

Intimate partner violence during pregnancy in Zimbabwe: a cross-sectional study of prevalence, predictors and associations with HIV

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Abstract

OBJECTIVE To describe the occurrence, dynamics and predictors of intimate partner violence (IPV) during pregnancy, including links with HIV, in urban Zimbabwe.

METHODS A cross-sectional survey of 2042 post-natal women aged 15–49 years was conducted in six public primary healthcare clinics in low-income urban Zimbabwe. An adapted WHO questionnaire was used to measure IPV. Multivariate logistic regression was used to assess factors associated with IPV and severe (six or more episodes) IPV during pregnancy.

RESULTS 63.1% of respondents reported physical, emotional and/or sexual IPV during pregnancy; 46.2% reported physical and/or sexual violence, 38.9% sexual violence, 15.9% physical violence and 10% reported severe violence during pregnancy. Physical violence was less common during pregnancy than during the last 12 months before pregnancy (15.9% [95% CI 14.3–17.5] *vs.* 21.3% [95% confidence interval 19.5–23.1]). Reported rates of emotional (40.3% [95% CI 38.1–42.3] *vs.* 44.0% [95% CI 41.8–46.1]) and sexual violence (35.6% [95% CI 33.5–37.7] *vs.* 38.9% [95% CI 36.8–41.0]) were high during and before pregnancy. Associated factors were having a younger male partner, gender inequities, past abuse, problem drinking, partner control of woman's reproductive health and risky sexual practices. HIV status was not associated with either IPV or severe IPV, but reporting a partner with a known HIV status was associated with a lower likelihood of severe abuse.

CONCLUSION The rates of IPV during pregnancy in Zimbabwe are among the highest ever reported globally. Primary prevention of violence during childhood through adolescence is urgently needed. Antenatal care may provide an opportunity for secondary prevention but this requires further work. The relationship between IPV and HIV is complex in contexts where both are endemic.

keywords intimate partner violence, pregnancy, HIV, prevalence, risk factors, Zimbabwe

Introduction

Intimate partner violence (IPV) is a serious public health and human rights problem across the globe with negative impacts on women's and child health as well as high use of health services (Campbell 2002; García-Moreno *et al.* 2005). IPV during pregnancy increases women's vulnerability to ill health both to herself and to her unborn child, in addition to the changes in physical, social, sexual and economic circumstances during pregnancy (Heise *et al.* 2002; Shah & Shah 2010). The WHO multicountry study on violence and women's health found 1–28% women reporting violence during pregnancy across 10 countries

(García-Moreno *et al.* 2005). A more recent systematic review of the prevalence of IPV during pregnancy in Africa found a wider range of between 2.3% and 57.1% women reporting such violence (Shamu *et al.* 2011). Gender-based violence including IPV is considered a structural driver of HIV (Jewkes *et al.* 2006a,b; Auerbach *et al.* 2011) but some studies show insignificant associations between IPV and HIV (Nyamayemombe *et al.* 2010; Hallett *et al.* 2006).

Two systematic reviews of risk factors associated with IPV during pregnancy found young age, poverty, marital status, past exposure to violence (childhood sexual abuse) and alcohol abuse as consistent risk factors across studies

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(Taillieu & Brownridge 2010; Shamu *et al.* 2011). Sexual risk behaviours and HIV-positive status were associated with IPV in some studies but not others (Campbell *et al.* 2008; Shamu *et al.* 2011). Similar risk factors have been reported in studies of IPV overall (Jewkes 2002; Jewkes *et al.* 2002; Abramsky *et al.* 2011). Perpetration studies have provided further evidence of the role of gender inequality and male controlling behaviours (Jewkes *et al.* 2006a,b, 2012). All these factors are critical for intervention, which has been a neglected research area. Jewkes' (2010) conceptual framework, based on evidence across the world, postulates that gender-based violence and HIV risk both stem from gender inequity and also deepen gender power differentials. Male power dominance in relationships and recurring exercise of violence against partners teach women not to resist attempts to abuse women.

