads of their households. The head of a household has the responsibility of taking care of the family, and this is also a sign of love and responsibility from the man. This means that when the husband does not provide for the wife, it is an indication of punishment to the wife or an

indication that the man no longer loves her. The participants' experiences have nullified the traditionally and socially constructed roles that men and women are supposed to play in society. The participants have been burdened by the triple roles of production, reproduction and caring. In addition to fulfilling their culturally assigned reproductive roles, they have to struggle in search for money to take care of their families, a bread winning role which is traditionally reserved for men. The participants stated that the men had abdicated their roles in the households to women leaving them psychologically uneasy. This is worsened by the fact that many come from already deprived backgrounds and did not have the opportunity to go to school thus they go through a great deal of difficulty looking for opportunities to provide unskilled casual labour to raise money for the family. Some had to hawk clothes for long distances while others walked from house to house asking if they had clothes or utensils that they could help wash and be paid some money. Their partners did not regard caring for children as part of their responsibility:

> "….. So you start fetching water for the neighbours because you are looking for money to buy salt and soap, and matchbox…." (Peace, 36 years old)

Irene also explained how the husband expects her to shoulder the burden of looking after the children alone.

> "... Sometimes he tells me that he is coming back then I wait and the children are looking at me for food. So I go look for someone who has clothes, I wash them quickly; they give me whatever they have so that I can cook for the children." (Irene, 32 years old)

5.3.3.2.2 Using threats

The participants also reported the experience of psychological violence through use of threats. This was in addition to reporting that psychological violence was perpetuated through inflicting physical pain, expulsion from the house, and burdening them with caring for the family single-handedly. The participants explained that their partners' use of threats left them psychologically distressed, anxious, tense and under the control of the partner. Some of the men threatened to kill the participants if they escaped. The participants explained that some men went further to threaten to even beat their parents

and others. Their intention is perhaps to isolate the women and control them to an extent of having no-one to offer them help. The participants added that the men sometimes kept weapons like knives, guns and machetes and keeping such weapons at their homes exerted psychological tension and stress on women. Sometimes the men used these weapons to threaten not only their intimate partners but also their parents and community members who would help the participants in the event of IPV. The men threatened them with the weapons by moving with the gun or shooting in the air. With such threats, for example, her partner was able to gain absolute control over Barbara because no one would want to risk their lives to help her. Therefore, when Barbara was thrown out at night, she would not run to neighbours like some of the other participants, but stayed in the water trenches:

> "Yes, he would beat me. Beat me in a way a woman should not be beaten. He threw me out the house at night, and I would sleep in water trenches. There was a time when water was going to kill me, and they took me to the hospital and got it from me. The man would beat me a lot; I lost weight and became bones. When that man beat me, I ran home and then he came and also beat my mother, he beat my parents. He would take me by force... He would intimidate people with a gun. So whenever he came with a pistol and other weapons, sometimes he would shoot in the air. The leaders tried to talk to him but they were also afraid of him..'' (Barbara, aged 38 years)

The presence of a weapon such as a gun and knife and acts of shooting in the air or threatening to stab communicate the intention to kill or cause harm and injury to the woman allowing the partners to increase their control over the women. Participants whose partners possessed weapons like guns and knives lived a life of fear because they knew that they could be killed any time if they did not obey whatever their partner told them to do. In this case, the partner was a soldier and possessed some power over the woman because of the power of that gun. The power of the gun also reduced the community resources who would help the participant because the partner who was a soldier threatened to harm anyone in the community if should they try to help the wife. Other participants described their experiences with the use of weapons by their male partners to threaten them with death.

> “He usually gets a knife to stab me, yes a knife but whenever he wants to stab me I usually get a way of avoiding him and I run away. Then I go and sleep at the neighbours’ house, I return in the morning.” (Macklean, aged 25 years)

> “He gets a machete and puts it on my head and threatens to kill me with it and also ropes. He says he will kill me and then he will kill himself. I am scared to death. All the time I feel like he is going to wake up and kill me.” (Agnes, 28 years old)

Shakira, a mother of three, explained that the partner threatened to kill her if she ran away with the children and because he was already a suspected killer in the area.

> ‘‘I feared that he was going to kill me because he is believed to be killing people in the area and he is wanted. He has also threatened to kill me if I took the children to my parents in the village.’’ (Shakira, 40 years old)

5.3.3.2.3 Verbal insults

The participants reported emotional violence from their partners’ verbal insults, which included name calling, abuse and being blamed for childlessness.

Some participants described experiences of psychological violence in terms of emotional abuse, name calling, and blaming**.** An interesting finding for example, was a participant who was emotionally and physically abused because she *‘brought the bad luck’* and was blamed for the financial constraints that their family was experiencing. Prior to her relationship the partner, he was supposedly doing well but when they got married to her, his fortunes ran out and this was blamed on the woman. This emotional abuse would result in the partner physically abusing her, which demonstrated how women are viewed as objects that can bring fame or misfortune and frequently blamed for the men’s lack of good fortune.

> “You know, they say that there are some women with good luck and there are those without. So when he married me they said that the luck used to be brought by the first wife. Can you imagine finding a man with four million shillings and then later he goes to zero? He even starts failing to get salt, and says you are the one bringing bad luck. So, he beat me and you could see that the situation wasn’t

> good, and he did not beat me because he did not love me, but because of poverty. The man loves me but he beats me because of poverty.'' (Sheila, aged 35 years)

5.3.3.2.4 Unfaithfulness

Several participants complained of emotional distress due to their partners' unfaithfulness. Some partners brought their concubines to the matrimonial bed. One participant described how the husband used to make her wash the bed sheets after him having sex with his concubines in their home. He treated her with a lot of disrespect by openly having extra-marital affairs with other women and did not set boundaries. It may be that he wanted her to eventually give up on the relationship and leave on her own:

> "… he would chase me out of the house and I had to go outside. And he would bring a woman into the house, exactly in my bed. The following day they would wake up and go, and he would want me to wash the bed sheets and if he found that I had not washed them, he beat me." (Barbara, aged 38 years)

In addition to the unfaithfulness, Barbara's partner enforced the unequal power, portraying the master-slave relationship, by making her *"remove his clothes, shoes, take water to the bathroom, and bathe him"* again subscribing to the view that a woman is there to serve the husband.

Another participant also described how she was tormented by her partner's unfaithfulness:

> "The man was torturing me with his unfaithfulness and beating me. Beating me and going out with women. Indeed, when a man has got another woman you can know, so you can't talk about him. When you talk about it he just beats you, don't you know that? When you say 'Now you have gone, where are you sleeping?' he beats you …So he would come and be very rough." (Julia, 36 years old)

Participants stated that the torture was worsened because the men did not even want to talk about it, they did not want to be asked where they had spent the night. Any complaints from the woman about the man's unfaithfulness would result in physical abuse. Besides the psychological torment from the partners' unfaithfulness, some

participants also had to put up with the insults from the men's partners with whom they had extramarital affairs:

> "There was a time he got a woman and started loving her. When I went to talk, the girl told me that 'what you are lacking is what they are looking for from me'. You know, for me I had polio on these legs. So he said 'for me, I can't marry a lame person, there are women that look nice'." (Natasha, 34 years old)

Natasha has a physical disability and uses crutches as her legs were affected by polio and described how the husband and his concubines kept on reminding her about this disability. She stated that they have had three children with the husband so her question was "what was he thinking all this time for them to produce all these children together?"

5.3.3.3 Sub-theme 3: Sexual violence

Another form of IPV that the participants echoed was sexual violence and this manifested in the form of marital rape or non-marital rape subsequently leading to a violent intimate partner relationship.

5.3.3.3.1 Marital rape

The participants shared experiences of how they were raped and forced to have painful vaginal and in some instances anal sex. The participants explained that this happened when their partners were drunk. Furthermore, the sexual violence did not occur in isolation but in relation to physical, psychological, economic and other forms of violence. Meron described her experiences of physical and sexual abuse from her partner who was a soldier. She stated that the partner would lock her up in a hole for several days without food and then forcefully have anal sex with her:

> "I have gone through a lot of suffering …he took me and he would lock me in the hole, those holes used by soldiers, he was a soldier. There I would spend a whole week without food…But the man, whenever he was drunk, would get me from there and start beating me. He would get me from there and start using me, and again he would use me in the anal opening. These days they call it homosexuality, for him that's what he loved. He would beat me a lot and I have a lot of scars. All these that you see" (showed some scars all over her body).

She described experiences of both sexual and physical violence from her partner. The man would rape her both anally and vaginally. According to her, what he enjoyed was anal sex and she described this as 'homosexuality' to depict that she considered it to be against the social norms of heterosexuality. In Uganda homosexuality is a contentious issue and in 2009, the Anti-Homosexuality Bill was tabled in parliament and generated a lot of debate locally and criticism internationally for promoting human rights abuses (Semugoma, Beyrer and Baral, 2012:174). Speaking on the Anti-Homosexuality Bill, of 2009, the Committee on Legal and Parliamentary Affairs (2015) said in its Report, *"The Bill aims at strengthening the nation's capacity to deal with emerging internal and external threats to the traditional heterosexual family*." Many women endure marital rape from their partners but in many societies including Uganda this is an area that is not in the public sphere. Many women have to endure marital rape from their partners but in many societies including Uganda this is an area that is not in the public sphere. In Ugandan society, these women suffer twice because the society does not recognise that there can be marital rape. In Zimbabwe, sex is seen as a right for the man and must be done out of cultural submission (Shamu et al 2012:103). Marriage is regarded as a licence to have sex, therefore once the woman is married, the man who is the head of the household has a licence to have sex at any time he wants. Women cannot report or seek help anywhere since they do not have any platform to talk about their partners' rape.

5.3.3.3.2 Non-marital rape

Some participants described how they ended up in violent relationships as a result of sexual violence thus being trapped in a vicious cycle of violence with their partners. For instance, Tina was raped by a married man and became pregnant as a result and efforts to get justice were fruitless as the man ran away. However, after giving birth to a son, the man came back and promised to look after her and the child and this is how she ended up in a violent relationship. The man returned because 'the baby was a boy' and this highlights the value that is placed on male children in the Ugandan society. Having a male child is seen as a way of perpetuating the man's bloodline and leaving an heir and where the man has many sons he chooses the most suitable among them as an heir (Beyeza-Kashesya, Neema, Ekstrom, Kaharuza, Mirembe & Kulane 2010:74). A girl cannot be considered an heir as she is expected to move to her

matrimonial home when married. Therefore, it is desirable that one gets at least one male child and in many instances a woman who has only girl children is considered as one who has no children and the man may decide to have other partners secretly or openly in order to get a boy child (Beyeza-Kashesya, Neema, Ekstrom, Kaharuza, Mirembe & Kulane 2010:75). Hence in this scenario even though Tina was raped and initially the man ran away when she told him of the pregnancy, he later came back because she bore a son and he took her and the child because of this. It is evident that the initial violence resulted in a non-ideal union because of the birth of a son and this formed the basis for relationship marred with IPV:

> "…I produced the first child when I was 20 years old but I was just raped. I had not known a man before that incident. When I told him I was pregnant, he quarrelled and exclaimed that he had a wife and he could not do anything for me. We reported him to the police but he ran away before he could be caught. Four months after giving birth he came back for me and claimed that he would take care of me and the baby. He said this because the baby was a boy. So he brought us to Kampala." (Tina, 29 years old)

The response in this scenario indicates an unusual phenomenon that may be deeply entrenched in the cultural norms whereby in cases of non-intimate partner violence sometimes a negotiated decision to take a fine or marriage is reached by both parties. In this case the negotiated position proposed by the perpetrator because his victim had given birth to a boy was to take her for a wife. This indicates a flawed system where an unacceptable situation has been turned in the favour of the perpetrator. Instead of pursuing justice, an alternative offer to take care of the participant and her child born out of the crime of sexual violence is chosen, which then traps her in a cycle of violence.

5.3.3.4 Sub-theme 4: Economic violence

The participants described experiences of economic violence at the hands of their partners. This economic disempowerment manifested in being forbidden to work, deprivation of material resources, and lack of access to education. The participants explained that this was through their partners stopping them from working, forcing them to leave their jobs. The participants reported that their men stopped them from working, accusing them of having extra-marital affairs and using work as a pretext to meet their

lovers. According to the participants, the men were very jealous and also felt insecure of progressive women.

5.3.3.4.1 Stealing and selling off women's resources

Some participants who engaged in business reported that their partners sold off their work equipment. After selling, some of the men spent the money on alcohol or married other women.

> "The man drinks alcohol and smokes. He does not leave anything at home. Everything is on me. He can come to my salon and take my money. Sometimes he steals the equipment and leaves the salon bare. As you can see, there is nothing in the salon. Even as we speak my husband is in a bar right now. He comes into the salon and starts counting the money that I am making and giving my customers a hard time. He took all my salon equipment and sold it. We even went to the police station." (Rhona, 28 years old)

The participants' accounts portray that some men feel that they have the right to control all the resources in the family, including what they have not worked for. This is a true reflection of the societal structure that allows men to inherit and control productive resources like land as well as the women's labour.

5.3.3.4.2 Role reversal

Although it is something that happens as the participants stated under the sub-theme of psychological violence, paying rent and buying food is usually seen as the man's responsibility in this cultural context. Some participants stated that men even expected the women to fend for the men, which went against the norm. This finding was also reflected in other participants narratives where they reported that the men would come back home and ask for food yet they do not leave any money to buy the food neither did they shop for the family's food themselves:

> "You also know issues of Kampala [the capital city], he wants to come back and find cooked food, and he eats and goes. He has not left you with money, but he wants to eat, when you have been working the whole day. He wants to come back and eat. He was mistreating me, he wasn't giving me any money, I was the

> one looking after children, so I said “staying here is useless, let me go and look after my children’’. (Sheila, aged 35 years)

> “He may ask you where the tea is, maybe the child is crying and you are also miserable. Even the tea he is asking for, there is no sugar for it. He has not given you anything. He can beat you for his clothes when he gives them to you to wash and there is no soap. Should I wash them without soap I ask, so for him all that, he would change it into war”. (Julia, 36 years old)

Interestingly, these findings reflect a shifting norm as men fail to provide and expect their women to look after them. Kampala thus has families that are being run by women even when their male partners are present and may not be making any contribution. Since traditionally, men are supposed to find money to take care of their families by all means, the men that do not fulfil their responsibility of being breadwinners are considered to be mistreating their women.

5.3.3.4.3 Prohibition from paid work

The participants also explained how they experienced economic violence by being prohibited from working by their partners. Macklean described how her partner did not want her to work because of jealousy. He accused her of lying to him that she had gone to work when she had gone to love other men:

> “When you go to get money for the children at work, he says ‘you have been loving other men, where were you?’ Then I tell him ‘I had gone to work, the children you don’t mind about them, for me let me work’. And then he says ‘you are lying, you had gone to love other men’. That’s what he says. He doesn’t want me to work, he wants me to be there with the children and yet when I don’t work the children don’t eat. The children ask me for something to eat, they do not ask him. They say mother there is no sugar. At school they told me to bring this and that. Such things” (Macklean, aged 25 years)

Jealousy and partner insecurity have been found to be a contributing factor to IPV including mere suspicion or perception of unfaithfulness (Conroy 2014:1). Sharon, a mother of four, described how her partner stopped her from working and still insists that she does not work:

> “I was working in people’s hotels and afterwards I left and started hawking clothes. After that I got a man and he stopped me from working. You want to try and work he doesn’t want you to work. I had another job cleaning in one of those buildings in town. They used to pay me per week. You know, the men are overprotective. He may think that maybe you will get other men, as you are returning you may meet men.” (Sharon, 39 years old)

Sharon explained that men were overprotective which forced them to stop their women from working. Stopping their women from working is a strategy to isolate and dis-empower the woman by controlling the economic power as well as her movements and networks. This reflects men’s desire to have power and control over what the partner does, where she goes, whom she meets and interacts with. With a job, some men feel that they cannot have that control which compels some to force their women not to work. In addition, prohibiting the woman from paid work makes her dependent on the man for all provision thus relegating them to a powerless position where they have to tolerate the violence. Participants stated that even when they obeyed and left the job, their partners kept on physically abusing them, thereby implying that leaving the job does not solve the problem of violence among intimate partners. Prohibition of woman from undertaking paid work is an attempt to gain power and control over the wife. The problem is not the work; the problem is the desire to have control over the woman. The man feels that when the woman is at work, he has no control over her and what she does. When the woman leaves the job, he will add beating so that he can still maintain his control over her when she is at home. Some participants stated that they stayed in abusive marriages because they could not stand on their own economically. One respondent felt that once she could get a job where she was able to sustain herself, she would be able to leave:

> “Maybe like if I get a job that gives money to maintain myself, then I can say, ‘let me leave him’; that’s what I would do when I am able to pay rent and other expenses.” (Sharon, 39 years old)

5.3.4 Impact and health needs of participants who had experienced IPV

In this study, health with its different dimensions referred to “a state of complete physical, mental and emotional wellbeing and not merely the absence of disease or infirmity” (WHO 1948). The participants shared how they experienced physical, mental, and emotional health needs resulting from the violence they experienced from their partners. Table 5.4 shows the sub-themes and categories under this theme.

Table 5.4 Health impact of IPV on participants

Themes	Sub-themes	Categories
2 Health impact of IPV	2.1 Physical care and treatment	2.1.1 Physical injuries, pain and health complications
		2.1.2 HIV infection
	2.2 Psychosocial health care and support	2.2.1 Stress and fear of death
		2.2.2 Shame and embarrassment
		2.2.3 Lack of access to education
		2.2.4 Poverty and loss due to IPV

The participants reported physical injuries, chronic pain, health complications, stress, fear of death, and STIs including HIV/AIDS as some of the health needs resulting from IPV. The participants also reported the impact of these experiences which could indirectly be linked to health needs resulting from IPV. These included shame and embarrassment, and loss of the relationship. Other reported impacts of IPV experiences were limited access to education and financial losses. All these could result in stress and mental health needs/problems. Consequently, the needed interventions must address these different health needs of these women. The participants stated that the health needs affected their productivity as because of the physical injuries sustained and/or the mental distress they cannot work as hard as they could.

5.3.4.1 Sub-theme 1: Physical care and treatment

5.3.4.1.1 Physical injuries, pain and health complications

Many of the participants reported that they had scars on their bodies and physical injuries as a result of violence. One participant was nursing a broken nose while two reported losing an ear through IPV. The participants reported that their health was poor because of IPV and consequently their bodies felt battered all the time. The participants described how they had to go to the health facilities to have their injuries treated. When the researcher mentioned health needs, the participants were quick to point to the different scars that they sustained due to injuries from beating, burning, pushing, and weapon assault by their partners. Joyner and Mash (2012:1) emphasise the importance of recognising injuries due to IPV and intervening for IPV:

> "He came while I was trying to prepare food. It was during the day, I was sick, and I was from the hospital, so I was going to serve food. He lifted a whole saucepan of beans I was cooking and poured it over me. From May to September, I was sick. Here is the scar where he poured hot sauce on me (showed a big scar on her arm). He took care of me and told me that I should forgive him. That he had stopped drinking alcohol; he would not drink again, and so on. So he spent like a month without taking it but then he went back to drinking alcohol. ." (Sharon, 39 years old)

Participants stated that women who could afford to seek care ended up in the hospitals for treatment for their injuries. However, most participants reported that they could not afford to do so and had to stay home, endure the pain first hand, until they were healed. Some men who inflict pain on their women go ahead and take them to the hospital. The participants said that some partners appear remorseful and ask for forgiveness which makes their women believe that their man has changed. However, other men do not care about the pain caused nor do they help their women seek care. According to participants, many partners who appear sorry and pretend to have changed do not sustain the change:

> "It happens for a short time and after you are healed, the old behaviours of violence come back."

While some participants stayed in anticipation of the behaviour changing for good, others stated that they did not leave for fear of being labelled ‘failures’ in marriage or of being asked about the injuries that they sustained. Women’s individual freedom and health is foregone in the name of societal image of the woman and the husband. One participant showed where the partner cut her on the leg and in her case care and treatment was sought at her home (her father and mother’s home), the partner did not want to know:

> “You see here where he cut me (showed a big scar on her leg) … He is the one who cut me. I went home to my parents and they looked after me.” (Sheila, 35 years old)

In addition, some participants reported that they experienced chest pain, broken ribs and body weakness due to IPV:

> “There was a time he injured my ribs, but then it later got healed, it later got healed. Because I went to the hospital and they told me the ribs had changed position. I could say he stamped on me as he kicked me, but it got healed. Whenever I would breathe the ribs would pain me. And they gave me some tablets in the health facility, now it got healed.” (Joan, 38 years old)

> “I have a lot of chest and backache pains due to broken ribs and this means I can’t do heavy duty jobs.” (Marina, 43 years old)

Besides sustaining injuries, some participants had to endure chronic pain, had been mutilated or lost body parts, or had undergone surgical operations as a result of the physical violence, including kicking and beating, from their partners:

> “He cut me with some knife that is used with the gun. So he pulled it from the gun and cut me. He wanted to cut off the whole ear but it only got one part of the ear. They found that the kidney was damaged and they removed it in the hospital. The doctors treated me and removed it. But again the chest, I got complications, I can’t carry something heavy like carrying water, I can’t carry a jerry-can. In the chest, I cough all the time, because of those kicks I got some damage in the body. Even my whole body, I always feel cold so I am always wearing warm clothes” (Barbara, 38 years old)

> "… he broke my tooth, you see? My teeth became weak; indeed, they are not strong, and they are shaky. So I went and told the health workers and they gave me some medicine. There is also where he pushed me and a nail hurt me here (on the leg). The nail hit me when he pushed me to the door and there was a nail." (Grace, 27 years old)

One participant reported losing her baby after undergoing a caesarean section following IPV experiences. This participant described difficulties of coping with the psychological agony of losing a child through the violence of the same partner who had impregnated her. Violence during pregnancy was found to put women at a higher risk of complications during birth which could result in death of the mother and the baby (Garcia-Moreno et al 2015b:1686). Other studies have also recorded the undesirable maternal and child health outcomes due to IPV in pregnancy (Shah & Shah 2010:2028; Shamu et al 2011:1). Furthermore, IPV in pregnancy has been found to be as high as 57% (Shamu et al 2011:6) showing how IPV in pregnancy is also a persistent problem.

> "He would not beat my face; he would just beat the ribs. Even when you are pregnant for him, he doesn't want to know. There was a time I was operated for one child but the child died." (Julia, 36 years old)

The participants described their children also sustaining injuries as their partners would beat them and the children. For a woman in Uganda, when a child sustains any injury, the overall care burden still falls on the woman. A participant narrated how the partner burnt the child with hot water after the child cried of hunger at night pointing to the fact that the hungry child was also perceived as a burden by the man and was punished for crying for food by being burnt. As a result the woman also experienced psychological trauma from seeing the child suffering from the burns and felt helpless as evidenced by the fact that she decided to "be strong and persevere" which means she did simply looked after the child and did not have any alternative out of the situation.

> "…. The children would go to sleep hungry; he would beat all the children with me the mother. One child he even burnt. When he cried for food at night, he poured water on him and it was hot water. So I was in that pain and I persevered and went through it. I told myself that my child must not die, let me be strong and persevere." **(**Barbara, 38 years old)

Some participants reported that they developed hypertension and persistent headaches because of worry caused by experiences of IPV.

> "This experience has left me with a stressful life and I usually get headaches." (Marian, 45 years old)

This is synonymous with other findings that have shown that hypertension is a consequence of IPV (Campbell 2002:1334) and that women exposed to severe emotional abuse have a high risk of hypertension (Mason, Wright, Hibert, Forman, & Rich-Edwards, 2012:566). The participants clearly sustained injuries because of IPV and interfaced with health facilities to seek medication for the injuries. However, the health officials/workers did not find out the cause of the injury nor did the participants take the initiative to talk about what caused the injury. This interface is a missing link that that must be exploited to provide greater response to survivors of violence. In Zimbabwe, Shamu et al (2013b:520) found that HWs have limited ability to identify and respond to IPV. Interventions must ensure that the different actors who come into contact with the survivors of IPV are involved to identify and even inquire about the violence-related injuries. Most of the participants stated that they approached government health facilities because at least the services are free or affordable, which implied that working with these facilities could present an effective avenue to help women that experience violence from their partners.

5.3.4.1.2 HIV infection

Participants also stated that their experiences of IPV had resulted in contracting STIs including HIV/AIDS. Their partners were unfaithful and had other women with whom they got involved. Culturally, the woman is not supposed to say anything or to complain about the man's extramarital affairs. Some participants ended up contracting HIV/AIDS because of this practice. The participants stated that what was most hurtful was that they had to have sex with the partner when he came back from the other women. This is because marriage is regarded as a license to have sex and the woman's body. Some partners did not even disclose that they were HIV positive to the participants, while some intentionally infected them. Some participants stated that they found out that they had HIV when they were pregnant and sought antenatal care services. This was against

the background that it was mandatory for all pregnant women to test for HIV/AIDS as part of the prevention of mother-to-child transmission (PMTCT) efforts. In addition, some only discovered then that their partners had already been on HIV treatment for years when their children were sickly and tested HIV positive:

> "For the fourth child, I went and tested for HIV during that pregnancy and I was found with the disease. So since then, my life, I started to shrink up to now… So now the current problem is the situation I go through, the challenge is the needs of the children and for me to look after myself, I am unable to go for medication on time." (Eunice, 43 years old)

Eunice found that she had HIV/AIDS when she went to test during antenatal care for her fourth child. The third child got infected with HIV/AIDS because she was not born in the hospital but the fourth is not infected because she got to test. Eunice stated that her partner had long tested and known that he was HIV positive and was already on medication. He used to hide the medication from her until one day when she discovered it herself. She now has to live with the disease as well as her child who is HIV positive, yet the husband does not provide them with the basics such as food. The experience of being infected intentionally by a partner through his failure to disclose could in itself be considered a form of violence

> "For him he already knew, because I investigated him. So I went and did my own search at home…So there is one chair he used to sit, that's where he was keeping his book and identity card for The AIDS Service Organization [commonly referred to as TASO in Uganda], because for me I read through he had enrolled in TASO before we got married. Because even the record book for taking medicine I got it. So as I didn't know how ARVs looked like, that tablet I had seen it before, he used to tell me that it's for *kabotongo* (STI)." (Eunice, 43 years old)

Before marriage to the intimate partners, some of the participants did not test for STIs, including HIV and this increased their vulnerability to STIs and HIV infection. In Rakai, Uganda, Kouyoumdjian et al (2013:1334) found that IPV was associated with new cases of HIV infection among women aged 15 to 49 years compared with women who did not experience IPV. Overall, the participants had been subjected to a spectrum of IPV that had affected their agency and dignity to extricate themselves from the violence perpetrated by their partners.

5.3.4.2 Sub-theme 2: Psychosocial health care and support

The participants reported three major effects of IPV on their lives, namely suffering, lack of happiness, and bringing up children as single parents. Sleeping out in the cold at night was indicated as one indicator of suffering while sorrow was caused partly by this.

5.3.4.2.1 Stress and fear of death

Women who survive IPV endure mental "torture" as a result of their experiences of violence. Some participants emphasised that the agony was especially related to the emotional or psychological abuse they were subjected to by their partners. The mental torment was a result of the care burden that the women had to shoulder singlehandedly because of the neglect and abandonment by their partners.

> "So you feel tortured and feel that men are really problematic… he would show me that he has money because he would pull it out of his pocket and say, 'have you seen this money? I will not give it to you. He would carry it and take it to other women. That's the torture of someone." (Jackline, 43 years old)

According to the participant, it was more tormenting when men had the financial capacity to offer financial support but refused to offer it. Jackline's partner had what she wanted but intentionally deprived her of money to buy the necessities for the children and family. This mother of six children had to peel potatoes as her job to raise income. She earned 3000 Uganda shillings (1.2 USD) a day, from which she had to pay for transport and buy basics for the family.

Another participant stated that she did not enjoy her life as she was full of sorrow and misery, and always crying:

> "It has affected me a lot in my life, I did not enjoy my life the way I would have. I realise I was in a lot of sorrow, every time miserable, crying. I hated myself because I would not even eat; I would just sit there and look on like a mad person." (Barbara, 38 years old)

The participants stated that they had physical and emotional scars, and led lives of emotional trauma. The participants reported that they were usually tense and fearful in anticipation of violence from their partners. Therefore they had to devise strategies and be on the look out to escape in case the partner turned violent:

> "He would get things like wood and throw at you and sometimes when you are near he would beat you with it. But if you were steady you could survive, so you had to be steady. I would be steady to run away as I know that he is drunk and he is going to beat me. For example, whenever I saw him looking for a whip I would move in a reverse direction like this, and get the child and at night he can't see you. Sometimes I would rotate around his house waiting for him to sleep, and then return. When you hear him snoring, you enter like around 12:00 o'clock or 2:00 o'clock." (Audrey, 30 years old)

> "My life is not at peace, I don't love myself, I am not at ease with myself… You get into a situation where you don't love yourself like other people and you say I wish I was also like so and so. I would say, you feel your life is not at peace. And yet you want to be alone but it's not possible." (Meron, 41 years old)

Participants described how IPV had impacted on the way they perceived themselves. They lead a life where they hate themselves and are always wondering why they were the ones chosen by God to go through such horrible experiences. Some of them question their self-worth in life and have low self-esteem, which affects their ability to move on:

> "I have very low self-esteem and a lot of backache and have to work hard for myself and the 3 children." (Susie, 23 years old)

While some of the physical scars had healed, the emotional ones were still evident. Many of the participants referred to religion (God) as their source of hopefulness amidst all the problems that they experienced in their families. For example, some prayed and fasted to see a change in their husbands' behaviours:

> "I have suffered a lot, I have seen sorrow and what can I add? You see, everything has reached my head. What I do is trust God who created me; he is the one who will help me." (Natasha, 34 years old)

The participants generally reported that they were afraid of dying because during IPV, their spouses or partners threatened to kill them. Moreover, they lived stressful lives. Their stress was caused by the regular beatings, death threats, the burden of bringing up the children single-handedly, and general absence of peace of mind.

5.3.4.2.2 Shame and embarrassment

The participants reported experiencing shame and embarrassment as a result of IPV. One participant described exceptionally embarrassing and shameful experiences that she would never forget when the partner physically and sexually abused her outside the house when the neighbours were watching. This behaviour could be a result of the man's sexual objectification of the woman and based on the cultural norm that a wife is supposed to please her husband at all times. It may also be a way of showing the level of control he has by openly raping the woman in the presence of the neighbours. Since there is no law against marital rape in the country and the issue of conjugal rights falls in the private sphere such an act would be considered a "stimulated explicit sexual activity" covered under the Anti-Pornography Act (2014:6) with a jail term of up to five years. Under the Domestic Violence Act (2010:8) this kind of conduct would be considered "sexual abuse" defined as "any conduct of a sexual nature that abuses, humiliates, degrades or otherwise violates the dignity of that person" and is liable to a jail term of up to two years. Public display of affection or intimacy in public is not acceptable culturally in Uganda (Otiso 2006:101) hence the man's behaviour was not congruent with the customs and traditions of the society:

> …it was one of those special days, we were in a barracks, he came drunk and he called me to 'come here'. I remember I was cooking food, I had just added meat to the saucepan. It was the 25th of the month and when he called me I told him, 'I am cooking on the charcoal stove; let me first finish cooking'. So he did not listen, he immediately started beating me that I don't want to sleep with him and then he used me a lot, in that very place. Like the charcoal stove is here and he sexually used me there…that embarrassment! People were there seeing...Did I tell you that he would use me in the anal opening? And then he would rape me again, he would not even wait for the children to sleep; he wants to do it when the children are awake so that you get embarrassed. Even the neighbours' he would want them to hear, he would not mind... '' (Barbara, aged 38 years)

Such experiences of physical and sexual violence humiliate and denigrate women, and cause them emotional trauma. The participants' experiences of physical violence have to be seen in the existing wider patriarchal system. Ugandan society has privileged men to be the decision-makers and in the households men control resources including money which affords them the opportunity to abuse alcohol. No matter what time they come home at night, they believe that the women are under obligation to serve them and they feel they have the power to 'discipline' the women if they do not do as they want. Participants stated that they could not leave the violent partner since they had nowhere to run to and were locked in violent marriages and lived in shame and embarrassment because they had children:

> "He is the father of the children. I don't have anywhere to take them.'' (Ruth, aged 30 years)

Consequently, any interventions must not ignore such emotional and psychological needs of women who have experienced IPV. These experiences work together to rob women of their dignity and agency which makes it difficult for some to leave such violent partners. Some participants reported that they were forced to end their intimate relationships. They explained that when they got tired of being beaten, kicked and verbal insults, they decided to end the relationship in an attempt to protect their lives:

> "The man used to beat me so much! I have a scar on my leg where he cut me with a machete. I now have a heavy burden of taking care of the children alone, which is not easy." (Hamida, aged 43 years)

Other participants reported shame and embarrassment from the bad relationships with their neighbours because of IPV. Although they looked at the neighbours enviously because they were not in violent relationships, they had bad relationships as a result of the neighbours' complaints over sleep disturbance at night and their actions to alert the authorities about it.

5.3.4.2.3 Lack of access to education

Some of the participants reported that they had dropped out of school because their partners threatened them with violence and witchcraft if they did not marry them then:

> "I was in love with this man in school when I was in level 2 but I dropped out at level 4. For him, when he finished senior 4 he wanted us to begin a life immediately. I tried to reason with him but to no avail. He threatened to kill me and even bewitched me, so my parents saw what was going on and they chased me away from home. They said I brought this on myself. So we went away to start a new life." (Namuli, 22 years old)

> "I stay at home because I never went to school even for a day. This means I got pregnant my very first time when I was so young. I was 15 years old." (Esther, 31 years old)

While the minimum age of marriage in Uganda is 18 years (Olayanju et al 2013: 107) the findings suggest that many women get married before attaining this age. Early marriages predispose young women and girls to IPV as in most cases they marry older men and lack the ability to continue with their education resulting in marginalization (UNFPA 2010:81). In Haiti, non-completion of primary education was significantly associated with all forms of IPV (Gage 2005:357). In India, IPV prevalence was considerably reduced for educated men and women and had a good yield in reaching young boys and girls with gender equality programmes, especially in school settings (Nanda et al 2014:ix).

5.3.4.2.4 Financial loss/poverty due to IPV

The participants also blamed their poverty and financial losses on IPV. According to them, they had poor diets in their homes because the money that should have been used to buy food was spent on treatment and drugs for injuries and bruises caused by IPV.

> "We don't eat well so we are not very healthy." (Harriet, 42 years old)

In contrast, the participants' partners spent their money on alcohol and drugs. This left the couples and their children with less money for food. In addition, the violence reduced the women's productivity due to the injuries sustained. In this way IPV acts as an impediment to women's ability to contribute to social and economic development (Garcia-Moreno et al 2015b:1686). IPV undermines women's productivity as women lose a lot of time that they could have earned an income nursing the health effects of abuse (McIlwaine 2013:74). A study conducted by ICRW (2009:2) found that about 10% of women who experienced IPV reported losing an average of eleven paid working days annually due to IPV.

5.3.5 Participants' perceptions of causes of IPV

The theme emerged with participants' perspectives on possible causes of IPV and how they are interpreted within the context of the women's realities. The participants discussed their own perceptions on the reasons why their partners perpetrated violence on them. Table 5.5 shows the sub-theme and categories of the perceived causes.

Table 5.5 Perceived causes of IPV

Theme	Sub-theme	Categories
3 Perceived causes of IPV	3.1 Women's perceptions on IPV causes	3.1.1 Alcohol and Drug abuse
		3.1.2 Increased responsibility associated with birth of children
		3.1.3 Peer influence
		3.1.4 Jealousy
		3.1.5 Young age
		3.1.6 Infertility

5.3.5.1 Sub-theme 1: Participants' perceptions of IPV causes

5.3.5.1.1 Alcohol and drug abuse

Most of the participants reported that IPV started with their partners' abuse of alcohol and or drugs. Some participants reported that they started experiencing IPV the moment they started living together and explained that IPV began early in their marriage/relationships. According to the participants, their partners were peaceful when sober and became violent when drunk:

> “After some time, he started drinking and in the process he became violent.” (Rukia, 30 years old)

> “When my husband is drunk, he is very violent towards me and my children. When he comes, he starts fights out of nowhere and starts beating me. He throws me to the children and then we start fighting.’’ (Nalongo, aged 30 years)

5.3.5.1.2 Increased responsibility associated with birth of children

Apart from drug abuse, some participants also reported that they started experiencing IPV in their relationships after conceiving or giving birth to their first children. The participants explained that after conception and/or delivery their partners feared the responsibility of providing for their families. Babies’ delivery was reported to be accompanied with pressure to provide for the family. In response to these events, the men hid their fear of providing for the families by getting drunk and exercising IPV.

5.3.5.1.3 Peer influence

The narratives also highlighted the perceived role of their partners’ peer association in influencing IPV. The participants reported that while drinking men also shared experiences on how they perpetrated IPV to demonstrate that the control they have on women. For example, men shared amongst themselves that they disciplined stubborn women through exercising IPV. The participants added that these stories influenced others to try and exercise IPV in their homes when they returned:

> “The alcohol and his friends he listens to. The friends are a bad influence because they make him behave like that.” (Rhona, 28 years old)

Peer influence has also been postulated to encourage IPV with bad peer association condoning violence against women (Heise 1998:276). This finding based on the women’s perceptions concurs with the Burgess-Akers Social Learning theory which posits that IPV is learned (Akers 2011:50).

5.3.5.1.4 Jealousy

The issue of jealousy in the intimate relationships played a central role and it was evident in most of the narratives that suspected unfaithfulness or the fear thereof was a major cause of IPV. The participants stated that jealousy together with inadequate trust in the intimate partner was a latent cause of IPV. Alcohol simply helped to manifest IPV. Some of the participants also did not trust their partners and always thought that their partners were not faithful. The participants believed that men with extramarital affairs pushed them to exercise IPV on the partners they least loved.

> "He realised that I had given birth and saw that now in his heart I no longer had room, so he started doing that. He would go sleep outside home and loved other women more…" (Barbara, aged 38 years)

The participant believed that the man no longer loved her because she had given birth and he now loved other women causing the IPV. This is because often when the men find new partners they give them their undivided attention and become violent towards the old partner as they perceive them to be nagging especially where the partner is aware of the extramarital affair and is considered jealous by the man. Polygamy increases IPV as it causes conflict and psychological violence (Human Rights Watch 2003:50) and a study in eastern Uganda found that 24% of women had experienced IPV because their husband had another partner (Karamagi et al 2006:9). On the other hand some of the participants also explained that the men's jealousy was also a cause of IPV as some of the men never wanted their partners to look presentable because they were afraid that they would be dated by other men. This concurs with finding in Haiti where jealousy was significantly associated with IPV (Gage 2005:357).

> "He keeps saying I am always with other men. He does not trust me. He thinks that I cheat on him." (Rita, 35 years old)

> ''He cuts all my hair because he doesn't want me to look good. When I buy things at home he starts a war." (Rhona, 28 years old)

5.3.5.1.5 Young age and low educational status

Some participants attributed the IPV to the young age and low educational level of the male partners. This coupled with men's belief that they are superior to women encouraged IPV. Sambisa et al (2010:165) emphasise that IPV-prevention programmes targeting men should consider spousal substance use and sexual risk behaviours as social and public health problems adding that they should also consider the socio-cultural context in which men who abuse their partners were embedded.

> "He is young and not highly educated. So he is frustrated because he does not have a good job." (Vivian, 23 years old)

The participants explained that men who could not meet their responsibilities because of low education, absence of a good job, or a combination of both exercised IPV out of frustration. Indeed, this suggestion by the women in this study is consistent with other studies that have singled out low education and young age when marrying and during marriage as important factors most associated with IPV both on the part of the perpetrators and survivors (Ackerson et al 2008:509; Olayanju et al 2013:103). Some participants reported that they did not know or remember when and how IPV started in their relationship.