Three reviews of studies on IPV during pregnancy (Devries *et al.* 2010; Taillieu & Brownridge 2010; Shamu *et al.* 2011) showed significant diversity across studies both in methods and conceptualisation of IPV, resulting in wide ranges of reported prevalence rates. Variations in the time during pregnancy when the interviews were conducted affect prevalence reported – those conducted at the onset of pregnancy record lower prevalence (Johnson *et al.* 2003), whilst those conducted at the end of pregnancy or soon after delivery record higher prevalence (Farid *et al.* 2008). Some studies also interviewed women as long as 18 months (Guo *et al.* 2004) or even – in Demographic and Health Surveys (DHS) – 5 years after delivery, likely resulting in lower prevalence due to recall bias. There are also differences in the number of pregnancies in which IPV was measured: some studies measured IPV in one pregnancy; others referred to all pregnancies a woman had ever had in the case of the DHS (Devries *et al.* 2010), also influencing prevalence and comparability. Many studies use small sample sizes, especially those from Africa (Shamu *et al.* 2011). IPV has been operationalised in different ways, although studies are increasingly using common instruments (Rabin *et al.* 2009). In addition to methodological differences, different prevalence rates also reflect real, substantive differences between cultures (Shamu *et al.* 2011).

The antenatal and post-natal periods have been identified as windows of opportunity for identifying women who experience abuse for development of interventions. This is very relevant for Zimbabwe, where up to 91.4% pregnant women attend antenatal care clinics with similar high levels of use of health services in the post-partum period (Munjanja *et al.* 2009). The country has high coverage of antenatal and post-natal care despite the current political and economic problems. Only two studies on

IPV have been conducted in Zimbabwe over the past two decades but neither focused on pregnancy (Watts *et al.* 1998; CSO and Macro 2007). Measuring prevalence of IPV during pregnancy helps us to understand IPV. Understanding the factors associated with IPV during pregnancy is necessary to plan prevention interventions with both men and women, as well as appropriate health sector interventions. In this article, we present the findings of a study reporting the prevalence of various forms of IPV including severity of the abuse throughout the pregnancy period as well as factors associated with IPV during pregnancy.

Methods

Cross-sectional study

A cross-sectional study of post-natal 15 to 49-year-old women attending either 10 days or 6 weeks post-natal clinics was conducted at six low-income urban clinics in Harare between May and September 2011. We calculated sample size (2024 participants) based on a South African study (Dunkle *et al.* 2004). Following the WHO (García-Moreno *et al.* 2005) guidelines, we recruited and trained female interviewers (six) for 7 days before conducting fieldwork. We conveniently recruited participants from the clinic queues and administered the questionnaire (face-to-face interviews) in Shona to all women until the required number was reached.

Data collection

We adapted the WHO multicountry study questionnaire (García-Moreno *et al.* 2005) to measure violence against women for the study. The adaptation included adding the pregnancy period to IPV questions and adding HIV-related factors to the questionnaire. The questionnaire covered socio-demographic characteristics, behaviours, reproductive health and sexual risk factors of women and their current or most recent partners. The choice of variables for risk factor analysis was based on previous theoretical studies (Jewkes 2010) especially the ecological basis of risk factors (Heise 1998), literature in Zimbabwe (Shumba 2001) and our formative qualitative research with women and midwives about local patterns and meanings of sexuality and violence, particularly in intimate partnerships (Shamu 2012). We tested the questionnaire among 60 post-natal women at a clinic, and the necessary adaptations were made.

Intimate partner violence was measured using six physical violence questions, three sexual violence questions and four questions for emotional violence. We also asked

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whether the violence was experienced in the year before her most recent pregnancy to measure past-year violence. Answering positive to one question in each of the specific types of violence was coded as that type of violence. To measure frequency and severity, we asked whether any of these acts happened once, twice, thrice or more during pregnancy and these were coded as low frequency (1–2 experiences) and high frequency (three or more experiences) during pregnancy.

We assessed whether a woman ever experienced physical and/or sexual abuse before age 15. The physical abuse question asked whether, before age 15, anyone ever excessively beat or physically mistreated her in any way. Child sexual abuse assessed whether anyone ever forced her to have sex or to perform a sexual act or ever touched her sexually when she did not want to. Because it is socially acceptable in Zimbabwe for parents and teachers to beat a child to enforce discipline (Shumba 2001), questions were phrased using the term ‘excessive’ to identify abuse from culturally acceptable disciplinary measures. This also emerged during the pilot study. An experience of either physical and/or sexual or both was coded child abuse.