5.3.5.1.6 Infertility

Other participants described the emotional abuse childless women go through. In Uganda, it is not uncommon that when a couple fails to have children, the woman is to blame even if the man was the one with a problem. Women bear the blame and stigma of failure to bear children. This abuse does not only come from the partner but also from the family and society at large. Marriage is viewed as an institution for producing children and if one does not have a child, she has to take the blame. In case she does not get a child, the man is at liberty to go and try for a child with other women (Beyeza-Kashesya, Neema, Ekstrom, Kaharuza, Mirembe & Kulane 2010:75). There is a high likelihood of IPV if a woman fails to bear children (McCloskey, Williams & Larsen 2005:124).

"Indeed when he comes he just quarrels, saying, 'you don't give birth for me, you eat my food for free.' It is because I do not have a child with him." (Joan, 38 years old)

5.3.6 Strategies to address IPV

The participants were asked to identify and recommend what they thought could be done to reduce IPV. In the past interventions were reactive rather than proactive and aimed at providing survivors of violence with support services and improving the justice system. More recent interventions, however, are increasingly aimed at preventing violence (Ellsberg et al 2015:1555; Garcia-Moreno et al 2015a:1575; Michau et al 2015:1673).Nevertheless, there is an urgent need to prevent and respond to IPV based on adequately evaluated strategies and improve availability of evidence for interventions (Temmerman 2015:e39). The participants raised various options but particularly emphasised economic empowerment to prevent and respond to IPV (see table 5.6).

Table 5.6 Strategies to reduce IPV

4 Strategies to reduce IPV	4.1 Economic empowerment	4.1.1 Access to capital for small businesses
	4.2 Legal and justice system	4.2.1 Strengthen legal and justice system
		4.2.2 Improve awareness and implementation of IPV legal frameworks
	4.3 Social and institutional support	4.3.1 Establish support groups and shelters for IPV survivors
		4.3.2 Improve access to sexual and reproductive health services

The recommended interventions are hereby elaborated:

5.3.6.1 Sub-theme1: Economic empowerment

To reduce the participants' and women's vulnerability to IPV and increase their independence, economic empowerment was emphasised as necessary to reduce IPV.

5.3.6.1.1 Access to capital for small businesses

The participants stated that they were stuck with their violent partners because they were not able to survive on their own without any income to meet their basic needs. Some participants felt powerless in front of their partners as they had to beg for most of the basics in the household:

> "When you have your own income, it's not easy for the man to undermine you; because he will know that when such a child is at school and has no exercise book, you will not leave the child to go without a book. But when you don't have it, he will know that when the child has no book or trousers, the child has no pen, a pen is only 500 shillings! All those make the man disturbed.'' (Sheila, 35 years old)

> "For me, if I had my money, I would have even left the marriage. I have given birth and I am no longer his love, I just want to look after myself and be there.'' (Eunice, aged 43 years)

With economic empowerment, women could sustain themselves and their families independently and would also have a voice and power to influence what went on in the household. The narratives uncovered how poverty is a major barrier affecting women's agency to leave violent relationships thus promoting entrepreneurship would empower women to escape IPV. Women's economic independence was found to be protective against psychological and physical violence in Haiti (Gage 2005:357; Murthy et al 2010:21; UNFPA 2010:35). In Maldives, the inability of women to disentangle themselves from violent partners has been attributed to economic marginalization (Fulu & Miedema 2015:5). Women's economic vulnerability makes them subject to exploitation by men (Shamu et al 2011:2). IPV prevention strategies have been found to be more effective when integrated as components of sexual and reproductive health and economic empowerment programmes, such as vocational training. These proved effective because there is strong evidence linking IPV and poverty (Ellsberg et al 2015:1559; UN WOMEN 2013:15). The participants in this study maintained that if they were economically empowered, the men would not undermine them:

> "I would like to get a job and work. Then I could also get my own house and be free so that I survive violence. If I have a job that pays, I go and get my small

> house and I give up on him. If I could get a job; be able to educate those children and buy them food, then I would know that I also work. I have a responsibility; the children need uniforms, such things. Nowadays it's not common to find men looking after these children. Men don't mind about them...'' (Joan, aged 38 years)

This participant was convinced that if she had a job, she could actually take up the family responsibilities, challenging the Ugandan patriarchal society that constructs men as the natural breadwinners for their families. While it is culturally acknowledged that men have to take care of the basic needs of their families, the participants explained that they felt burdened with the responsibilities because they had insufficient if any income to meet their children's basic needs. Some men ride on these inequalities that society has created where women are denied opportunities through which wealth can be amassed thus relinquishing them to begging positions. The findings indicate clearly that most of the participants did not get a chance to complete their education and therefore could not find employment and have an income to sustain their needs. Male privilege has turned women into chattels because they know that they have no way out since they are dependent on the men for survival.

The participants did not want economic empowerment only to afford their basic needs and those of their children; money is also an important determinant for accessing justice in Uganda. Most of the participants indicated that they stayed with their violent partners because they did not have any money to take them back to their village or any other place where they could seek refuge. The participants argued that an economically empowered woman could hire a lawyer and get transport to the police and to a safer place. In addition, an economically independent woman had the capacity to get her independent home and take care of the children instead of staying in a violent relationship as well as the economic power to be heard in children and family protection institutions in Uganda. Participants explained how important money is if women are to access justice and the help that they need. She explained that a friend was assisted to get maintenance from her partner only after paying the lawyers a bribe pointing to the corruption in the system as well as the need for one to have some money to navigate the system and tip decisions in their favour:

> "…Without money, lawyers can't help you but when you have some money they can listen. A friend of mine went, she brought Sh 80,000, so that they could go

> and arrest her husband. So the other one went out of the office and she gave him that money in the toilet. He told her, 'go to the toilet and I meet you there' and she went and gave him the money in the toilet. When she paid it, they came and arrested the man and told him he had to give the children medical treatment and get money for taking care of them…. When the man got arrested and realised what he had done. He was arrested for four months and he also learnt why he was arrested and he started sending the money on time. So that shows that when you have money, the lawyers can help you, but when you don't have money, they can't help you." (Barbara, 38 years old)

The participants suggested that they could be empowered economically if government gave them small start-up capital for small income generating activities. They also encouraged other women to join and form women's groups where they could come together to save money to invest at a later stage when it has accumulated.

> "There is persisting and you also work. You work harder, when you join these groups, they help a lot. Because when you are unable, you could borrow money there and take it back, as you will be able.'' (Sheila, aged 35 years)

The participants suggested that improving their access to credit services could help them to start small- and medium-scale businesses.

> "To me, each person has their needs but for me what I lack is capital. Yes, money. If I had my own work, because I have experience in work, I only fail to get capital, so that I work, look after those children, they study, then I also stay; so that I can develop and maintain myself, then I would feel good.'' (Eunice, aged 43 years)

One participant worked in a bar where she was not given a salary but the employer paid her rent. This HIV-positive participant said all she worried about was having capital to start a business to meet her and her children's needs. This appeared to imply that supporting these women to access credit that they could use to start up income-generating activities would enable them to be independent. Culturally, women do not inherit or own properties like land (from their families) that they can use as security/guarantee to access credit to start and/or boost small businesses. Economic empowerment interventions must take into consideration the positions that women are

in. Therefore, interventions must ensure avenues on how women can gain money if they are to respond to and even prevent IPV. Participants also suggested empowering women to go to their villages and get engaged in farming.

> "… women go through a lot of violence especially those staying here in Kampala. The situation is still very bad because in Kampala, getting a way to survive is hard. If women don't think about going back to the village and doing farming and if they keep thinking of staying here in Kampala while the men make money and consume it. Those who have their men, it's hard because these days money is scarce, people have been chased away, people are going through poverty. Even if you have your business, you go to the village and put it there it can work. Kampala has become expensive." (Sonia, aged 37 years)

A focus on poverty reduction has been identified as an important, but not singular, strategy to reduce IPV globally (Jewkes 2002:1427; VanderEnde et al 2015:696). The participants' recommendations on economic empowerment concurred with other recommendations encouraging countries to consider economic empowerment and social and gender equality strategies for women in order to prevent IPV (WHO 2014b:29; Garcia-Moreno et al 2015b:1687).

5.3.6.2 Sub-theme 2: Legal and justice system

5.3.6.2.1 Strengthen the legal and justice system

A few participants reported that they attempted to seek help from legal institutions like the police and courts of law. They described how they were thwarted by these systems. They highlighted how the officials in the systems are corrupt and often bribed by the perpetrators. Most of the participants could not afford the fees asked for in these institutions; for example, the police often ask for money to facilitate the costs involved in arresting the perpetrator such as transportation. This reflects the weak enforcement of legislation and the poor resource allocation for the police institution hence they ask for money for fuel. These barriers perplex the women who then do not have options for redress and remain at risk of even more violence due to this impunity:

> "Even if you go to report, you don't have money. They ask you for money to arrest him, and even when you look for it and pay it, they arrest him for one day

> and release him. So I would say you just put up with the pain and even him he would say 'there is nothing you will do to me'. He does whatever he wants to you. He tells you that 'for us men, we have our freedom I can even kill you if I like'. That's when he cut off part of my ear and told me, 'never run away again'. Then he said, 'there is nowhere you will go to report me', and I also saw and I gave up… " (Barbara, aged 38 years)

The issue of police taking informal payments from domestic violence survivors has been previously reported in Uganda (Human Rights Watch, 2003:56). The informal payments required, contribute to the double victimisation of women experiencing IPV. In this study, the participants explained that the absence of a responsive legal system left them at the mercy of their violent partners. Some of the men boasted that they had their own ''freedom'' and could kill their partners if they wished. The participants explained that the IPV perpetrators knew that the legal system was weak and therefore would not receive any punishment for their violent actions. The police's inaction may reflect the patriarchy and reluctance to involve themselves as a male dominated force in what is perceived as a domestic situation.

> "Yes I had him jailed and I told him let us separate and he told me I am not going anywhere…So the police officer told me to go and sort ourselves and they released him.'' (Macklean, aged 25 years)

Participants suspected that their partners could have bribed the police and postulated that they and other women stopped reporting to police because they knew that it would not help them. While corruption is a serious problem in the police institution, police still need to be trained on how they should respond to cases of IPV. Some participants stated that arresting and releasing their husbands did not guarantee cessation of IPV. According to them, having men arrested and then released was like a license to intensify the physical violence they inflicted on women. In Brazil women of low economic standing seek conflict resolution services at women's police stations and most are not interested in filing charges against their partners (McIlwaine 2013:75). IPV interventions need to target deeply entrenched patriarchy and promote dialogue between men and women (Nanda et al 2014:viii). Some of the participants believed that by giving serious warnings to the men, some would change compared to just being released without any caution.

> “Now there is nothing else I have tried to do, because since I went to the police and failed, where else could I go? They are the people who handle laws who usually save people, where else could I go? There is nowhere else I could go because tried to police…The authorities, the legislators should be helping us. Like for us women, you can’t say that you are going to have your partner arrested, you take him to be arrested and later he is released. And he tells you ‘I will come back, take me and arrest me I will leave and be back’. The authorities should sensitise the men, educate them. They may listen to them and fear.’’ (Vero, aged 29 years)

The participants also highlighted the Local Council (LC) system as another institution that was compromised because the LC officials were usually family or friends of the perpetrators of IPV. When the women went to the LCs to report their husbands and got letters to go to police so that the men could be arrested, the LCs were said to backstab the participants by telling the husbands to disappear because the women had gone to police. The LC system was perceived to be less responsive to the needs of women yet this was the first authority that should be more accessible and affordable to women in the communities.

> “The LC1 they know them, they have grown up here and they know them. The LC1s of this place they know them and the men undermine them so much. Even when he tells him something he doesn’t accept it because he is used to him. So even the LC1 can talk about the man but because he is so familiar with him, like someone you are very much used to …. For instance, will you go and tell that chairman of ours and he allows taking this man and arresting him? The child is born here and grew up here. Eh, he can’t arrest him.’’ (Macklean, aged 25 years)

The participants stated that the legal system frustrated the women who reported IPV. The corrupt legal system means that many women cannot pay unofficial fees to the officials. Due to the feminisation of poverty in Uganda, most women have given up seeking help from authorities like the police and judiciary because they know that they will not access justice. Women continue to experience IPV as the perpetrators know that there are no repercussions from the legal authorities. This indicates that efforts to ensure proper prevention and response to IPV must also strengthen the legal system to prevent impunity.

The participants stressed that the legal system in Uganda, particularly the police and local councils, was less responsive to the needs of women that experience IPV. These are the first level institutions that women had to approach when seeking redress for the violence they were experiencing. However it is clear was that if these systems were strengthened and facilitated, they have the potential to reduce IPV cases (Garcia-Moreno et al 2015b:1689). Should such institutions condemn this violence through serious action on cases reported, women would be encouraged to report more cases and the perpetrators would be scared off. It is suggested that men would know that their women had an institution that could listen and help them. Some men abuse their women because they know that the women could not report anywhere. A study by ICRW (2009:1) in Uganda found that about 9% of women reported to the local council mechanism while only 2% reported to the police. This shows some cases are not carried forward from this level. Ellsberg et al (2015:1558) and Michau et al (2015:1675) support this finding and maintain that improvements in legislation alone do not translate to reduction in IPV unless accompanied by serious law enforcement and multi-sectoral collaboration. The participants recommended a responsive legal system that would give survivors of violence a chance to seek redress. Moreover, the government should show its commitment to women's protection by financing and facilitating these institutions so that they were able to protect women.

The participants suggested that developing pro-women interventions would help to reduce IPV. The interventions should also focus on reduction of drug abuse. Policies should also aim at disciplining men when they perpetuated IPV and building the confidence of women by actually taking steps to address IPV. Some participants reported their violent partners to the police who did little or nothing to have the men arrested.

> "The police should stop doing nothing. When you report these cases, they come for the men. But when they see the police, these men start to act like they are crazy so the police leave them because they don't want the burden of having someone like that." (Judith, 40 years old)

Tjaden and Thoennes (2000:v) found that in some instances women did not report IPV to police because they believed that no action would be taken. Women's concerns

about the lack of law enforcement in the justice system were generally legitimate. In Uganda, there actually exists a handbook to guide the police in handling IPV (Turyasingura 2007:1; Olayanju et al 2013:107). However, in view of the findings that have demonstrated low reporting rates and the women have faulted the system of corruption and inaction, more needs to be done to connect the women and the police system. The WHO (2014:38) recommended that the criminal justice sector and other security institutions including the police be strengthened to deter and prevent potential violence and accord justice where the crime had already been committed.

5.3.6.2.2 Improve awareness and implementation of the legal frameworks against IPV

The participants pointed to the need for promulgated laws to curtail IPV and to also regulate alcohol abuse. They stated that their partners subjected them to violence when under the influence of alcohol and substances and thus recommended that alcohol consumption and other substance abuse should be regulated by implementing laws that stipulate the time men should be in the bars and when they should be home. Participants stated that their partners came home drunk after midnight and started torturing them. With regulations in place, time in the bars could be regulated. Some participants suggested corporal punishment for the perpetuators of IPV. The participants stated that having tough laws was not enough; they had to be strictly implemented.

> "I don't think anybody can be violent when he has not taken alcohol…So if they could put regulations that at such and such a time everybody should be home, those men could be checked. If he has been leaving work at 8:00 o'clock and the government law says that at 10:00 o'clock everybody should be home, by 9:00 pm, he would have to check himself." (Rukia, 30 years old)

While participants agreed that IPV was caused by alcohol and drug use, some suggested that the authorities and legal institutions should be on the look out to ensure that whoever abused their partner was given corporal punishment to deter them from repeating the same:

> "…. If man takes marijuana, even if you take him to his parents they will not get that habit out of him, but those Local Council leaders are the ones that can help.

> They can cane [beat] him like that. So I say such drugs if these leaders were on the ground here they would see what is in their area and they put some order." (Grace, 27 years old)

In addition to tough laws on alcohol and drug use, tough laws were also recommended for men that beat their wives. Not only should the laws be in place, but they should have serious punishments that are followed and implemented by the relevant authorities, such as jail because men fear being jailed.

> "These men should be subjected to laws that when you beat a woman you will be arrested for such a period... because they fear jail that is what I know." (Grace, 27 years old)

The law the participant was recommending already exists under the Domestic violence Act (2010) and the fact that she recommends this signals to the fact that she is not aware of the existence of such a law and perhaps that it is poorly enforced. This sub-theme highlights the critical issue of the limited knowledge and awareness of existing laws against IPV:

> "So the men should be given laws to stop their violence. Only that law is not yet passed. But they talked about it. Because many women are violated by men after using them, they kill them, aah. Only that, the law is not yet passed but I heard it being talked about. On Women's Day that was all that was talked about, how women are made to suffer. We ask that the government should also help us in that situation of ill-treatment so that we may also have freedom." (Meron, 41 years old)

Meron was referring to the Marriage and Divorce bill gazetted in 2009 and has been tabled in Parliament several times without consensus due to the contentious debate on some of the clauses among parliamentarians and the general public (Godiva, 2015:1). The Bill addressed pertinent issues affecting women like marital rape as well as recognition of cohabitation in relation to the sharing of property between couples and outlaws the practice of men demanding to be given back their bride price upon dissolution of marriage (ActionAid, 2015:1). This was rejected by various sections of the society including religious leaders on the basis that it promoted divorce as an option to end marriage belittling the institution of marriage and also seeks to legalize cohabitation

and polygamy which are frowned upon by the society (Godiva, 2015:2). In addition, the bill was criticized as some stakeholders felt that the issue of conjugal rights should not be regulated by the state and therefore no-one should face prosecution for marital rape (ActionAid, 2015:1). There was also a general concern that some people would opportunistically get into relationships with the sole intent of benefitting from the sharing of property upon dissolution of the cohabiting relationship. The delayed passing of the Bill has been cited as an impediment by human rights activists to redressing the injustices constructed around patriarchy in the Ugandan society (Larok, 2013). The participants' experiences of IPV clearly indicate that a stronger law to protect women survivors is needed more urgently than ever before in Uganda.

5.3.6.3 Sub-theme 3: Social and institutional support

This theme showed a pattern for a defined need for community discourses with fellow women on IPV in the form of support groups, the establishment of shelters for survivors of IPV and improving access to sexual and reproductive health services.

5.3.6.3.1 Establish support groups and shelters for IPV survivors

Most of the participants stated that establishing support groups to help them share ideas and self-defence tips would be very helpful to them.

> "Women should be encouraged to join the different groups that can support them.'' (Charity, 36 years old)

Some explained that they wanted shelters where women could go in the event of domestic violence. However, in Uganda as in many low income countries shelters are often short-term and have little funding support (UN WOMEN 2012:17).

> "There should be places that we can go to in order to escape violence in the home.'' (Hannah, 28 years old)

Others described how they ran back to their parents in the villages when they experienced IPV but they or their children were turned away indicating further the barriers they face. The WHO (2015:12) states that a tightly woven social support

network is a social determinant of health and this includes family, friends and communities and has a positive effect on health. For women experiencing IPV a network of social support is useful in helping them to acquire some life skills and coping mechanisms to prevent and respond to IPV.

5.3.6.3.2 Improve access to sexual and reproductive health services

The participants stated that improving access to sexual and reproductive health services especially family planning services was one way to help women experiencing IPV:

> "We should be taught how best to live in this kind of life because now I have many children, but I can't afford to go for family planning." (Rita, 35 years old)

This finding indicates that women are unable to access sexual and reproductive health services and continue to have unintended pregnancies due to IPV and the impact it has on their reproductive health decision-making. Other authors have reported similar findings in India (Koski, Stephenson &Koenig 2011:251). Improving access to these services would help them when beaten up and prevent unwanted pregnancies. This concurs with women-centred interventions focused on provision of support to women to reduce their risk of violence in the future and offered mainly in the health care setting including family planning and antenatal care services (Ellsberg et al 2015:1557; Garcia-Moreno et al 2015a:1567; Michau et al 2015:1681). Other authors have also suggested that the availability of health care support especially targeted and tailored at IPV has potential for yield (John, Lawoko & Oluwatosin 2011:113; Olayanju et al 2013:111).