Respondents were asked whether their first sexual intercourse occurred when they were willing, tricked, persuaded, forced or raped. Our variable forced first sexual intercourse referred to respondents who reported non-consensual first sex.

Respondents’ and partners’ alcohol use during pregnancy and partner’s problem drinking during pregnancy were assessed by asking whether a woman ever had money problems or there were conflicts/violence in the house/with friends or authorities as a result of the partner’s use of alcohol (Dunkle *et al.* 2004).

We adapted concepts from three scales to measure gender equity in relationships (García-Moreno *et al.* 2005; Jewkes *et al.* 2006a,b; Gilbert *et al.* 2007), specifically women’s attitudes towards wife-beating situations (six questions), sexual abuse situations (six) and partner controlling behaviours (six) with unstandardised Cronbach’s alpha for the three scales of 0.75, 0.69 and 0.60, respectively. The sexual abuse scale was dichotomised with zero representing endorsement of two or less sexual abuse attitudes, whilst one represented more than two sexual abuse attitudes. A three-level variable (none, 1–2 attitudes/behaviours and 3–6 attitudes/behaviours) was created for both wife-beating and controlling behaviours to measure the relative importance of fewer and more negative attitudes/behaviours on violence experiences whilst compared to none (Dunkle *et al.* 2004).

Reproductive health- and pregnancy-related questions comprised: women’s lifetime contraception use; number

of pregnancies in lifetime; age at first pregnancy; women and partners’ willingness and decision-making to become pregnant (recent pregnancy) and use of antenatal care services during recent pregnancy.

Sexual risk practices

We sought and obtained respondents’ informed written consent to access their HIV test results from the antenatal clinic. HIV status was collected. The results were based on HIV diagnostic tests conducted at the clinics during antenatal care. The clinics used the Determine™ rapid test with positive results confirmed using Capillus, and the Western blot used to resolve any conflicts. We also asked respondents whether their partners knew their (own) HIV status.

We measured HIV risk practices using questions drawn from the Sexual Risk Behaviour Questionnaire tested in the United States (Gilbert *et al.* 2007) and repeated in South Africa (Dunkle *et al.* 2004; Jewkes *et al.* 2006a): ever treated for STI during most recent pregnancy; ever engaging in anal sex; ever having sex with partners who inject drugs; if partner ever had an STI and respondents’ ever engagement in transactional sex for material gain.

Ethics

The study followed the WHO guidelines for researching violence against women and girls. Ethical clearance was received from the Medical Research Council of Zimbabwe and the University of the Western Cape.

Data analysis

After data had been entered, a random 10% sample was checked for validation and minor discrepancies which did not require re-entry of all data set were fixed. Data were cleaned and prepared for analysis in Stata version 11 (StataCorp 2009). Prevalence using percentages and confidence intervals (CIs) of emotional, sexual and physical violence during pregnancy as well as prevalence of combined forms of violence such as physical and/or sexual violence and physical, sexual and/or emotional violence during pregnancy were calculated. Lifetime experiences and frequency of violence were calculated. Socio-demographic, behavioural, reproductive health and HIV risk characteristics of women and those of their partners were described by experience of violence during pregnancy using chi-square tests to determine differences between the groups. We summarised continuous variables using standard deviations. Our primary analysis was to determine factors associated with physical and/or sexual IPV

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and severe physical and/or sexual IPV during pregnancy, and an exploratory analysis at univariate level was performed to identify factors for the building of the multivariate models. A multivariate logistic regression model was developed with candidate variables grouped into four clusters, and the model was built first with the demographic factors at the base adding the behavioural factors followed by the pregnancy factors and lastly adding the HIV-related factors.

We developed two models: one to determine factors associated with ever experiencing physical and/or sexual violence during recent pregnancy (*vs.* no violence) and a second to determine the factors associated with severe physical and/or sexual violence during recent pregnancy defined as experiencing six or more episodes of physical and/or sexual violence during pregnancy (*vs.* five or fewer episodes).

We adjusted the models for known covariates, that is, those that could influence experience of violence (age, education, past violence, interviewer effects and time of interview) and tested for interactions. We used backward stepwise regression analysis by first fitting all candidate variables at each stage (e.g. fitting all socio-demographic variables in the first stage) and removing variables that were not significant at the 5% level, starting with one with the highest *P*-value until a best fitted model was achieved with the remaining significant variables.

Results

We approached 2101 women. 25 refused to participate, six were ill or incapacitated, and a further 28 incomplete questionnaires were removed from the analysis, giving a response rate of 97.1%. This analysis is based on the remaining 2042 women, of which 1156 (56.6%) were interviewed when attending the clinic on the tenth day after giving birth. 886 (43.4%) women were interviewed on their sixth week post-natal clinic visit. Respondents' age ranged from 15 to 48 years with a mean of 26 years [standard deviation (SD) 5.71 years]; their partners' mean age was 31.3 (SD: 6.49 years; range 18–68 years). Table 2 shows participants' socio-demographic characteristics. More than nine in ten had at least 11 years of formal education. More than a third (35%) had been pregnant only once; more than half (53.4%) had a pregnancy before the age of 20.

Table 1 shows the prevalence of the various forms of violence measured. Overall, 63.1% reported physical, sexual and/or emotional violence. 44% women reported emotional abuse, 38.9% sexual violence and 15.9% physical violence during recent pregnancy. Nearly half (46.2%) reported physical and/or sexual violence. Nearly

Table 1 Prevalence and 95% confidence intervals of various forms of violence (*N* = 2042)

Violence during pregnancy	<i>n/N</i>	% (95% confidence interval)
Emotional violence	898/2042	44.0 (41.8–46.1)
Physical violence	325/2042	15.9 (14.3–17.5)
Sexual violence	794/2042	38.9 (36.8–41.0)
Physical and/or sexual violence	943/2042	46.2 (44.0–48.3)
Physical, emotional and/or sexual violence	1289/2042	63.1 (61.0–65.2)
High-frequency physical violence (3+ episodes)	134/2042	6.6 (5.5–7.6)
High-frequency (3+) sexual violence	617/2042	30.2 (28.2–32.2)
High-frequency (3+) physical and/or sexual violence	694/2042	34.0 (31.9–36.0)
High-frequency (6+ episodes) physical and/or sexual violence	207/2042	10.1 (8.8–11.4)
Past emotional violence	822/2042	40.3 (38.1–42.3)
Past physical violence	435/2042	21.3 (19.5–23.1)
Past sexual violence	737/2042	35.6 (33.5–37.7)
Past physical and/or sexual violence	945/2042	46.3 (44.1–48.4)
Past physical, sexual and/or emotional violence	1253/2042	61.3 (59.2–63.4)
Lifetime emotional violence	1311/2042	64.2 (62.1–66.2)
Lifetime physical violence	762/2042	37.3 (35.2–39.4)
Lifetime sexual violence	1054/2042	51.6 (49.4–53.8)
Lifetime physical and/or sexual violence	1327/2042	65.0 (62.9–67.1)
Lifetime physical, sexual and/or emotional violence	1625/2042	79.6 (77.8–81.3)
Use of force at first sexual intercourse	315/2036	15.5 (13.9–17.0)

a third of the women (30.2%) reported severe sexual violence (three or more episodes), whilst one in ten (10.1%) reported six or more episodes of physical and/or sexual violence during pregnancy. The range of IPV episodes during pregnancy ranged from 0 to 22. Nearly one in two women (46.3%) reported physical and/or sexual abuse during the 12 months before pregnancy, and 15.5% reported their first sexual intercourse as forced/raped. Two-thirds (65%) of the women had ever experienced physical and/or sexual IPV.