5.4 OVERVIEW OF THE QUALITATIVE RESULTS

The participants explained that their intimate partners subjected them to physical violence by beating, pulling, pushing, shoving, slapping and kicking them. In addition, several participants reported that the men stabbed them with knives or sharp instruments sometimes cutting off body parts. The participants maintained that the main trigger for physical violence was drunkenness although children crying at night and men's demands to be served food or tea also triggered IPV. Some of the women were blamed for infertility and faced social stigma leading to IPV. The participants stated that

psychological violence was more often followed by physical violence. Furthermore, the physical violence left them exposed to psychological violence.

According to the participants, they were subjected to psychological violence when men failed to execute their responsibilities as the breadwinners. The participants were subjected to further psychological violence when they desperately sought informal casual work in order to provide for themselves and the children. These ways of perpetuating IPV were in addition to being made to sleep out in the cold after being beaten, kicked out the house, and the shame these attracted. Children in such relationships were vulnerable to generational poverty because with their mothers' little earnings, they could hardly complete schooling. In addition, such women and their children would end up in dire socio-economic situations when they were sick or unable to do their informal casual work.

The traditional Ugandan perspective is that the gender roles are specified and men are ideally expected to be the breadwinners and heads of the households. A head of a household has the responsibility of taking care of the family including meeting the needs of his wife and children. This is a sign of love and responsibility from the man. Therefore, when the husband does not provide for the wife, it is an indicator of punishment to the wife; an indicator that the man is tired of you and wants you to leave. It is generally unheard of that a woman contributes towards paying rent, which is supposed to be purely a man's responsibility. Due to the high cost of living and limited job opportunities, some men could not live up to societal expectations of earning enough money to take care of their families and therefore resorted to violence to express their frustration.

The researcher observed that there seems to be a unique kind of violence that women in Kampala experienced. Given that it is an urban area, there were men who also came there for survival and to look for employment. Thus the participants who could not rent a house were vulnerable to men who might also want to depend on the women's income.

5.5 CONCLUSION

This chapter discussed the qualitative data analysis and results. The qualitative interviews revealed the health impacts of IPV on the participants and their perceptions of the causes of IPV as well as potential strategies to address this problem.

Chapter 6 integrates and discusses the quantitative and qualitative results.

CHAPTER 6

Integrated quantitative and qualitative results

6.1 INTRODUCTION

This chapter presents an integration of the quantitative and qualitative results from the mixed methods approach used. The researcher discusses the study results in relation to the research questions and main themes. Chapters 4 and 5 discussed the quantitative and qualitative analysis and results separately to clarify the datasets prior to merging the results. This, in turn, facilitated development of linkages and allowed for substantiation, contrasting and extension of the dialogue on potential strategies. Data integration was guided by the research objectives and according to the foundation of the mixed methods approach.

6.2 MIXED METHODS APPROACH

This cross-sectional sequential explanatory study employed quantitative and qualitative methods. This involved three distinct phases, namely quantitative, qualitative and strategy formulation. In a sequential mixed methods study, the approach to integration is iterative, highlighting the links between the quantitative and qualitative phases (Plano Clark, Garret & Leslie-Pelecky 2010:155). Both quantitative and qualitative methods provided good insight into IPV but integrating both approaches provided a deeper understanding of IPV than possible with these methods independently (Testa, Livingston & VanZile-Tamsen 2011:236). The qualitative phase provided more details about the IPV experiences by selecting participants with rich experience and therefore augmented the quantitative findings (Driscoll, Appiah-Yeboah, Salib & Rupert, 2007:21; Thaler 2012:19). In addition, combining the qualitative and quantitative strands compensates for the weakness of one strand, thereby allowing for stronger inferences to be made (Thaler 2012:13). Figure 6.1 depicts the quantitative and qualitative data sources on IPV prevalence and experiences among the participants from Kabalagala slums was obtained and integrated to achieve the study aim.

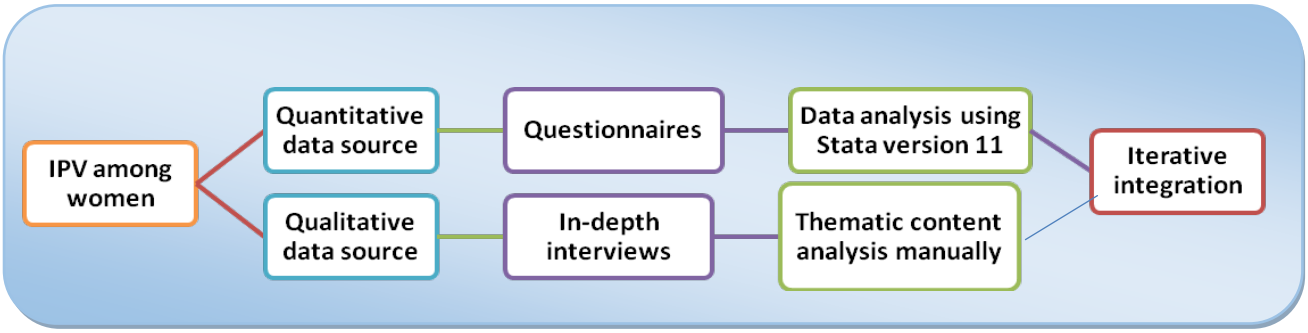

Figure 6.1 Data sources in the study

The quantitative data gave a general understanding of the nature and prevalence of IPV among the participants while the qualitative phase helped to illuminate and elaborate on the quantitative results obtained, and explored the participants' views in greater depth. Both the quantitative and qualitative phases were connected in the intermediate stage of the study and sought to answer the questions in table 6.1.

Table 6.1 Research questions in the study

Quantitative question	Qualitative questions
1. What are the prevalent forms of IPV among women in this study setting?	1. What are the IPV experiences of women in the Kabalagala urban slums in Kampala?
	2. How does the IPV experience influence women's health needs?
	3. What factors influence women's experiences and responses to IPV?
	4. What practical interventions can be used to reduce IPV?

6.3 MIXED-METHOD DATA ANALYSIS

Mixed analysis is the use of quantitative and qualitative analytical methods in the same study, steered by analytical choices made before and in the course of the study (Onwuegbuzie & Combs 2011:3). The initial data analysis of the quantitative and qualitative sets was done separately. The quantitative data analysis was done using Stata version 11. For the qualitative data analysis, the researcher read, coded, discussed and interpreted the transcripts to understand the diversity of the participants' IPV experiences and highlighting quotes supporting the phenomenon holistically (Testa,

Livingston & VanZile-Tamsen 2011:244). The researcher analysed the qualitative data manually by initially coding the transcripts and classifying the data in the thematic content analysis (Terre Blanche & Durrheim 2002:324; Green & Thorogood 2009:198). In the preliminary coding each transcript was structured into an individual table highlighting the main themes. The researcher familiarised herself with the data; identified, categorised, labelled and described themes by comparing the transcripts according to what the data represented, context, manner and timing of when it was mentioned as well as the emphasis on the idea (Miles & Huberman, 1994). A theme codebook was then developed consisting of the themes and sub-themes with numerical codes attached to each theme and sub-theme. The thematic content analysis involved the use of descriptive, analytical and hierarchical coding where the text was summarized in relation to the objectives, the phenomenon explained and key themes identified based on the study objectives respectively in the systematic process of formal coding (Richards & Morse 2007:138; Saldana 2012:88; Taylor & Gibbs 2010:1).

6.4 PROCESS OF INTEGRATION

Integration in the mixed analysis involves cross-over analysis where qualitative data are analysed with quantitative data (Onwuegbuzie & Combs 2011:3). Integration involves the merging of quantitative and qualitative datasets and merging occurs in three main forms. In this study, the researcher applied merging in a discussion and with a matrix.

6.4.1 Merging in a discussion

This is the most widely used approach to integration and involves the presentation and interpretation of the quantitative and qualitative results in the study's conclusion (Plano Clark, Garret & Leslie-Pelecky 2010:156). The first step is to understand the independent findings separately; identify common findings in both datasets; refine the analyses based on the preliminary findings in the two datasets, and conduct a comparative analysis of the key findings. This is followed by a presentation of the results of both datasets in sequence and a discussion of how the results relate to each other focusing on the findings that substantiated findings from one dataset, detailed understanding of a scenario and dissimilarity. For example, in substantiating the quantitative findings on alcohol and IPV, the researcher corroborated the quantitative

and qualitative results on how increased alcohol use and drug abuse reinforced IPV. This, in turn, conclusively identified alcohol and drug abuse as a key driver in IPV.

The process of merging also helped to provide a holistic view of the quantitative findings. For instance, the quantitative findings showed that the majority of the participants had not reported their experiences of IPV to the authorities but it was not clear why this was so. However, the qualitative results indicated a lack of confidence in the justice system among the participants and economic disempowerment as major barriers. The researcher also looked for divergence. For instance, the findings indicated that though education was protective against IPV, men felt insecure with educated women and empowered women although this has generally be found more common among women of lower education status. The qualitative study showed that men were insecure with empowered women.

6.4.2 Merging with a matrix

This involved comparative analysis of the quantitative and qualitative results to highlight similar and divergent findings and characteristics.

6.4.3 Merging by data transformation

Data transformation “involves ‘quantitising’ qualitative information and ‘qualitising’ quantitative information” (Plano Clark, Garret & Leslie-Pelecky 2010:157; Onwuegbuzie & Combs, 2011:4). In this study, the aim was not to quantitise the qualitative, but rather to focus on defining and understanding the unique IPV experiences. The quantitative part of the study sufficiently defined the nature and extent of IPV prevalence. The researcher used two merging strategies in the study, namely merging in the discussion and merging with a matrix (see table 6.2).

Table 6.2 Merging strategies used in the study

Merging strategy for the current IPV study	Techniques	Questions
1 Merging in a discussion	Contrast quantitative and qualitative findings for substantiation	To what extent do the quantitative findings on the prevalence of the different forms of IPV support the qualitative themes on the experiences of these forms of IPV?
	Provide a holistic view of the quantitative findings	How do the qualitative results on the experiences of IPV complement the quantitative results on prevalence?
	Identify differing results and perspectives in the two methods	In what ways do the qualitative themes about the experiences of IPV present alternative perspectives to the quantitative results?
2 Merging with a matrix	Examine variations in qualitative findings based on quantitative characteristics	How do the experiences of older women differ from those of younger women?
	Scrutinise variations in qualitative findings based on statistical significance in the independent variables	How do participants' experiences explain the statistical significance between IPV and the independent variables?
	Analyse differences in the qualitative findings in contrast to the typical qualitative results	How do the reported IPV prevalence levels and associated factors differ by the nature of IPV experiences as pronounced in the qualitative results?

Adapted from: Plano Clark, Garret & Leslie-Pelecky (2010:163)

6.5 KEY FINDINGS

6.5.1 IPV prevalence

The first objective was to determine the types of IPV prevalent among the participants in two Kabalagala slums in Kampala, Uganda. The quantitative survey was undertaken to fulfil this objective using an interviewer-administered questionnaire. The types of IPV prevalent were revealed by answers to the psychological, sexual, physical and economic violence constructs. All these forms of IPV were highly prevalent in the study area. The most prevalent form of IPV was psychological violence which was reported by 99.7% (n=371) of the participants; 93% (n=346) reported experiencing economic

violence, 91.7% (n=341) had encountered physical violence in their lifetime, and 91.4% (n=340) in the past year; while sexual violence was experienced by 88.4% (n=329) of the participants. The qualitative findings further elucidated that there were no single woman who was exposed to only one particular type of IPV. The participants described how their partners abused them physically, sexually, psychologically and economically in no particular order. Despite the varied order in which IPV happened, physical IPV was usually the first one followed by either psychological or sexual violence. The IPV prevalence in this study was higher than that reported in urban areas and nationally of up to 59% among married women in Uganda and 80% among married women in a post-conflict setting in Uganda (UDHS 2012:239; Saile et al 2013:1). Similar findings were reported among HIV-infected patients in South-western Uganda where IPV prevalence was up to 50% (Osinde et al 2011:54). The prevalence of IPV in this study population was still higher than that reported in the WHO multi-country study where IPV ranged between 15% and 71% (Abramsky et al 2011:120).

6.5.2 Manifestations of IPV

While the quantitative data established the IPV prevalence and its different forms, it did not establish the details of how these IPV types manifested themselves. The qualitative interviews revealed how IPV manifested in depth. Physical IPV was perpetuated through kicking, slapping, hair pulling, arm twisting, beating, being slammed against walls, stoning, piercing, pushing, choking and shoving. In contrast psychological violence occurred in the form of insults, being left to look after the children single-handedly, being blamed for infertility and experiencing unfaithfulness. Sexual violence was experienced in the form of forced sex both in the marriage relationship and outside of marriage. Economic violence manifested in the form of deprivation of material resources and economic disempowerment by being forbidden to work or to access education or inability to work due to IPV resulting in economic loss. While perpetrating physical violence, the perpetrators used sticks, stones, knives, pangs and sometimes weapons like guns. This finding was similar to what Karamagi et al (2006:293) found in Eastern Uganda among women with infants. This study also revealed that psychological violence was perpetuated through abuse and insults while economic violence was perpetuated by denying economic support and refusing to buy basic needs. A unique form of economic violence that was identified in the qualitative study was one of role

reversal whereby some of the male partners of participants expected the women to look after them while they did not make an effort to look after their families.

6.5.3 Protective factors against IPV

Even though the quantitative data showed that there were factors that were protective against IPV and some that increased the exposure to IPV, it did not show the mechanism of how these worked to reduce or increase the exposure to IPV. The qualitative data revealed that employed women were empowered to an extent of avoiding some of the triggers of IPV. For example, they had the economic capacity to lessen the economic burden on their male partners by buying the basic needs in a home. Also the quantitative data showed that university education was protective against IPV. However, the qualitative data revealed that this was not necessarily the case because men felt insecure before educated women. This is explained by the resources theory which suggests that men with few resources may use violence to assert their power in an intimate relationship (Olayanju et al 2013:103; Ogland et al 2014:2). While being divorced or widowed were found protective against sexual, physical and economic IPV, this did not mean that divorcees and widows did not remarry as the qualitative data revealed that some women ended one intimate relationship and entered another one.

The study established that there was no single factor associated with psychological IPV. However, there were specific factors associated with particular IPV types. All these factors were protective against IPV except for young age. Widowhood and having an income above 58,000 Uganda shillings were singled out as protective factors against physical, economic and sexual violence. Being employed in a business sector was established as protective against economic and physical violence, but not against sexual violence. Whereas being divorced was protective against economic and sexual violence, it was neither protective against nor risky for physical violence. Higher education seemed protective against only physical violence. Some studies identified factors positively and negatively associated with IPV at large and some specifically associated with particular IPV types (Abramsky et al 2012:126; Karamagi et al 2006:290; Kouyoumdjian et al 2013:1332). The strength of the present study is the finding that in designing and implementing interventions against IPV several layers of the intervention need to be considered, such as which type of IPV to target, the

environment in which it is unfolding, the survivors and the perpetuators. A single intervention may not fully address IPV in a community where it happens (Wagman et al 2015:29).

6.5.4 Risk factors for IPV

In addition to the protective factors against IPV, the study found that alcohol consumption and drug abuse were risk factors for experiencing IPV in the study area. The qualitative interviews revealed alcohol consumption and other drug abuse as the main causes of physical, sexual and psychological IPV. Other reported causes of IPV were poverty, peer influence, suspected unfaithfulness, and being jealous of the woman. This was not new since research in Uganda and Sub-Saharan Africa reported alcohol and drug abuse as risk factors for experiencing IPV (Jewkes 2002:1425; Ali and Gavino 2007:1421; Abramsky et al 2012:2; Sambisa et al 2010:165; Shamu et al 2011:6; McIlwaine 2013:69; Peltzer & Pengpid, 2013:20; Shamu et al 2013:700; WHO 2014b:ix). The quantitative data showed that alcohol use was highly prevalent among the participants' male partners. The qualitative data provided deeper insight into the role of alcohol and drug use/abuse in the perpetuation of IPV. The qualitative interviews revealed that alcohol and drug abuse were one of the main triggers of IPV. According to the participants, the men commonly turned aggressive and violent after alcohol or drug abuse. There are suggestions that alcohol use leads to IPV but that IPV can also lead to alcohol use (Bacchus et al 2006:601; Widom et al 2006:684).

In addition, poverty emerged as a main underlying cause of IPV in this study. Other authors have postulated that IPV is higher in Africa due to high poverty levels (Olayanju et al 2013:103). Similarly in Pakistan, Ali and Gavino (2007:1421) found that the main causes of IPV were financial pressure. Failure to live up to these societal expectations and economically support the women and children could be interpreted as a threat to their masculine identity resulting in IPV which provided an alternative means of expressing this identity (Jewkes 2002:1424; Jewkes, Flood & Lang 2015:1581). A man could not confess that he had no money because this was a sign of weakness culturally. Economic stress centred on men failing to be providers made them feel insecure thereby becoming controlling and subjecting their partners to IPV (Nanda et al 2014:49). Both quantitative and qualitative data were consistent in identifying the means used to perpetuate IPV. Table 6.3 shows the factors commonly related to IPV in this study.

Table 6.3 Common factors associated with IPV from the quantitative data and reported causes of IPV from the qualitative data

Factor	Quantitative results	Qualitative results
Alcohol use	Majority of the male partners of the women (85%) in this study used alcohol or drugs	Alcohol and other drug abuse were reported as the underlying causes of IPV though some used these as a medium of IPV perpetuation. "When my husband is drunk, he is very violent towards me and my children. When he comes home, he starts fights out of nowhere and starts beating me."
Economic deprivation	Majority of the women (83%) pointed out that their partners deliberately deprived them of money and stopped them from working (76%)	Poverty and economic pressure were identified as causes of IPV. The male partners stopped their women from working, exercised IPV by not basic needs like food, abandoned the wife and children and women had to singlehandedly raise the children. Stole/forcefully demanded for money from the women. Deliberate refuse to provide even when they had money. "He was mistreating me, he wasn't giving me any money, I was the one looking after children, so I said "staying here is useless let me go and look after my children". "And he would show me that he has money because he would pull it out of the pocket and say, "have you seen this money?" I will not give it to you. He would carry it and take it to the women. That's the torture of someone."
Jealousy/unfaithfulness	Most (81%) of the study participants reported that their partners were jealous and suspected them of cheating without cause	Men had extra-marital affairs and also thought that women were cheating on them, felt insecure of economic empowered women. Aimed at controlling them by accusing them of unfaithfulness when the real cause of IPV was jealousy and suspicion. Peer influence and young age was only reported in the qualitative data as a cause of IPV. "… now when you go to get money for the children at work, he says 'you have been loving other men, where were you?' Then I tell him 'I had gone to work, the children you don't mind about them, for me let me work'. And then he

Factor	Quantitative results	Qualitative results
		says ‘you are lying you had gone to love other men’.”
Fear	81% hid the truth from others because they were afraid	Men’ perception of being superior to women allowed them to boast that they could kill their partner if they wished. This coupled with their physical strength and the women’ weakness allowed perpetuation of violence. Men kept weapons like guns, ropes, machetes at their homes to always remind the women that they were in danger. “He gets a machete and puts it on my head and threatens to kill me with it and also ropes. He says he will kill me and then he will kill himself. I am scared to death. All the time I feel like he is going to wake up and kill me.”
Weapons	59% reported that their partners keep weapons in their homes which they threaten to use on them	Kept weapons like guns, knives at home. Always promised to stab the women. “He usually gets a knife to stab you, yes a knife. He has never, whenever he wants to stab me I usually get a way of avoiding him and I run away then I go and sleep at the neighbours’ house, I return in the morning”

6.5.5 Health impacts of IPV

Although the study set out to identify health needs resulting from IPV exposure, the qualitative data further showed that the impact of IPV on women varied from health to economic and social ones. Common health needs resulting from IPV experiences included injuries, chronic pain and health complications; STIs including HIV; low self-esteem, shame and embarrassment; loss of relationships; stress and fear of death as well as financial costs. The health impacts were not mutually exclusive and in some cases participants reported these in the different dimensions. For example, participants reported physical health complications resulting in psychological distress and financial loss, while in some cases the financial losses as a result of ill-health due to IPV were also a source of psychological distress. Figure 6.1 illustrates the health impacts of IPV.