Table 2 shows significant differences found for partner variables with more violence reported if partners were younger, more educated, had other wives, had not paid a bride price and if they did not live with relatives. Significant differences were found for all variables on past

S. Shamu *et al.* Intimate partner violence during pregnancy**Table 2** Frequency for socio-demographic variables for women reporting violence during pregnancy and those not reporting violence during pregnancy ($N = 2042$)

Variable	Total (%)	No physical/sexual violence reported		Physical/sexual violence reported		P-value
		<i>n</i>	%	<i>n</i>	%	
Woman's age ($n = 2038$)						
15–24 years	909 (44.6)	462	42.11	447	47.50	0.01
25–49 years	1129 (55.4)	635	57.89	494	52.50	
Marital status ($n = 2041$)						
Married	1800 (88.2)	985	89.71	815	86.43	0.02
Not married	241 (11.8)	113	10.29	128	13.57	
Woman's education ($n = 2037$)						
Primary	148 (7.3)	69	6.30	79	8.39	0.07
Secondary and tertiary	1889 (92.7)	1026	93.70	863	91.61	
Woman's employment status ($n = 2027$)						
Employed	606 (29.9)	330	30.28	276	29.46	0.68
Unemployed	1421 (70.1)	760	69.72	661	70.54	
Partner's age ($n = 2034$)						
18–29 years	929 (45.7)	462	42.23	467	49.68	0.001
Over 30 years	1105 (54.3)	632	57.77	473	50.32	
Partner's education ($n = 2022$)						
Up to secondary	1734 (85.8)	955	87.94	779	83.23	0.003
Tertiary	288 (14.2)	131	12.06	157	16.77	
Partner has other wives ($n = 1982$)						
Yes	316 (15.9)	151	14.01	165	18.25	0.01
No	1666 (84.1)	927	85.99	739	81.75	
Brideprice payment ($n = 1984$)						
All	190 (9.6)	130	12.12	60	6.60	<0.0001
Partly	1413 (71.3)	764	71.20	649	71.40	
Nothing	379 (19.1)	179	16.68	200	22.00	
Couple lived with partner's parent/relative ($n = 1985$)						
Yes	1305 (65.7)	744	69.02	561	61.85	0.001
No	680 (34.3)	334	30.98	346	38.15	

violence, gender equity and alcohol abuse during pregnancy (Table 3) except for the women's sexual abuse attitudes ($P = 0.062$). Among the pregnancy-related factors (Table 4), more violence was reported if either the woman or her partner independently decided to become pregnant ($P < 0.0001$), if women were unwilling to become pregnant ($P < 0.0001$) and if partners prevented women from using contraception or visiting antenatal care ($P < 0.0001$). More violence was reported by respondents who reported having more than three lifetime sexual partners ($P = 0.028$), were treated for STI during the recent pregnancy ($P < 0.0001$), ever had transactional sex ($P < 0.0001$), were HIV positive ($P = 0.64$), had partners who tested STI positive and did not know their HIV status ($P < 0.0001$).

Table 5 shows the factors associated with both physical and/or sexual violence and severe physical and/or sexual violence during pregnancy. The only socio-demographic variable associated with physical and/or

sexual violence was having a partner younger than 30 years, whilst having a partner with more than one wife was associated with severe violence. There were similarities with the behavioural factors associated with both levels of violence experienced, which included forced first sexual intercourse, women's use of alcohol during pregnancy, experiencing three or more partner controlling behaviours, reporting that a partner fought with another man, quarrelling with partner and having been injured by a partner. Severe violence during pregnancy was also associated with partner's problem drinking and women endorsing three or more wife-beating attitudes, whilst physical and/or sexual violence was also associated with child abuse and women endorsing three or more sexual abuse attitudes.

More reproductive health and pregnancy-related factors were associated with physical and/or sexual violence but not severe violence during the pregnancy. Younger age at first pregnancy, woman and partner independently

Table 3 Frequency for behavioural variables for women reporting violence during pregnancy and those not reporting violence during pregnancy