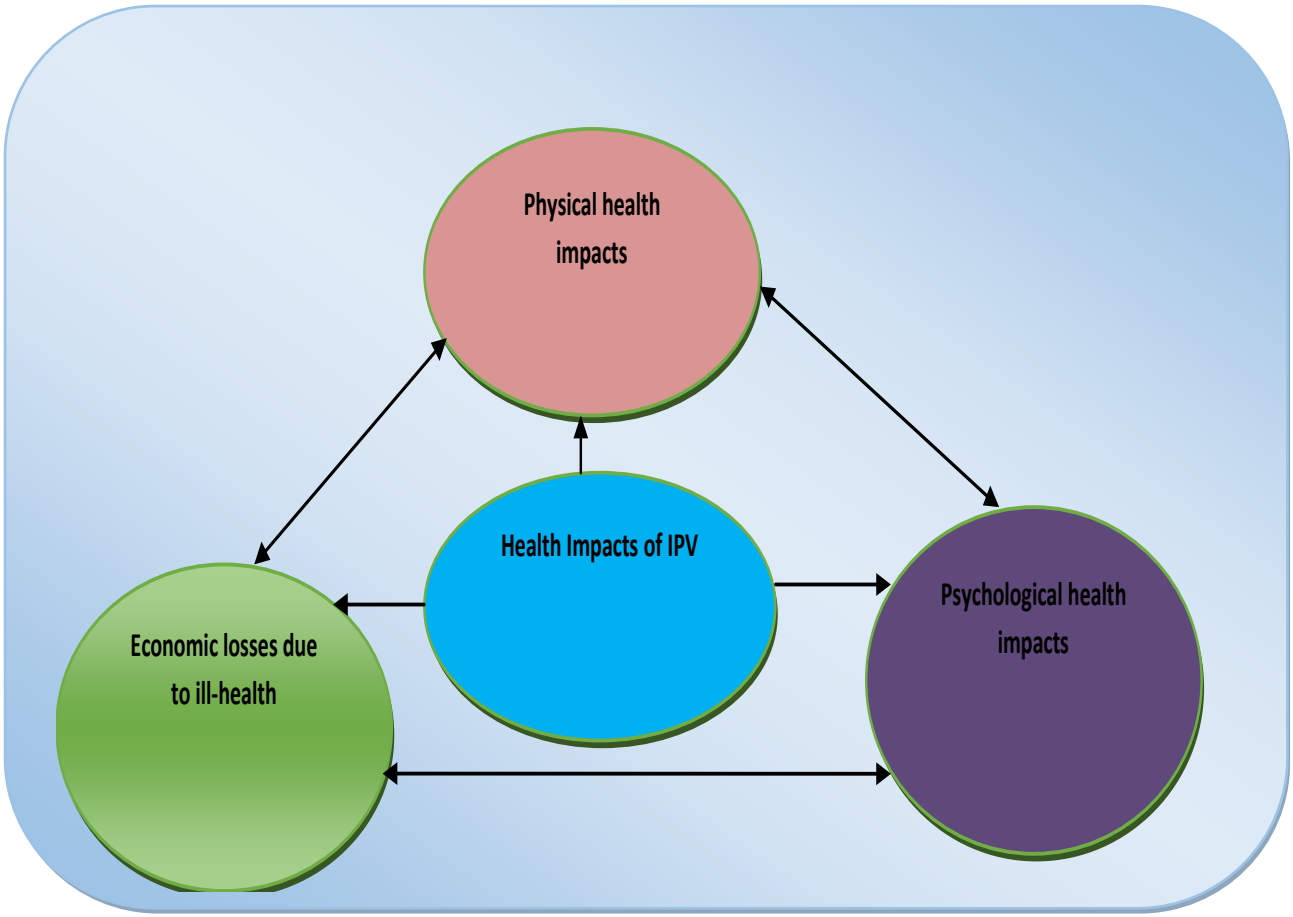

Figure 6.2 Health impacts of IPV

The study showed that a variety of health needs/complications resulted from the participants' IPV experiences. The participants identified the urgent need for care for STIs, including HIV/AIDS, chronic injuries and pain as well as psychosocial care. While HIV/AIDS and other STIs resulted mainly from sexual IPV, other health care needs resulted from a combination of sexual, economic, physical and psychological IPV. Most research has focused largely on associations between sexual IPV and STIs including HIV/AIDS and less on health needs resulting from other forms of IPV (Dunkle et al 2006:2111). Accordingly, this is one of the strengths of the current study. In Rakai and Kabale in Southwestern Uganda, women who had experienced IPV were found to have a higher incidence of HIV. At the same time, women who were on Anti-Retroviral Therapy were at increased risk of IPV (Osinde et al 2011:55; Kouyoumdjian et al 2013:1336). The findings also indicate that women face neglect and lack support to improve their nutrition and that of their HIV-infected children.

6.6 THE INTEGRATED ECOLOGICALLY NESTED MODEL REVISITED

6.6.1 Individual level factors

The study has shown that there are various individual characteristics that pre-dispose women in this context to IPV, including low education status, low socio-economic status, and lack of agency to disentangle themselves from the abusive relationships. Other studies have found significant relationship between socio-economic class, age, marital status and IPV (Cunradi, Caetano & Schafer 2002:378; Hindin, Kishor, Ansara 2008:xii; Fox & Benson 2006:420). While in this study there was no significant association between women's age and IPV, it was clear from the qualitative interviews that many of the women had gone into these abusive relationships at a young age. This may support the notion by Shamu et al (2011:8) that women's young age and being of a low socio-economic standing increases their vulnerability to IPV.

Interestingly, in the qualitative component of this study, the women attributed the men's young age, poverty and low economic levels as the causes of IPV in their accounts. This supports the theory that the lack of maturity and low socio-economic position of men increases their likelihood of perpetrating IPV. This is in agreement with findings by Shamu et al (2013:700) which indicated that having a male partner aged below 30 years was associated with physical and sexual violence. While other authors have found that 70% of women in Uganda condone IPV and believe that it is a man's role to discipline them if they do not match the expectations (Uthman, Lawoko & Moradi 2010:4; Ogland et al 2014:10). In the narratives the women in this study appeared to recognize that IPV was bad but simply lacked the agency to move on mainly due to economic reasons.

6.6.2 Household/family level factors

The study has revealed that the male partners' alcohol abuse, owning of weapons, and low socio-economic status, and the household poverty form the close system in which this violence occurs. The finding on the role of poverty in influencing IPV is supported in the literature by the Family Stress and Resource theory which posits that the availability and decision making regarding resources affects IPV (Fox & Benson, 2006:420; PATH 2002:3; Murthy et al 2010:12; Nanda et al 2014). It is evident in this study that most of the women are economically dependent on the men and thus faced a high risk of IPV

confirming this theory. The women also lack a support system to enable them to discuss the issues of IPV or explore options to escape IPV. There are no targeted interventions addressing IPV focusing on the male partners. Violence at the micro-system level as described in the qualitative narratives emanated from economic hardship leading to couple conflict over money for basic needs, allegations of infidelity, suspected infertility, the male partner's alcohol use with underlying poor communication between partners. Women's pursuit of financial independence and autonomy by getting jobs was met with resistance by some male partners who forbade the women to work. IPV was also linked to the male partners' stress as a result of the pressure to provide for the family particularly heightened with the birth of the first child. This study has shown that in this context IPV extends to violence against children where women narrated how their partners provoked them into arguments or fights by first exercising violence against children. Alternatively, the male partners first verbally and physically assaulted the women and then turned on the children. Addressing IPV will also help to address violence against children in the family setting.

6.6.3 Community level factors

While it appears that the communities are aware of the problem of IPV, there are hardly any interventions aimed at addressing this issue. The inability of community members to intervene aside from the times community members feel threatened by the perpetrators may reflect a culture of high violence where the way partners relate in an intimate relationship is considered a private issue (Heise 1998:275). This may show that IPV is still regarded as a personal or family issue. Therefore women are not in a position to seek support from the community. The role of key community, political and religious leaders in addressing IPV is not pronounced. This may be particularly worse in urban slums where neighbours are usually strangers compared to villages where families may be settled according to kinship with extended family. This may be particularly true in view of the fact that while another study found that living with the extended family unit was associated with domestic violence (Kaye et al 2006:99), in this study this did not emerge as an issue. In addition, one key finding of this study was that the women attributed their experiences of IPV to the low socio-economic standing of their male partners. Indeed, there is strong evidence linking IPV to the low socio-economic status of men (Heise 1998:273). This may be linked to a sense of hopelessness as a result of

stress and frustration due to failure to live up to cultural expectation of being breadwinners.

6.6.4 Macro level factors

The study has shown that implementation of the existing laws is a challenge and the participants feel that the legal and justice system has failed them due to corruption whereby male perpetrators are able to bribe the officials and for the women to access justice they are also required to pay bribes. In view of their low economic standing, this is often difficult. Women do not have access to information on IPV and support systems with limited agencies working on this area. The role of health workers was absently glaring and while some of the women interfaced with the health system the health workers did not play an active role in preventing nor responding to IPV beyond treating the health impacts. This may also reflect the social context where IPV may be considered a personal issue. Yet the health workers have an opportunity to screen for IPV and support survivors of IPV (WHO 2002a:131Bott, Guedes, Claramunt & Guezmes 2010:109; Murthy et al 2010:21). They can do this by linking the women to agencies that can also give legal and economic empowerment support.

In addition, the participants do not have confidence in the legal and justice system as they believe that there is impunity even when they report their experiences. This is similar to findings in other research (Payne and Wermeling, 2009:180). Easy access to alcohol spurs IPV and little is being done to regulate alcohol and substance abuse which has been found to be a strong risk factor for IPV. Evidence suggests that IPV can be prevented through the reduction of alcohol abuse and implementing interventions for problem drinkers (UNFPA 2010:35). On the whole, the lack of intervention at the macro-level by the necessary institutions reflects a cultural tolerance for IPV and the inferior position of women in the Ugandan society that in turn also influences factors operating at the ontogenic, microsystem and exosystem levels. There are suggestions that the deeply rooted patriarchal traditions, widespread discrimination against women and lack of comprehensive strategies in the country act as a serious impediment to addressing IPV (Olayanju et al 2013:110). The study has revealed the gender inequalities often rooted in socio-economic conditions of the society where women have a subservient role (Jones 2003:94; Dutton & Nicholls 2005:683; Gage & Hutchinson 2006:13; Clowes et al 2009: 22).

6.7 LIMITATIONS OF THE STUDY

The researcher identified the following limitations in the study:

- The study was restricted only to women aged 20-45 years living in Kabalagala urban slums in Kampala, Uganda and therefore may not be implied to characterise or mirror the circumstances and experiences of all women in the country. The researcher acquired deeper insight into and understanding of the occurrence of IPV and consequent health needs among the participants. The findings assisted the design of practical interventions to reduce IPV.
- The quantitative study was cross-sectional hence no causal inferences can be made. However, the qualitative interviews enabled the researcher to gain an insight into possible testable causes of IPV. The reported causes can now be tested quantitatively.
- The participants were purposively sampled based on their experience of IPV. Therefore, it may not be possible to generalise the findings to the entire population from which they were drawn.
- Intimate relationships, however, involve two individuals. The results of this study therefore only represent the participants' experiences and perceptions. The men's side was beyond the scope of this study. Furthermore, a comprehensive picture of IPV would ideally include all stakeholders including men, health workers, police, courts of law, local council officials, and religious leaders.

Chapter 7 concludes the study and makes recommendations for practice and further research.

CHAPTER 7

Conclusions and recommendations

7.1 CONCLUSIONS

Chapters 4, 5 and 6 presented the data analysis and interpretation and results, and the integration of the results. This chapter concludes the study, briefly presents its limitations, and makes recommendations. The researcher achieved the objectives as she was able to determine the nature and prevalence of IPV among the participants living in Kabalagala slums. Furthermore, the participants' experiences of IPV highlighted how this impacts on women's health.

The study results indicate a high prevalence of IPV and a gap in IPV interventions in the urban slums of Kabalagala. While the legal environment is considerably strong on paper, the reality is that in practice the laws are not enforced due to weaknesses or perceived weaknesses in the judicial system, particularly corruption. Women suffer from stress due to IPV and some of them have debilitating conditions due to IPV. The Participants understand the gravity and consequences of IPV but lack the agency and alternatives to escape from this due to their poverty. Heightened efforts to reduce IPV are needed and this can be done within families, communities and places of worship by addressing the very fabric in these institutions that condones patriarchy which is a dominant cause of IPV (Carter 2015:e41). The results call for a multi-sectoral response to IPV in which health workers and the judicial system are equipped to prevent and respond to IPV. Women also need to be empowered economically and socially to prevent IPV and a strong emphasis on interventions for working with men to reduce the risk of IPV is indicated.

7.1.1 Nature and prevalence of IPV among women living in Kabalagala slums in Kampala, Uganda

The first objective was to determine the nature and prevalence of IPV among women living in the Kabalagala slums in Kampala. This objective was met through the quantitative phase of the study, using a quantitative questionnaire with constructs

designed to assess the different types of IPV, namely psychological, physical, economic and sexual violence. The questionnaire was administered to 372 participants aged 20-45 years.

The study found that psychological violence was by far the most prevalent (99.7%), and economic, physical and sexual violence were also very high at 93%, 92% and 88%, respectively. The most common forms of physical violence were being pushed or grabbed (88%); slapping (87%); arm-twisting (84%); being slammed against the wall (81%); kicking (80%); choking (78%), and burning (74%). Logistic regression was used to determine the contribution of the socio-demographic factors with forms of IPV as the outcome variables. The participants aged 21 to 29 years were more exposed to violence than the other age groups; participants with no educational and occupation status were more exposed to IPV. Participants with an income <58,000 Uganda shillings (21 USD), in cohabiting relationships, were more exposed to IPV. For all the forms of IPV apart from psychological violence having an income of 58,000 to 100,000 Uganda shillings was associated with sexual, physical and economic violence. Business occupation was associated with physical and economic violence while being divorced was associated with sexual and economic violence. Having a university education was also associated with physical violence.

The majority of the participants' partners (85%) used alcohol or drugs and out of these 99% were reported to be verbally or physically abusive when drunk. Of the participants, 59% mentioned that their partners had weapons which they threatened to use when they were angry. In regard to IPV interventions, only 13% of the participants reported that they had someone with whom they discussed issues of violence, which would seem to indicate that this is a hidden or 'silent' problem and many of the participants suffer in silence without any help.

The study found a higher prevalence of IPV in the Kabalagala slums than the national rate of 59% (UDHS 2012:239) and this indicates the need to devise and introduce interventions in this context, both to prevent and to respond to this "silent" or hidden problem.

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interventions in this context, both to prevent and to respond to this “silent” or hidden problem.

7.1.2 Experiences of IPV among the participants living in Kabalagala slums in Kampala, Uganda

The second objective was to explore instances of IPV among the participants in order to deepen understanding of how IPV is experienced. This objective was achieved by the qualitative phase, which explored the participants’ lived realities and corroborated the quantitative findings. The qualitative interviews were guided by a grand tour question supported by the use of probes.

In exploring the participants’ experiences of IPV, the study found that they suffered physical, psychological, economic as well as sexual violence from their intimate partners. The participants suffered more than one form of violence with psychological violence emerging as a denominator. The different forms of violence are interconnected. For instance, psychological violence meant that the participants’ chances of physical violence were much higher.

The IPV had to be viewed in terms of the general patriarchal system, as well as the cultural beliefs and values about men and women into which they and their partners had been socialised. The violence is a mirror of the deprivation to which the patriarchal society subjected women and not necessarily of the perpetrators’ individual characteristics. Most of the men reportedly behaved the way they did to gain power and control over the women as culturally expected. However, it emerged strongly that there is a role reversal that is occurring contrary to the social norms whereby men are increasingly depending on women economically. The main causes of IPV were alcohol and/or drug abuse and inability to meet responsibility or the fear of responsibility.

The participants’ experiences of IPV point to the deep-seated patriarchal values in the Ugandan society and emphasise the serious need for genuine commitment to advancing gender equity and empowerment. The underlying low socio-economic status of women must be addressed.

7.1.3 How IPV experiences affect women's health needs

The third objective was to understand how IPV experiences affect women's health needs. This objective was met by the qualitative study in which the participants described the ways in IPV had affected their health.

The findings revealed that IPV affected the participants' physical and mental health. The participants described injuries, health complications including mutilation of body parts, and mental agony that they had endured. Their experience of IPV had left physical and emotional scars. While some of the physical scars had healed, the emotional ones were still evident.

IPV impacts on the well-being of women and affects their ability to live healthy and productive lives. There is a serious need for effective, proactive interventions aimed at preventing IPV as well as ensuring access to justice and safe spaces for survivors of IPV.

7.1.4 Practical interventions to reduce IPV

The fourth objective was to recommend practical interventions to reduce IPV. This was achieved by taking the participants' experiences and perceptions into consideration and integrating the quantitative and qualitative results. Based on the study findings an IPV prevention and response framework/theory of change for the implementation of IPV prevention programmes was developed.

The study found a high prevalence of IPV and highlight the need for concerted efforts to address this problem. The researcher proposes a multi-level intervention based on the rationale that many factors contribute to IPV. These factors were found at individual, family/household, community and macro levels. Accordingly, the researcher proposed an intervention with targets on individual, household/family, community and macro levels. This intervention was developed using the Integrated Ecologically Nested Model (Finkel & Eckhardt 2011:12). Figure 7.1 depicts the proposed IPV prevention and response framework.

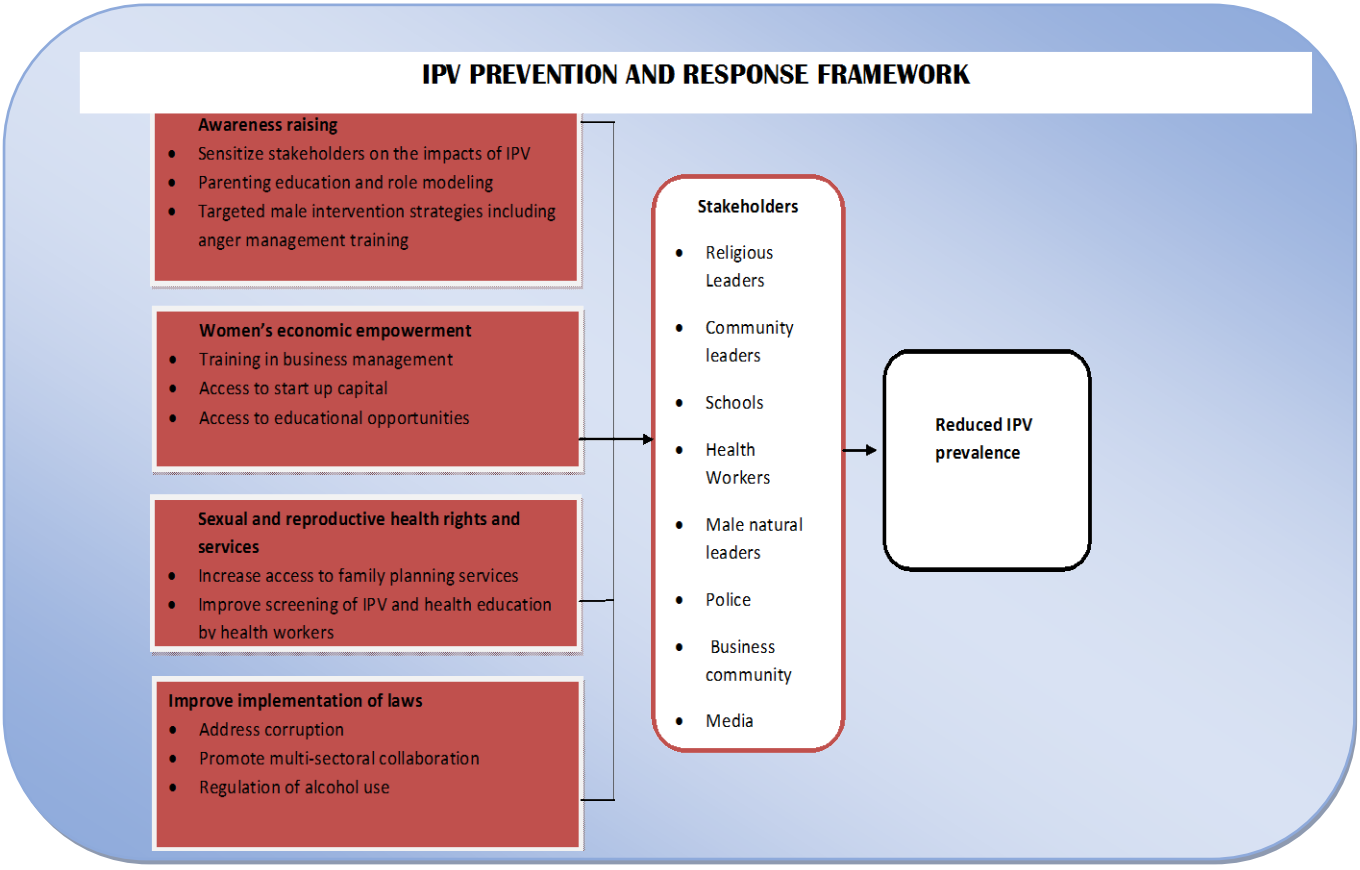

Figure 7.1 IPV prevention and response framework

7.2 RECOMMENDATIONS FOR PRACTICE AND FUTURE RESEARCH

Based on the findings, the researcher makes the following recommendations for practice and further research.