Variable	Total (%)	No physical/sexual violence reported		Physical/sexual violence reported		P-value
		<i>n</i>	%	<i>n</i>	%	
Wife-beating attitudes endorsed (<i>n</i> = 1980)						
0–2 attitudes	1767 (89.2)	971	91.09	796	87.09	0.004
3–6 attitudes	213 (10.8)	95	8.91	118	12.91	
Sexual abuse attitudes endorsed (<i>n</i> = 1877)						
0–2 attitudes	1250 (66.6)	312	68.52	315	64.45	0.062
3–6 attitudes	627 (33.4)	679	31.48	571	35.55	
Experiences of partner's controlling behaviours (<i>n</i> = 1962)						
No behaviours	472 (24.1)	309	29.43	163	17.87	<0.0001
1–2 behaviours	1083 (55.2)	600	57.14	483	52.96	
3–6 behaviours	407 (20.7)	141	13.43	266	29.17	
How often do you quarrel? (<i>n</i> = 2025)						
Rarely	1466 (72.6)	844	78.29	622	66.10	<0.0001
Sometimes	466 (23.1)	210	19.48	256	27.21	
Often	87 (4.3)	24	2.23	63	6.70	
Child physical and/sexual abuse (<i>n</i> = 2033)						
Yes	422 (20.8)	157	14.32	265	28.28	<0.0001
No	1611 (79.2)	939	85.68	672	71.72	
First sexual intercourse (<i>n</i> = 2036)						
Willing	1144 (56.2)	718	65.57	426	45.27	<0.0001
Persuaded/tricked	577 (28.3)	265	24.20	312	33.16	
Forced/raped	315 (15.5)	112	10.23	203	21.57	
Ever injured by partner (<i>n</i> = 2031)						
Yes	142 (7.0)	26	2.39	116	12.33	<0.0001
No	1889 (93.0)	1064	97.61	825	87.67	
Abused in past 12 months before pregnancy (<i>n</i> = 2042)						
Yes	945 (46.3)	261	23.75	684	72.53	<0.0001
No	1097 (53.7)	838	76.25	259	27.47	
Partner's mother was abused (<i>n</i> = 2004)						
Yes	225 (11.23)	104	9.67	121	13.04	0.019
No	889 (44.36)	481	44.70	408	43.97	
Parents did not live together	281 (14.02)	141	13.10	140	15.09	
Don't know	609 (30.39)	350	32.53	259	27.91	
Partner involved in a fight with someone since they partnered (<i>n</i> = 1908)						
Yes	336 (17.6)	120	11.88	216	24.05	<0.0001
No	1572 (82.4)	890	88.12	682	75.95	
Woman used alcohol during pregnancy (<i>n</i> = 2037)						
Yes	139 (6.8)	52	4.75	87	9.24	<0.0001
No	1898 (93.2)	1043	95.25	855	90.76	
Partner's problem drinking during pregnancy (<i>n</i> = 2042)						
Yes	388 (19.0)	141	12.83	247	26.19	<0.0001
No	1654 (81.0)	958	87.17	696	73.81	

wanting the pregnancy and women's decision to become pregnant were associated with physical and/or sexual abuse. The only pregnancy and reproductive health-related factors associated with severe violence were partners preventing women from using contraception and attending antenatal care. HIV-related risk factors were only associated with severe violence (*vs.* less severe violence) and the only significant factor was partner's

knowledge of his HIV status, which was associated with lower likelihood of severe abuse.

Discussion

This is the first Zimbabwean study with a focus on IPV during pregnancy. The only two previous studies on prevalence of IPV during pregnancy were conducted in 1998 measur-

S. Shamu *et al.* Intimate partner violence during pregnancy**Table 4** Frequency of reproductive, pregnancy and HIV-related variables for women reporting violence during pregnancy and those not reporting violence during pregnancy