7.2.1 Recommendations against IPV

At individual level: The researcher proposes interventions that aim at increasing women's awareness of the available services for survivors of IPV. This could be the immediate intervention against IPV. When women' awareness is increased, they will be able to seek health, legal and psychosocial support when faced with IPV. This will also help to increase/create the demand for such services. In addition to awareness creation, the researcher proposes a medium-term intervention to IPV involving economic empowerment at an individual level. Economic empowerment reduces women's vulnerability and increases their economic independence and power. Economic

empowerment is critical in reducing IPV because it increases women's agency and independence to sustain their lives and those of their children. Some women are stuck with abusive partners because of lack of options caused by economic dependence. This empowerment could take the form of training in business management, increasing women's access to start-up capital, and easing their access to credit.

Training in business management could be combined with encouraging the women to join self-help groups and credit-saving groups to work together for saving future capital. The long term intervention against IPV at an individual level would be capacity building. This could be achieved by discouraging girls from dropping out of school, giving them access to scholastic materials and tuition, and offering career guidance. Overall, the emphasis at individual level must on increasing women's access to resources including education and economic empowerment to reduce their dependency on men. In addition, they need to have access to sexual and reproductive health resources including family planning information and methods so that they can make decisions about their sexual and reproductive rights.

At the household/family level: The researcher proposes a short-term intervention aimed at increasing awareness at the family level. In addition, to increasing awareness about the dangers of IPV to women, the perpetrators and the family members should be aware of the dangers to health as well as where to seek help. In the medium term, the researcher proposes an intervention aimed at improving the welfare of the families at large and in particular families affected by IPV. This would involve capacity building in business management, easing access to credit, trust building, and joining self-help groups as well as capital-saving groups. The targets for this economic empowerment would be the intimate partners. The long-term intervention at family level would be the dependants of the intimate partners. The children should be encouraged to stay longer in school for higher skills acquisition. The partners should be encouraged to keep their children in school and informed about the importance of education. The partners should also be encouraged to adopt parenting styles that do not promote IPV. Generally, at the family level there is need for increased social support by family members. Interventions at this level also need to target the men so that the climate is conducive for living in harmony. This can be achieved by targeted messages in male-dominated places of work or leisure and community dialogues on IPV.

At the community level: The researcher proposes an intervention aimed at creating awareness about the existence of IPV and its dangers. This should include sensitising men and women about the impact and consequences of IPV in various health promotion settings, including communities, schools, health facilities and places of worship. Key opinion leaders such as community, political, sports and religious leaders should be engaged in advocating against IPV and break the silence on IPV. At this level, the media should also be involved in promoting awareness about IPV. Mass media and social marketing campaigns are needed to effect behaviour change and to help community members in understanding their roles in preventing and responding to IPV. Strategies need to target community and religious leaders as well as male natural leaders and role models.

At the macro level: The researcher proposes several interventions that involve activating and advocating full implementation of the existing laws. The targets of this intervention would the judicial system including the police, prisons, courts of law, and local council chair persons. The participants stated that the legal system in Uganda failed women from accessing justice, especially through their minor charges as well as corruption. The participants recommended that government should show commitment to their protection by strengthening the systems through empowering them financially and by informing them on how to manage cases of IPV. This is both preventive and reactive and will have a positive impact on reducing IPV. The participants continue to experience IPV because they know that they have nowhere to report or seek redress. In addition, Parliament should be lobbied for strengthening the existing laws and developing policies and legislation on regulating alcohol and substance abuse by introducing time limits sales of alcohol and time frames for accessing alcohol. There is need to enforce existing laws and implement relevant policies by investing financial resources needed to do this effectively.

In addition, at the macro level, more synergy is needed between sectors so that all actors rally behind a common plan to achieve better results. All healthcare workers and those in the criminal justice sector, including the police, should be trained in IPV prevention and response and referral pathways should be defined and made known to all. Accurate records should be maintained by all involved on the number of women who report instances of IPV and the follow-up actions taken to assist them. The researcher proposes lobbying the government to improve service delivery generally in terms of

health and social support including support groups and shelters that provide accessible safe spaces for women survivors of IPV. Integration of IPV prevention and response in health services package is crucial. There is a need to work with the health workers to enable them to identify and provide the necessary support to IPV survivors. The participants stated that they approached health workers to treat the injuries sustained through IPV. Health workers should be trained to professionally ask and identify women who need further support by integrating this in the health services package offered.

7.2.2 Future research

Further research should be done on the following topics:

- An investigation into experiences of intimate partner violence and health needs of women in urban and rural areas of Uganda
- An investigation into the role reversal and relationship dynamics of providing families among men in urban slums
- Perceptions of intimate partner violence of nurses, social workers and welfare agencies
- The role of the community, health workers, police, schools, local council officials, and religious leaders in reducing intimate partner violence
- The role of cultural socialisation and taboos in intimate partner violence
- An examination of effective, feasible, affordable and accessible interventions against IPV

7.3 CONTRIBUTIONS OF THE STUDY

IPV is increasingly recognised as one of the major drivers of the HIV epidemic as a result of forced sex and the inability of women to negotiate safe sex, among other factors (Kouyoumdjian et al 2013:1335). The study covered other health consequences and socio-economic impacts. In order to reduce these and alleviate the burden of IPV, interventions need to be targeted at some of fundamental issues. Ogland et al (2014:11) maintain that feminist qualitative research is important for increasing understanding the nuanced IPV experiences of women from Africa that are often difficult to comprehend using standardised quantitative measures. The study's findings have deepened

awareness on the prevalence of IPV among urban poor women. In addition, the nature and diverse qualitative experiences of the manifestation of IPV have increased understanding and consciousness about the processes and possible causes of IPV and the factors that facilitate or hinder women's agency in responding appropriately to IPV. The study explored the participants' own perspectives on potential interventions to address IPV thus lending credibility to the proposed strategies. The researcher defined a framework for intervention in view of the context of urban slums. Based on the findings, the researcher proposed an IPV prevention and response framework that can be operationalised across the different sectors in the country and similar settings.

Overall, the Integrated Ecologically Nested Model has provided a sound guiding framework in answering the research questions; contributed to the understanding of IPV in the study context, and guided the development of interventions. The study was informed by the family stress and resource theory; feminist theory, and the social learning theory. The family stress and resource theory posits that IPV is a product of poverty-related stress (Fox & Benson 2006:420; PATH 2002:3; Murthy et al 2010:12; Nanda et al 2014) which deepened insight into the occurrences of IPV and how poverty-related stress contributes to this in this context. The feminist theory illuminated understanding of IPV as a product of patriarchal male dominance which puts women in a position of vulnerability to IPV (Gage & Hutchinson 2006:13). The social learning theory, which posits that situational influences such as drug and alcohol abuse and poverty influence behaviour, also had a bearing on IPV (Sana 2001:1). The findings indicate that these theories are inter-twined and no single theory can explain IPV.

Thus, the researcher is of the opinion that this study has contributed to the African and global body of knowledge on IPV by bringing to the fore an issue that is always in the background of development and inter-sectoral debate. The ability to tackle and reduce this problem would help to achieve gender equity and improve health outcomes for women and children nationally, regionally and internationally.

The study determined the prevalence of IPV among women aged 20-45 years in two urban slums in Kampala, Uganda and found a high prevalence of psychological, economic, physical and sexual violence. The participants described their experiences of IPV including physical violence, psychological pain, economic deprivation, and marital rape both in private and in public. IPV had a severe impact on their health, such as

physical and mental pain, backache, headaches, high blood pressure, stress and economic loss due to time lost from work as a consequence of IPV. The participants maintained that the current legal and justice systems did not make justice accessible and they felt trapped due to lack of economic means. Many participants indicated that access to economic empowerment programmes would help them to be less susceptible to IPV and emphasised poverty as a key contributing factor to their experiences of IPV. Based on the findings and the integrated ecologically nested model, the researcher proposed a framework to address IPV at all operational levels. The interventions at the different levels need to be implemented simultaneously and intensively for maximum effectiveness.

LIST OF REFERENCES

Abramsky, T, Devries, K, Kiss, L, Francisco, L, Nakuti, J, Musuya, T, Kyegombe, N, Starmann, E, Kaye, D, Michau, L & Watts, C. 2012. A community mobilisation intervention to prevent violence against women and reduce HIV/AIDS risk in Kampala, Uganda (the SASA! Study): study protocol for a cluster randomised controlled trial. *Trials* 13:96. doi: 10.1186/1745-6215-13-96. Pages 1-22. Available from: http://www.trialsjournal.com/content/pdf/1745-6215-13-96.pdf (accessed 23 April 2015).

Abramsky, T, Watts, CH, Garcia-Moreno, C, Devries, K, Kiss, L, Ellsberg, M, Jansen, HAFM & Heise, L. 2011. What factors are associated with recent intimate partner violence? Findings from the WHO multi-country study on women's health and domestic violence. *BMC Public Health* 11:109 doi:10.1186/1471-2458-11-109. Pages 1-17. Available from: http://www.biomedcentral.com/content/pdf/1471-2458-11-109.pdf (accessed 12 June 2015).

Ackerson, L, Kawachi, I, Barbeau, E & Subramanian, S. 2008. Effects of individual and proximate educational context on intimate partner violence: A population-based study of women in India. *American Journal of Public Health* 98(3):507–514.

ActionAid. 2015. The Marriage and Divorce Bill coalition minimum position. http://www.actionaid.org/uganda/2015/05/marriage-and-divorce-bill-coalition-minimum-position [Accessed 14 March 2016]

Akers RL. 2011. Social Learning and Social Structure: A General Theory of Crime and Deviance. New Brunswick, NJ: Transaction Publishers. 469 pages.

Ali, TS & Gavino, MI. 2007. Prevalence of and reasons for domestic violence among women from low socio-economic communities of Karachi. *Eastern Mediterranean Health Journal* (6):1417-1426.

Allsworth, JE, Anand, M, Redding, CA, & Peipert, JF. 2009. Physical and Sexual Violence and Incident Sexually Transmitted Infections. *Journal of Women's Health*, *18*(4), 529–534.

Archer, J. 2002. Sex differences in physically aggressive acts between heterosexual partners: a meta-analytic review. *Aggression and Violent Behavior* 7(4):313-351.

Babbie, E. 2007. The practice of social research. 11th edition. Belmont: Wadsworth.

Babbie, E. 2005. *The basics of social research.* 3rd edition. Toronto: Wadsworth.

Babbie, ER & Mouton, J. 2001. *The practice of social research.* Cape Town: Oxford University Press.

Bacchus, L, Mezey, G & Bewley, S. 2006. A qualitative exploration of the nature of domestic violence in pregnancy. *Violence Against Women* 12:588–604.

Bailey, PH. 1997. Finding your way around qualitative methods in nursing research. *Journal of Advanced Nursing* 25:18-22.

Bank of Uganda. 2014. *Foreign exchange rates*. Available from: https://www.bou.or.ug/bou/collateral/interbank_forms/2014/Nov/Major_10Nov14.html (accessed 14 November 2014).

Belsky, J. 1980. Child maltreatment: an ecological integration*. American Psychologist* 35(4):320-335.

Berhe, N, Tegabu, D, & Alemayehu, M. 2013. Effect of nutritional factors on adherence to antiretroviral therapy among HIV-infected adults: a case control study in Northern Ethiopia. BMC Infectious Diseases, 13, 233:1-9

Beyeza-Kashesya, J, Neema, S, Ekstrom, AM, Kaharuza, F, Mirembe, F & Kulane, A. 2010. “Not a Boy, Not a Child”: A Qualitative Study on Young People’s Views on Childbearing in Uganda. African Journal of Reproductive Health Mar 2010; 14(1): 71-82

Bornman, E., Van Eeden, R. & Wentzel, M. (Eds.). 1998. *Violence in South Africa: A variety of perspectives*. Pretoria: Human Sciences Research Council.

Bott, S, Guedes, A, Claramunt, MC & Guezmes, A. 2010. *Improving the health sector response to gender-based violence: a resource manual for health care professionals in developing countries.* Western Hemisphere Region: IPPF.
Available from:
http://www.ippfwhr.org/sites/default/files/GBV_cdbookletANDmanual_FA_FINAL.pdf
(accessed 10 March 2014).

Braun, V & Clarke, V. 2006. Using thematic analysis in psychology. *Qualitative Research in Psychology* 3:77-101

Brink, P & Wood, M. 2001. *Basic steps in planning nursing research: from question to proposal*. 5th edition. London: Jones & Bartlett.

Burns, N & Grove, SK. 2005. *The practice of nursing research: conduct, critique and utilization.* 5th edition. St Louis: Elsevier.

Campbell, T & Campbell, A. 2007. Emerging disease burdens and the poor in cities of the developing world. *Journal of Urban Health* 84(Suppl 3):54-64.

Campbell, JC. 2002. Health consequences of intimate partner violence. Violence Against Women II. *Lancet* 359:1331-1336.

Carl, EK. 1999. *Violence in our lives: impact on workplace, home and community*. London: Allyn and Bacon.

Carter, J. 2015. Patriarchy and violence against women and girls. *Lancet* 385:e40-41.

Casselman, M. 2008, 2012. The New Backwardness. Excerpt from *TALKING THE WALK: the grassroots language of feminism.* Chapter 6, pp. 71-74. Available from: http://www.freebornproject.com/FPTexts/newbackwardness.pdf (accessed 13 July 2015).

Clark, S, Bruce, J and Dude, A. Protecting Young Women from HIV/AIDS: The Case Against Child and Adolescent Marriage. International Family Planning Perspectives Volume 32, Number 2, June 2006. Pg 79-88.

Clowes, L, Shefer, T, Fouten, E, Vergnani, T, Jacobs, J. 2009. “Coercive sexual practices and gender-based violence on a university campus.” *Agenda* 80:22-32.

Coltrane, CR. 2001. *Sociology of marriage: Gender, love and property*. London: Sage.

Conroy, AA. 2014. Marital infidelity and intimate partner violence in rural Malawi: a dyadic investigation. *Archives of Sex Behavior* 43(7):1303-1314.

Creswell, JW. 2013. *Research design: Qualitative, quantitative, and mixed methods approaches*. 4th edition. London: Sage.

Creswell, JW. 2007. Research design: Qualitative and Quantitative approach. 2nd edition. London: Sage.

Cunradi, C, Caetano, R & Schafer, J. 2002. Socioeconomic predictors of intimate partner violence among White, Black, and Hispanic couples in the United States. *Journal of Family Violence* 17:377-389.

de Pee S & Semba RD. 2010. Role of nutrition in HIV infection: review of evidence for more effective programming in resource-limited settings. Food Nutr Bull. 2010 Dec;31(4 Suppl):S313-44.

De Vaus, D. 2001. *Research Design in Social Research*. London: Sage.

De Vos, AS, Strydom, H, Fouche, CB & Delport, CSL. 2001. *Research at grass roots: a primer for the caring professions*. Pretoria: Van Schaik.

Douglas, G. 2004. *An Introduction to Family Law.* 2nd edition. United States. Oxford University Press Inc. New York

Drew, CJ, Hardman, ML & Hart, AW. 1996. *Designing and conducting research. inquiry in education and social science.* London: Allyn and Bacon

Dries, AW & Rowthorn, R. 2002. *The law and economics of marriage and divorce.* Cambridge University Press.

Driscoll, DL, Appiah-Yeboah, A, Salib, P & Rupert, DJ. 2007. Merging qualitative and quantitative data in mixed methods research: How to and why not. *Ecological and Environmental Anthropology* 3(1):18-28.

Du Prel, JB, Hommel, G, Röhrig, B & Blettner, M. 2009. Confidence Interval or P-value? Part 4 of a Series on Evaluation of Scientific Publications. Deutsches Ärzteblatt International 2009; 106(19):335-339.

Dunbar, NE, & Burgoon, JK. 2005. Perceptions of power and interactional dominance in interpersonal relationships. Journal of Social and Personal Relationships, 22(2), 207-233.

Dunkle, KL, Jewkes, RK, Nduna, M, Levin, J, Jama, N, Khuzwayo, N, Koss, MP & Duvvury, N. 2006. "Perpetration of partner violence and HIV risk behaviour among young men in the rural Eastern Cape, South Africa." *AIDS* 20(16):2107-2114.

Dutton, DG, and Nicholls, TL. 2005. "The gender paradigm in domestic violence research and theory: Part 1—The conflict of theory and data." *Aggression and Violent Behavior* 10 (6):680-714.

Ellis, D, Stuckless, N and Smith, C. 2015. Marital Separation and Lethal Domestic Violence. Routledge Publisher. 236 pages.

Ellsberg, M, Arango, DJ, Morton, M, Gennari, F, Kiplesund, S, Contreras, M & Watts, C. 2015. Prevention of violence against women and girls: what does the evidence say? *Lancet* 385:1555-1566.

Ellsberg, M. 2006. Violence against women and the Millennium Development Goals: Facilitating women's access to support. *International Journal of Gynecology and Obstetrics* 94(3):325-332.

Erlich, HS. 2003. Experience: what is it? *The International Journal of Psychoanalysis* 84:1125-1147.

Erulkar, A. 2013. Early Marriage, Marital Relations and Intimate Partner Violence in Ethiopia. International Perspectives on Sexual and Reproductive Health, 2013, 39(1):6–13

Fawcett, B, Featherstone, B, Hearn, J & Toft, C. 1996. *Violence and gender relations: theories and interventions*. London: Sage.

Family Health International. 2005. *Qualitative research methods: a data collector's field guide.* Research triangle Park, North Carolina USA: Family Health International.

Finkel, EJ & Eckhardt, CI. 2011. Intimate partner violence. In *The Oxford handbook of close relationships*, edited by JA Simpson and L Campbell. New York: OUP.

Fox, GL & Benson, ML. 2006. Household and neighborhood contexts of intimate partner violence. *Public Health Reports*/July-August 121:419-427.

Frankfort-Nachmias, CF & Leon-Guerrero A. 2011. *Social statistics for a diverse society*. 6th edition. London: Sage.

Fulu, E & Miedema, S. Violence Against Women: Globalizing the Integrated Ecological Model. *Violence Against Women July 26, 2015 1077801215596244* pp. 1–25. Available from: http://vaw.sagepub.com/content/early/2015/07/25/1077801215596244.full.pdf+html (accessed 7 August 2015).

Gage, AJ & Hutchinson, PL. 2006. Power, control, and intimate partner sexual violence in Haiti. *Archives of Sexual Behavior* 35(1):11-24.

Gage, AJ. 2005. Women's experience of intimate partner violence in Haiti. *Social Science and Medicine* 61:343-364.

Garcia-Moreno, C, Hegarty, K, d'Oliveira, AFL, Koziol-McLain, J, Colombini, M & Feder, G. 2015a. The health-system's response to violence against women. *Lancet* 385:1567-1579.

Garcia-Moreno, C, Zimmerman, C, Morris-Gehring, A, Heise, L, Amin, A, Naeemah Abrahams, N, Montoya, O, Bhate-Deosthali, P, Kilonzo, N & Watts, C. 2015b. Addressing violence against women: a call to action. *Lancet* 385:1685-1695.

Garcia-Moreno, C & Watts, C. 2011. Violence against women: an urgent public health priority. Editorial. *Bulletin of the World Health Organization* 89(1):1-2.

Garcia-Moreno, C. 2002. Dilemmas and opportunities for an appropriate health-service response to violence against women. Violence against women IV. *Lancet* 2002; 359:1509-1514.

Gifford, S. 1998. Unit 86 – Analysis of non-numeric research. In *Handbook of public health methods,* edited by C Kerr, R Taylor and G Heard. Sydney: McGraw Hill:543-554.

Glanz, K, Rimer, BK & Lewis, FM. 2002. *Health behavior and health education: theory, research and practice*. 3rd edition. San Francisco: Jossey-Bass.

Godiva, A.M. 2015. How long shall we wait? An analysis of the Marriage and Divorce Bill 2009. Pg 1-12. http://parliamentwatch.ug/how-long-shall-we-wait-an-analysis-of-the-marriage-and-divorce-bill-2009/ [Accessed 14 March 2016]

Government of Uganda. 2008. National Action Plan for Women. Ministry of Gender, Labour and Social Development.

Gray, DE. 2011*. Doing research in the real world.* London: Sage.

Green, C, Mukuria, A and Rubin, D. 2009. Addressing Early Marriage in Uganda. Washington, DC: Futures Group, Health Policy Initiative, Task Order 1. Pg 1-31.

Green, J & Thorogood, N. 2009. *Qualitative methods for health research*. 2nd edition. London: Sage.

Greiff, S. 2010. *No justice in justifications: Violence against women in the name of culture, religion, and tradition*. The Global Campaign to Stop Killing and Stoning Women and Women Living Under Muslim Laws. Edited by Rochelle Terman.

Gul, A, Zeb, L & Faiz, NR. 2013. Frequency of different types of domestic violence in antenatal patients. *Journal of Postgraduate Medical Institute* 27(3):331-335.

Guruge, S, Bender, A, Aga, F, Hyman, I, Tamiru, M, Hailemariam, D, Kassa, A & Refaie-Shirpak, K. 2012. Towards a global interdisciplinary evidence-informed practice: intimate partner violence in the Ethiopian context. International Scholarly Research Network Nursing. Pp 1-8

Hague, G, Mullender, A & Aris, R. 2003. *Is anyone listening? Accountability and women survivors of domestic violence.* London: Routledge.

Hardon, A, Boonmongkon, P, Streefland, P & Tan, ML. 2001. *Applied Health Research Manual: Anthropology of Health and Health Car*e. 3rd edition. Amsterdan: Het Spinhuis

Harwin, N, Hague, G & Malos, E. 1999. *The multi-agency approach to domestic violence: new opportunities, old challenges?* London: Whitting and Birch.

Heise, LL. 1998. Violence against women: an integrated, ecological framework. *Violence Against Women* 4:262-290.

Herbert, PC. 1983. *Wife battering*. Canada: College of Physicians of Canada; 1983:2204-2208.

Hester, M, Westmarland, N, Gangoli, G, Wilkinson, M, O'Kelly, C, Kent, A. and Diamond, A. 2006. Domestic Violence Perpetrators: Identifying Needs to Inform Early Intervention, Bristol: University of Bristol in association with the Northern Rock Foundation and the Home Office. Pg 1-17.

Hindin, MJ, Kishor, S and Ansara, DL. 2008. *Intimate partner violence among couples in 10 DHS countries: Predictors and health outcomes:* Macro International Incorporated.

Holosko, MJ. 2001. An overview of qualitative methods. In *Handbook of social work research methods*, edited by B Thyer. Thousand Oaks, CA: Sage:263-273.

Horn, R, Puffer, ES, Roesch, E & Lehmann, H. (2014). Women's perceptions of effects of war on intimate partner violence and gender roles in two post-conflict West African Countries: consequences and unexpected opportunities. *Conflict and Health*, *8*, 12:1-13.

Howard, R. 2015. Personality disorders and violence: what is the link? *Borderline Personality Disorder and Emotion Dysregulation*, *2*, 12:1-11

Humaira, N. 2011. *Violence Against Women*. *The Dialogue* 4(3):290-299.

Human Rights Watch. 2003. Uganda: Just Die Quietly: Domestic Violence and Women's Vulnerability to HIV in Uganda. 77 pages

ICRW. 2009. Intimate Partner Violence: High Costs to Households and Communities. Kampala: ICRW. pp 1-17

Interagency Gender Working Group (IGWG) of USAID. 2008. *Addressing gender-based violence through USAID's health programs: A guide for health sector program officers.* 2nd edition. Washington, DC: IGWG of USAID. Available form: http://www.igwg.org/igwg_media/GBVGuide08_English.pdf (accessed 28 April 2013).

Jewkes, R, Flood, M & Lang, J. From work with men and boys to changes of social norms and reduction of inequities in gender relations: a conceptual shift in prevention of violence against women and girls. *Lancet* 2015; 385:1580-1589.

Jewkes, R, Sikweyiya, Y, Morrell, R & Dunkle, K. 2009. "Understanding men's health and use of violence: interface of rape and HIV in South Africa." *Cell* 82 (442):3655.

Jewkes, R. 2002 Intimate partner violence: causes and prevention. *Lancet* 359(9315):1423-1429.

John, I, Lawoko, S, & Oluwatosin, A. 2011. Acceptance of screening for intimate partner violence, actual screening and satisfaction with care amongst female clients visiting a health facility in Kano, Nigeria. *Journal of Family Violence* 26(2):109-116.

Johnson, RB, Onwuegbuzie, AJ & Turner, LA. 2007. "Toward a Definition of Mixed Methods Research." *Journal of Mixed Methods Research* 1(2):112-133.

Jones, N, Vargas, R & Villar, E. 2008. Cash transfers to tackle childhood poverty and vulnerability: an analysis of Peru's Juntos programme. *Environment & Urbanization*. 20(1):255-273

Jones, P. 2003. Feminist Theories. In Introducing Social Theories. Polity Press. Cambridge. 224 pages

Joyner, K & Mash, R. 2012. Recognizing Intimate Partner Violence in Primary Care: Western Cape, South Africa. *PLoS ONE* 7(1):1-5.

Joyner, K & Mash, RJ. 2011. The value of intervening for intimate partner violence in South African primary care: project evaluation. British Medical Journal Open 2011:1-11.

Karamagi, CAS, Tumwine, JK, Tylleskar, T & Heggenhougen, K. 2006. Intimate partner violence against women in eastern Uganda: implications for HIV prevention. *BMC Public Health* 6:284. Pages 1-12.

Kaye, DK, Mirembe, FM, Bantebya, G, Johansson, A & Ekstrom, AM. 2006. Domestic violence as a risk factor for unwanted pregnancy and induced abortion in Mulago Hospital, Kampala, Uganda. *Tropical Medicine and International Health* 11(1):90-101.

Kendall-Tacket, KA. 2004. *Health consequences of abuse in the family: a criminal guide for evidence-based practice*. London: Sage.

Kettles, AM, Creswell, JW & Zhang, W. 2011. Mixed methods research in mental health nursing. *Journal of Psychiatric and Mental Health Nursing* 18(6):535-542.

Kirkpatrick, P & Van Teijlingen E. 2009. Lost in translation: reflecting on a model to reduce translation and interpretation bias. *The Open Nursing Journal* 3(8):25-32. Available from: http://www.bentham.org/open/tonursj/openaccess2.htm (accessed 10 October 2013).

Kitson, AL, Rycroft-Malone, J, Harvey, G, McCormack, B, Seers, K, & Titchen, A. 2008. Evaluating the successful implementation of evidence into practice using the PARiHS framework: theoretical and practical challenges. *Implementation Science : IS*, *3*, 1:1-12.

Kitson, AL, Rycroft-Malone, J, Harvey, G, McCormack, B, Seers, K, Koenig, MA, Lutalo, T, Zhao, F, Nalugoda, F, Wabwire-Mangen, F, & Kiwanuka, N. 2003. Domestic violence in rural Uganda: evidence from a community-based study. *Bulletin of the World Health Organization* 81:53-60.

Koski, AD, Stephenson, R & Koenig, MR. 2011. Physical violence by partner during pregnancy and use of prenatal care in rural India. *Journal of Health, Population, and Nutrition* 29:245-254.

Kouyoumdjian, FG, Calzavara, LM, Bondy, SJ, O'Campo, P, Serwadda, D, Nalugoda, F, Kagaayi, J, Kigozi, G, Wawer, M & Gray, R. 2013. Intimate partner violence is associated with incident HIV infection in women in Uganda. *AIDS* 27(8):1331-1338.

Larok, A. 2013. The Marriage and Divorce Bill: Looking Beyond a 'Contaminated' Discourse to a Larger Failure of Leadership and Government. Paper presented at a Dialogue organised by the School of Women and Gender Studies at Makerere University. Available from: http://uwonet.or.ug/2013/05/02/the-marriage-and-divorce-bill-looking-beyond-a-contaminated-discourse-to-a-larger-failure-of-leadership-and-government/ [Accessed 14 March 2016].

Leech, NL, Onwuegbuzie, AJ & Combs, JP. 2011. Writing publishable mixed research articles: guidelines for emerging scholars in the health sciences and beyond. *International Journal of Multiple Research Approaches* 5(1):7-24.

Leedy, PD & Ormrod, JE. 2005. Practical research: Planning and design. 8th edition. New Jersey: Merrill Prentice Hall.

Liebling-Kalifani, H, Ojiambo-Ochieng, R, Marshall, A, Juliet Were-Oguttu, J, Musisi, S & Kinyanda, E. 2008.Violence against women in Northern Uganda: The neglected health consequences of war. *Journal of International Women's Studies* 9(3):175-192.

Lincoln, YS & Guba, EG. 1985. Naturalistic inquiry. Newbury Park, CA: Sage.

LoBiondo-Wood, G & Haber, J. 2002. *Nursing research: methods, critical appraisal and utilization*. 5th edition. St Louis: Mosby.

Loseke, DR, Gilles, RJ & Cavanaugh, MM (eds). 2005. *Current controversies in family violence.* Thousand Oaks, CA: Sage.

Ludin, H & Vetten, L. 2005. *Spiral of entrapment: abused women in conflict with the law.* Johannesburg: Jacana Media.

Madanda, A, Ngolobe, B & Amuriat, GZ. 2009. *Uganda: Violence against women and information and communication technologies.* Kampala: Association for Progressive Communications (APC).

Mason, S, Wright, R, Hibert, EDS, Forman, J & Rich-Edwards, J. (2012). Intimate partner violence and incidence of hypertension in women. Annals of Epidemiology, 22(8), 562–567.

Mason, M. 2010. *Sample size and saturation in PhD studies using qualitative interviews [63 paragraphs*]. Forum Qualitative Sozialforschun /Forum: Qualitative Social Research, 11(3):Art. 8 Available from: http://nbn-resolving.de/urn:nbn:de:0114-fqs100387 (accessed 15 June 2013).

Martinez, P, Roislien, J, Naidoo, N & Clausen, T. 2011. Alcohol abstinence and drinking among African women: data from the World Health Surveys. *BMC Public Health* 11:160.

McCloskey, LA, Williams, C & Larsen, U. 2005. Gender inequality and intimate partner violence among women in Moshi, Tanzania. *International Family Planning Perspectives* 31(3):124-130.

Michau, L, Horn, J, Bank, A, Dutt, M & Zimmerman, C. 2015. Prevention of violence against women and girls: Lessons from practice. *Lancet* 385:1672-1684

Miles, MB & Huberman, MA. 1994. *An expanded source book: qualitative data analysis*. 2nd edition. New York: Sage.

Ministry of Gender, Labour and Social Development. 1997. The Uganda Gender Policy:1-35.

Mitra, N. 2011. *Domestic violence research: expanding understandings but limited perspective.* Feminist review conference proceedings 2011 (e62–e78). Feminist Review. Available from: www.feminist-review.com (accessed 20 February 2014).

Mooney, J. 2000. *Gender, violence and the social order*. London: Macmillan Press.

Murthy, P, Upadhyay, U & Nwadinobi, E. 2010. Violence against women and girls: A silent global pandemic. Chapter 2. In *Women's global health rights,* edited by P Murthy and LC Smith. Massachusetts: Jones and Bartlett.

Nanda, P, Gautam, A, Verma, R, Khanna, A, Khan, N, Brahme, D, Boyle, S & Kumar, S. 2014. *Study on masculinity, intimate partner violence and son preference in India*. New Delhi: International Center for Research on Women.

Neuman, WL. 2006. *Social research methods: qualitative and quantitative approaches*. 6th edition. Boston: Pearson Education.

Nnadi, I. 2012. An insight into violence against women in Nigeria: a critique. *Journal of Politics and Law* 5(3):48-56.

Ogland, EG, Xu, X, Bartkowski, JP & Ogland, CP. 2014. Intimate partner violence against married women in Uganda. *Journal of Family Violence*:1-11.

Olayanju, L, Naguib, RNG, Nguyen, QT, Nguyen, Bali, RK and Vung, ND. 2013. Combating intimate partner violence in Africa: Opportunities and challenges in five African countries. *Aggression and Violent Behavior* 18(1):101-112.

O'Leary, DK & Maiuro, RD. 2000. *Psychological abuse in violent domestic relations*. New York: Springer.

Osinde, MO, Kaye, DK & Kakaire, O. 2011. Intimate partner violence among women with HIV infection in rural Uganda: critical implications for policy and practice. *BMC Women's Health* 11:50.

Otiso, KM. 2006. Culture and Customs of Uganda. Greenwood Publishing Group. 193 pages

Parliament of Uganda. 2015. Parliament Outlaws Homosexuality. Committee on Legal and Parliamentary Affairs. Available from: http://www.parliament.go.ug/new/index.php/about-parliament/parliamentary-news/326-parliament-outlaws-homosexuality [Accessed 14 March 2016].

Park, YF, Fedler, J & Dangor, Z. 2000. *Reclaiming women's spaces: new perspectives on violence against women and sheltering in South Africa*. Johannesburg: Nisaa Institute for Women's Development.

PATH. 2002. Violence against women: Effects on reproductive health. *Outlook* 20(1):1-8.

Payne D and Wermeling, L. (2009). Domestic Violence and the Female Victim: The Real Reason Women Stay! Journal of Multicultural, Gender and Minority Studies. Volume 3, Issue 1, 2009:178-185.

Peltzer, K & Pengpid, S. 2013. The severity of violence against women by intimate partners and associations with perpetrator alcohol and drug use in the Vhembe district, South Africa. *African Safety Promotion Journal* 11(1):13-24.

Pitpitan, E, Kalichman, S, Eaton, L, Cain, D, Sikkema, K, Skinner, D & Pieterse, D. 2013. Gender-based violence, alcohol use, and sexual risk among female patrons of drinking venues in Cape Town, South Africa. *Journal of Behavioral Medicine* 36(3):295-304.

Plano Clark, VL, Garrett, AL & Leslie-Pelecky, DL. 2010. Applying three strategies for integrating quantitative and qualitative databases in a mixed methods study of a nontraditional graduate education program. *Field Methods* 22(2):154-174.

Polit, DF & Beck, CT. 2008. *Nursing research: generating and assessing evidence for nursing practice.* 8th edition. Philadelphia: Lippincott Williams & Wilkins.

Polit, DF & Beck, CT. 2006. *Essentials of nursing research: methods, appraisal and utilization.* 6th edition. Philadelphia: Lippincott Williams & Wilkins.

Polit, DF & Beck, CT. 2004. *Nursing research: principles and methods.* 7th edition. Philadelphia: Lippincott.

Polit, D and Hungler, B. 2004. “Nursing Research, Principles and Methods” Philadephia: Lippincott.

Pope, C & Mays, N. 1995. Reaching the other parts methods cannot reach: an introduction to qualitative methods in health and health services research. British Medical Journal 311:42-45.

Rashid, SF. 2011. Human rights and reproductive health: political realities and pragmatic choices for married adolescent women living in urban slums, Bangladesh. *BMC International Health and Human Rights* 11(Suppl 3):S3

Rathus, JH & Feindler, EL. 2004. *Assessment of partner violence*. New York: American Psychological Association.

Republic of Uganda. The Anti-Pornography Act, 2014. Pages 1-17

Republic of Uganda. The Domestic Violence Act, 2010. Pages 1-20

Richards L & Morse, JM. 2007. *ReadMe first for a user's guide to qualitative methods research*. London: Sage.

Rico, N. 1997. *Gender-based violence: a human rights issue.* Women and Development Unit, Economic Commission for Latin America and the Caribbean. Santiago: United Nations.

Rider, EA. 2005. *Our voices: psychology of women*. Hoboken, NJ: Wiley.

Roberts, AR. 2002. *Handbook of domestic violence intervention strategies: policies, programs and legal remedies.* Oxford: Oxford University Press.

Rubin, A & Babbie, E. 2007. Essential research methods for social work. Belmont: Brooks/Cole.

Ryan, C, Anastario, M & DaCunha, A. 2006. Changing coverage of domestic violence murders: a longitudinal experiment in participatory communication. *Journal of Interpersonal Violence* 21(2):209-228.

Saile, R, Neuner, F, Ertl, V, Catani, C. 2013. Prevalence and predictors of partner violence against women in the aftermath of war: A survey among couples in Northern Uganda. *Social Science & Medicine* 86:17-25.

Saldana, J. 2012.*The coding manual for qualitative researchers*. London: Sage.

Sambisa, W, Angeles, G, Lance, PM, Naved, RT & Curtis SL. 2010. Physical and sexual abuse of wives in urban Bangladesh: husbands' reports. *Studies in Family Planning* 41(3):165-178.

Sana, L. 2001. *Intimate partner violence: Societal, medical, legal and individual responses.* New York: Kluwer Academic/Plenum.

Saunders, M, Lewis, P & Thornhill, A. 2009. *Research methods for business students.* 5th edition. Harlow: Prentice Hall.

Semugoma P, Beyrer C, Baral S. Assessing the effects of anti-homosexuality legislation in Uganda on HIV prevention, treatment, and care services. SAHARA J. 2012;9(3):173-6.

Shah, PS & Shah, J. 2010. Maternal exposure to domestic violence and pregnancy and birth outcomes: a systematic review and meta-analyses. *Journal of Women's Health19*: 2017-2031.

Shamu, S, Zarowsky, C, Shefer ,T, Abrahams, N, Temmerman, M. 2013a. Intimate partner violence during pregnancy in Zimbabwe: A Cross-sectional study of prevalence, predictors, and associations with HIV. *Tropical Medicine and International Health* 18(6):696-711.

Shamu, S, Abrahams, N, Temmerman, M, Zarowsky, C. 2013b. Exploring opportunities and obstacles to screening pregnant women for intimate partner violence during antenatal care in Zimbabwe. Culture, Health and Sexuality: *An International Journal for Research, Intervention and Care* 15(5):511-524.

Shamu, S, Abrahams, N, Temmerman, M, Shefer, T, Zarowsky, C & Vermund, SH. 2012. That pregnancy can bring noise into the family: exploring intimate partner sexual violence during pregnancy in the context of HIV in Zimbabwe. *Plos ONE* 7(8):1-9.

Shamu, S, Abrahams, N, Temmerman, M, Musekiwa, A, Zarowsky, C. 2011. A Systematic Review of African Studies on Intimate Partner Violence against Pregnant Women: Prevalence and Risk Factors. *PLoS ONE* 6(3):1-9.

Stadley, K (ed). 2006. *Family law*. Palgrave: MacMillan.

Szumilas, M. 2010. Explaining odds ratios. *Journal of the Canadian Academy of Child Adolescent Psychiatry*, 19(3): 227-229.

Swift, JA & Tischler, V. 2010. Qualitative research in nutrition and dietetics: getting started. *Journal of Human Nutrition and Dietetics* 23(6):559-566.

Taylor, C & Gibbs, GR. 2010. *What is Qualitative Data Analysis (QDA)?* Available from: onlineqda.hud.ac.uk/Intro_QDA/what_is_qda.php (accessed 20 January 2014).

Terre Blanche, M & Durrheim, K (eds). 2002. *Research in practice: applied methods for social sciences.* Cape Town: UCT.

Testa, M, Livingston, JA & VanZile-Tamsen, C. 2011. Advancing the study of violence against women using mixed methods: Integrating qualitative methods into a quantitative research program. *Violence Against Women* 17:236-250.

Thaler, K. 2012. The utility of mixed methods in the study of violence. MICROCON Research Working Paper 59, Brighton: MICROCON.

The Royal College of Physicians and Surgeons of Canada. 2012. *Defining societal health needs.* Royal College Definition and Guide. Available from: http://www.royalcollege.ca/portal/page/portal/rc/common/documents/policy/shn_definition_and_guide_e.pdf (accessed 5 June 2014)

Timmerman, M. 2015. Research priorities to address violence against women and girls. *Lancet* 385:e38-40.

Titchen, A. 2008. Evaluating the successful implementation of evidence into practice using the PARiHS framework: theoretical and practical challenges. *Implementation Science* 3:1-12.

Tjaden, P & Thoennes, N. 2000a. *Extent, nature and consequences of violence against women: findings from the national violence against women survey*. Washington, DC: US Department of Justice.

Tjaden, P & Thoennes, N. 2000b. *Full report of the prevalence, incidence, and consequences of violence against women: Findings from the national violence against women survey.* Washington, DC: National Institute of Justice, US Department of Justice.

Tjaden, P & Thoennes, N. 1998. *Prevalence, incidence, and consequences of violence against women: findings from the national violence against women survey. Research in Brief.* Washington, DC: National Institute of Justice, US Department of Justice. CDC.

Tumwesigye, NM & Kasirye, R. 2005. Gender and the major consequences of alcohol consumption in Uganda. In *Alcohol, Gender and Drinking Problems: perspectives from low and middle income countries*, edited by I Obot and R Room. Geneva: World Health Organization:189-208.

Turyasingura, H. 2007. Responding to domestic violence: A handbook for the Uganda police force. Kampala, Uganda: CEDOVIP and Uganda Police Force. pp. 1-36. Available from: http://preventgbvafrica.org/wp-content/uploads/2013/10/PoliceHandbook.CEDOVIP.pdf (accessed 21 June 2015).

Uganda Demographic and Health Survey (UDHS). 2012. *Uganda Demographic and Health Survey, 2011.* Pages 1-224. Kampala, Uganda: UBOS and Calverton. Maryland: ICF International.

UNAIDS/UNFPA/UNIFEM. 2004. *Women and HIV/AIDS: confronting the crisis.* New York: United Nations Publications.

UNFPA. 2010. *Addressing violence against women and girls in sexual and reproductive health services: a review of knowledge assets.* New York: United Nations Publications.

UN HABITAT. 2003. *The challenge of slums: global report on human settlements*. United Nations Human Settlements Programme. Nairobi: Earthscan Publications.

United Nations (UN). 1994. *International Conference on Population and Development, ICPD. Summary of the Programme of Action. Cairo, Egypt*. United Nations. Electronic document, Available from: http://www.un.org/ecosocdev/geninfo/populatin/icpd.htm (accessed 17 June 2014).

United Nations (UN). 1989. *Publication on violence against women in the family*. New York: United Nations Publications.

United Nations (UN). 1979. *Convention on the elimination of all forms of discrimination against women*. New York: United Nations Publications.

United Nations Statistics Division. 2013. *Country profile. Uganda*. Available online: http://data.un.org/CountryProfile.aspx?crName=Uganda (accessed 18 February 2013).

Uthman, O, Lawoko, S & Moradi, T. 2010. Sex disparities in attitudes towards intimate partner violence against women in sub-Saharan Africa: Socio-ecological analysis. BMC Public Health, 10(223):1-8. Available from: http://www.biomedcentral.com/content/pdf/1471-2458-10-223.pdf (accessed 17 September 2015).

UN WOMEN. 2012. *Report on the online discussion on eliminating violence against women and girls: gaps, challenges and strategic directions in prevention and multi-sectoral services and responses*. CSW 57 Online Discussion, 23 July and 7 August. New York: United Nations Publications.

VanderEnde, KE, Sibley, LM, Cheong, YF, Naved, RT & Yount, KM. 2015. Community economic status and intimate partner violence against women in Bangladesh: compositional or contextual effects? *Violence Against Women* 21:679-699.

Wagman, JA, Gray, RH, Campbell, JC, Thoma, M, Ndyanabo, A, Ssekasanvu, J, Nalugoda, F, Kagaayi, J, Nakigozi, G, Serwadda, D & Brahmbhatt, H. 2015. Effectiveness of an integrated intimate partner violence and HIV prevention intervention in Rakai, Uganda: analysis of an intervention in an existing cluster randomised cohort. *Lancet Global Health* 3(1):e23-e33.

Wathen, CN & MacMillan, HL. 2013. Children's exposure to intimate partner violence: Impacts and interventions. *Paediatrics & Child Health*, *18*(8), 419–422.

WHO. 2015. *Health in all policies: training manual*. Geneva: WHO.

WHO. 2014a. *Uganda country profile.* Available from: http://www.who.int/countries/uga/en/ (accessed 8 June 2014).

WHO. 2014b. *Global status report on violence prevention, 2014*. Geneva: WHO.

WHO. 2014c. *Global Alcohol Report: Uganda.* Available from: http://www.who.int/substance_abuse/publications/global_alcohol_report/profiles/uga.pdf (accessed 28 June 2015).

WHO. 2012. Understanding and Addressing Violence Against Women. Available from: http://apps.who.int/iris/bitstream/10665/77432/1/WHO_RHR_12.36_eng.pdf [Accessed 13 March 2016].

WHO. 2007. *Our cities, our health, our future: acting on social determinants for health equity in urban settings: Report to the WHO Commission on social determinants of health from the knowledge network on urban settings*. WHO Kobe Centre: WHO. Available from: http://www.who.or.jp/knusp/KNUS_final_report.pdf (accessed 3 March 2014).

WHO. 2002a. *World report on violence and health*. Edited by EG Krug, LL. Dahlberg, JA Mercy, AB. Zwi and R Lozano. Geneva: WHO.

WHO. 2002b. Intimate partner violence. Factsheet. Available from: http://www.who.int/violence_injury_prevention/violence/world_report/factsheets/en/ipvfacts.pdf [Accessed 13 March 2016]

WHO. 1946. Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June 1946, and entered into force on 7 April 1948. New York: WHO

Widom, CS, Schuck, AM & White, HR. 2006. An examination of pathways from childhood victimization to violence: the role of early aggression and problematic alcohol use. *Violence and Victims* 21:675-690.

Winton, A. 2004. Urban violence: a guide to the literature. *Environment and Urbanization* 16(2):165-184.

Wisdom, JP, Cavaleri, MA, Onwuegbuzie, AJ & Green, CA. 2012. Methodological reporting in qualitative, quantitative, and mixed methods health services research articles. *Health Services Research* 47(2):721-745.

Woolley, CM. 2009. Meeting the mixed methods challenge of integration in a sociological study of structure and agency. *Journal of Mixed Methods Research* 3(1):7-25.

World Vision. 2011. *Uganda country profile*. Available from: https://www.worldvision.com.au/Libraries/globalone_docs/Uganda-Country_Profile.pdf (accessed 20 March 2014).

ANNEXURES

Annexure A

Certificate of clearance from the University of South Africa Health Studies Higher Degrees Committee

UNISA

UNIVERSITY OF SOUTH AFRICA
Health Studies Higher Degrees Committee
College of Human Sciences
ETHICAL CLEARANCE CERTIFICATE

HSHDC/327/2014

Date: 26 February 2014 Student No: 5103-927-3

Project Title: Experiences of intimate partner violence and the health needs of women living in urban slums in Kampala, Uganda.

Researcher: Constance Sibongile Shumba

Degree: D Litt et Phil Code: DPCHS04

Supervisor: Dr JM Mathibe Neke
Qualification: PhD
Joint Supervisor: Prof BL Dolamo

DECISION OF COMMITTEE

Approved √ **Conditionally Approved**

Prof L Roets
CHAIRPERSON: HEALTH STUDIES HIGHER DEGREES COMMITTEE

Prof MM Moleki
ACADEMIC CHAIRPERSON: DEPARTMENT OF HEALTH STUDIES

PLEASE QUOTE THE PROJECT NUMBER IN ALL ENQUIRES

Annexure B

Letter of clearance from the Uganda National Council for Science and Technology

Uganda National Council for Science and Technology

(Established by Act of Parliament of the Republic of Uganda)

Our Ref: SS 3475

4th November 2014

Ms. Constance Sibongile Shumba
IHUG
Kampala

Re: Research Approval: **Experiences of Intimate Partner Violence and the Health needs of women living in urban slums in Kampala, Uganda**

I am pleased to inform you that on **14/05/2014**, the Uganda National Council for Science and Technology (UNCST) approved the above referenced research project. The Approval of the research project is for the period of **14/05/2014** to **14/05/2015**.

Your research registration number with the UNCST is **SS 3475**. Please, cite this number in all your future correspondences with UNCST in respect of the above research project.

As Principal Investigator of the research project, you are responsible for fulfilling the following requirements of approval:

1. All co-investigators must be kept informed of the status of the research.
2. Changes, amendments, and addenda to the research protocol or the consent form (where applicable) must be submitted to the designated Research Ethics Committee (REC) or Lead Agency for re-review and approval **prior** to the activation of the changes. UNCST must be notified of the approved changes within five working days.
3. For clinical trials, all serious adverse events must be reported promptly to the designated local IRC for review with copies to the National Drug Authority.
4. Unanticipated problems involving risks to research subjects/participants or other must be reported promptly to the UNCST. New information that becomes available which could change the risk/benefit ratio must be submitted promptly for UNCST review.
5. Only approved study procedures are to be implemented. The UNCST may conduct impromptu audits of all study records.
6. A progress report must be submitted electronically to UNCST within four weeks after every 12 months. Failure to do so may result in termination of the research project.

Below is a list of documents approved with this application:

	Document Title	Language	Version	Version Date
1	Research proposal	English	N/A	N/A
2	Participant Information Sheet	English	1.0	1st July 2013
3	Consent Form	English	1.0	1st July 2013
4	Survey Questionnaire	English	1.0	1st July 2013

Yours sincerely,

Winfred Badanga
for: Executive Secretary
UGANDA NATIONAL COUNCIL FOR SCIENCE AND TECHNOLOGY

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Annexure C

Participant information sheet

Topic: Experiences of intimate partner violence and the health needs of women living in urban slums in Kampala Uganda

Researcher: Constance Shumba

Research organization and address: University of South Africa, Department of Health Studies, PO Box 392, UNISA, 003, SOUTH AFRICA

Hello. My name is Constance Shumba. I am a student pursuing a Doctor of Literature and Philosophy degree in Health Studies (DLitt et Phil) at the University of South Africa. I am conducting a survey and interviews about women's experience of violence in Kabalagala. I want to explore this so that the findings can be used to develop appropriate programmes to improve women's lives. If you agree to join this study you have 24 hours to think about your participation in this study and thereafter if you are willing to participate we can arrange a suitable time for us to spend up to one hour asking you questions and would like this discussion to be tape-recorded if you accept.

Participating in this research study is voluntarily. I do not envisage any risks in the study. If you choose to participate and in case some questions make you feel uncomfortable, you may refuse to answer them or you can also stop the interview at any time. All of the answers you give will be kept private and the interview notes will be kept in a locked filing cabinet or on a computer that only the researcher can use. The researcher will only analyse the data without your names. Your name or any facts that could identify you or your family will not appear in any report of this study. All audio recordings will be transcribed, analysed, and modified to ensure that they cannot be linked to you as the study participant. I will share with you the main findings from this study and with other relevant stakeholders from the government and non-governmental sector. No payments are associated with participating in this study.

If at any time during the study you have questions, you can speak to me, Constance Shumba on 51039273@mylife.unisa.ac.za /+256774534599.

Annexure D: Consent form

Topic: Experiences of intimate partner violence and the health needs of women living in urban slums in Kampala Uganda

I have read and understood the information sheet and this consent form. I have had an opportunity to ask questions about my participation.

I understand that I am under no obligation to take part in this study.

I understand that I have the right to withdraw from this study at any stage without giving any reason.

I agree to participate in this study.

I consent for the interview to be audio recorded

Name of participant: _____

Signature of participant: _____

Signature of researcher: _____

Date: _____

Contact details of the researcher

Name of researcher: Constance Shumba

Address: University of South Africa, Department of Health Studies,

PO Box 392

UNISA, 003,

SOUTH AFRICA

Email / Telephone: 51039273@mylife.unisa.ac.za /+256774534599.

Annexure E: Questionnaire

Section A: Demographic data

1. Date of Birth[dob]: dd|mmm|yyyy |__|__|__|__|__|__|__|__|__|__|
2. What is your marital status [marital]?

☐ Single ☐ Married ☐ Cohabiting ☐ Divorced ☐ Widowed

3. What is your occupation [occup] ?.....
4. What is your monthly income [income]?.....
5. What is your level of education [educ]?

☐ No formal education ☐ Primary school but did not complete

☐ Completed primary school

☐ Some secondary education but did not complete

☐ Secondary school completed ☐ High school completed

☐ High school completed ☐ Diploma ☐ Degree

6. Religion [religion]

☐ Catholic ☐ Anglican ☐ SDA ☐ Pentecostal ☐ Moslem ☐ Traditional

Other (specify)….☐……..

7. How many people live in your household?[hsize] ☐☐
8. How many children below 18 live in your household?[children] ☐☐
9. Do you live with your in-laws?[inlaws]

☐ Yes ☐ No

Section B: Experiences of Intimate Partner violence (IPV)

This section asks about your experiences in adult intimate relationships with a husband or partner

1. Have you ever been in an adult intimate relationship from the time you turned 16 years? [rship] ☐ Yes ☐ No

If yes, please go to question 2 however if no then terminate the interview

2. Are you currently in a relationship? ☐ Yes ☐ No [crship]

I am going to ask you if you have experienced any of the following actions especially in the last one year. If you did not have a partner in the past 12 months, could you please answer for the last partner that you had.

3. Does your partner/ex become very upset and angry when he drinks? [upset]

☐ Yes ☐ No

4. Does your partner forbid you from having any friends and socializing with them [forbid]
   ☐ Yes ☐ No
5. Does your partner insult you in front of others? [insult]
   ☐ Yes ☐ No
6. Does your partner get angry if you disagree with your point of view? [angry]
   ☐ Yes ☐ No
7. Does your partner deliberately deprive you of money? [money]
   ☐ Yes ☐ No
8. Does your partner stop you from working? [stop]
   ☐ Yes ☐ No
9. Are you afraid of your partner? [afraid]
   ☐ Yes ☐ No
10. Does your partner hit you or throw things at you when he is angry?[hit]
    ☐ Yes ☐ No
11. Does your partner cause damage to your property when angry? [damage]
    ☐ Yes ☐ No
12. Is your partner jealous and suspects you of cheating without reason/cause? [suspect]
    ☐ Yes ☐ No
13. Does your partner force you to have sex when you do not want?[fsex]
    ☐ Yes ☐ No
14. Does your partner steal from you (money or other valuables) leaving you stranded? [stranded]
    ☐ Yes ☐ No
15. Does your partner discourage your contact with family? [contact]
    ☐ Yes ☐ No
16. Has he threatened to hurt your family or friends? [hurt]
    ☐ Yes ☐ No
17. Does he punish or deprive the children when he was angry at you?[punish]
    ☐ Yes ☐ No
18. Does he threaten to take the children if you left him? [take]
    ☐ Yes ☐ No
19. Has he ever locked you outside or inside the house?[locked]
    ☐ Yes ☐ No

20. Does he threaten to end the relationship if you didn't do what he wanted? [rship]

☐ Yes ☐ No

21. Has he tried to force you to leave your home? [force]

☐ Yes ☐ No

22. Does he threaten to commit suicide when he was angry at you? [suicide]

☐ Yes ☐ No

23. Does your partner threaten to harm/kill you? [harm]

☐ Yes ☐ No

24. Does your partner threaten to kill/harm your children? [threaten]

☐ Yes ☐ No

25. Does your partner follow you or hang around the house to monitor your movements? [monitor]

☐ Yes ☐ No

26. Does your partner make you feel like a prisoner? [prisoner]

☐ Yes ☐ No

27. Does he make you feel unsafe even in your own home? [unsafe]

☐ Yes ☐ No

28. Do you feel ashamed of the things he does to you? [ashamed]

☐ Yes ☐ No

29. Does he make you feel like you have no control over your life and no power? [power]

☐ Yes ☐ No

30. Do you hide the truth from others because you are afraid?[hide]

☐ Yes ☐ No

31. Does your partner use money or make important financial decisions without talking to me about it? [money]

☐ Yes ☐ No

32. Does your partner harass you at work? [harass]

☐ Yes ☐ No

33. Has your partner in the last one year;

a. Slapped you [slapped]
☐ Yes ☐ No

b. Physically twisted my arm [armtwist]
☐ Yes ☐ No

c. Slammed you or held me against a wall [slammed]
☐ Yes ☐ No

d. Kicked you [kicked]
☐ Yes ☐ No

e. Tried to choke you [choke]
☐ Yes ☐ No

f. Pushed or grabbed you [push]
☐ Yes ☐ No

g. Burned you [burned]
☐ Yes ☐ No

h. Hit you with a fist (punching) [fist]
☐ Yes ☐ No

i. Stabbed you with a knife [knife]
☐ Yes ☐ No

34. Does your partner use drugs and/or alcohol? [drugs]
☐ Yes ☐ No

35. If yes, how does he act when he is drinking or on drugs? Is he ever verbally or physically abusive? [abusive]
☐ Yes ☐ No

36. Do you have weapons in your home? [weapons]
☐ Yes ☐ No

37. Has your partner ever threatened to use them when he was angry? [angry]
☐ Yes ☐ No

38. Do you have anyone you can talk to about issues of violence? [vconsult]

☐ Yes ☐ No

39. Have you ever attended talks on violence against women? [vtalks]

☐ Yes ☐ No

40. Do your health workers advise you on ways of preventing and managing violence? [vadvice]

☐ Yes ☐ No

41. Are there any agencies in your community involved in the dissemination of information on violence against women? [agencies]

☐ Yes ☐ No

42. Interview Date[intdate]: dd|mmm|yyyy |__|__|__|__|__|__|__|__|

Annexure F

Gantt chart for D Litt et Phil (Health Studies)

ACTIVITY	**TIMEFRAME FOR ACTIVITY COMPLETION**					
Proposal & Literature review	Jan 2013 to Jan 2014					
UNISA Ethics approval	Feb 2014					
Chapters 1 & 2	February to April 2014					
Chapter 3	April to May 2014					
In-country Ethical approval	May 2014					
Pre-test study tools	July 2014					
Data Collection	July to Dec 2014					
Data analysis		Dec 2014 to April 2015				
Interpretation of results/ Results chapters			Dec 2014 to April 2015			
Discussion and conclusions				April to June 2015		
Draft thesis chapters					July 2015	
Feedback from supervisors and refinement of draft thesis					July to Oct 2015	
Notice of intention to submit					Oct 2015	
Thesis submission						Nov 2015