Variable	Total (%)	No physical/sexual violence reported		Physical/sexual violence reported		P-value
		<i>n</i>	%	<i>n</i>	%	
Age at first pregnancy (<i>n</i> = 2038)						
Up to 19 years	950 (46.6)	493	44.90	457	48.62	0.094
20+ years	1088 (53.4)	605	55.10	483	51.38	
No. of lifetime pregnancies (<i>n</i> = 2042)						
1–2 pregnancies	720 (35.3)	397	36.12	323	34.25	0.37
3–8 pregnancies	1322 (64.7)	702	63.88	620	65.75	
Planning of most recent pregnancy (<i>n</i> = 2036)						
Planned together	830 (40.8)	493	45.02	337	35.81	<0.0001
Woman's decision	157 (7.7)	76	6.94	81	8.61	
Partner's decision	488 (23.9)	240	21.92	248	26.35	
Unplanned pregnancy	561 (27.6)	286	26.12	275	29.22	
Woman wanted to become pregnant (<i>n</i> = 1994)						
Yes	1382 (67.8)	788	71.83	594	63.06	<0.0001
No	657 (32.2)	309	28.17	348	36.94	
Partner wanted woman to become pregnant (<i>n</i> = 1967)						
Yes	1553 (76.5)	851	78.00	702	74.76	0.086
No	477 (23.5)	240	22.00	237	25.24	
Partner prevented woman from using contraception (<i>n</i> = 2032)						
Yes	128 (6.3)	35	3.19	93	9.94	<0.0001
No	1904 (93.7)	1061	96.81	843	90.06	
Partner prevented woman from visiting antenatal care (<i>n</i> = 2021)						
Yes	39 (1.9)	14	1.29	25	2.68	<0.0001
No	1737 (86.0)	971	89.33	766	82.01	
Partner had no interest	245 (12.1)	102	9.38	143	15.31	
HIV status (<i>n</i> = 2042)						
Positive	299 (14.6)	156	14.19	143	15.16	0.64
Negative	1652 (80.9)	897	81.62	755	80.06	
Unknown/not tested	91 (4.5)	46	4.19	45	4.77	
Total lifetime sexual partners (<i>n</i> = 2038)						
1–2 partners	1920 (94.2)	1046	95.26	874	92.98	0.028
3+ partners	118 (5.8)	52	4.74	66	7.02	
Treated for STI during pregnancy (<i>n</i> = 2031)						
Yes	131 (6.5)	51	4.67	80	8.53	<0.0001
No	1900 (93.5)	1042	95.33	858	91.47	
Transactional sex (<i>n</i> = 2036)						
Yes	318 (15.6)	131	11.94	187	19.91	<0.0001
No	1718 (84.4)	966	88.06	752	80.09	
Partner ever treated for STI (<i>n</i> = 2030)						
Yes	120 (5.9)	45	4.12	75	8.00	<0.0001
No	1834 (90.3)	1016	92.96	818	87.30	
Don't know	76 (3.7)	32	2.93	44	4.70	
Ever had a partner who injects drugs (<i>n</i> = 2013)						
Yes	36 (1.8)	14	1.29	22	2.38	0.066
No	1977 (98.2)	1074	98.71	903	97.62	
Partner knows own HIV status (<i>n</i> = 2029)						
Yes	1174 (57.9)	686	62.88	488	52.03	<0.0001
No	723 (35.6)	341	31.26	382	40.72	
Don't know	132 (6.5)	64	5.87	68	7.25	

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Table 5 Multiple logistic regression models showing factors associated with physical and/or sexual violence and those associated with severe physical and/or sexual violence after adjusting for age, education, interview time, interviewer and past exposure to violence

Variable	Physical and/or sexual violence during pregnancy						Severe physical and/or sexual violence during pregnancy							
	Stage 1		Stage 2		Stage 3		Stage 1		Stage 2		Stage 3		Stage 4	
	AOR	LCI UCI	AOR	LCI UCI	AOR	LCI UCI	AOR	LCI UCI	AOR	LCI UCI	AOR	LCI UCI	AOR	LCI UCI
Socio-demographic factors														
Partner was 30+ years (<i>vs.</i> <30)	0.74	0.56 0.96	0.67	0.49 0.90	0.66	0.48 0.89								
Partner has 2+ wives (<i>vs.</i> one)	1.41	1.06 1.87	1.37	0.99 1.91	1.39	0.99 1.94	2.06	1.42 2.99	1.67	1.06 2.61	1.56	0.99 2.47	1.58	1.00 2.50
Partial brideprice paid (<i>vs.</i> all)	1.35	0.92 1.97												
No brideprice paid (<i>vs.</i> all)	1.63	1.06 2.51												
Behavioural factors														
Child physical and/or sexual abuse (<i>vs.</i> no)	1.45	1.08 1.96	1.47	1.08 1.99										
Forced first sexual intercourse (<i>vs.</i> willing first sex)	1.44	1.13 1.82	1.43	1.12 1.83					1.55	1.06 2.29	1.54	1.04 2.28	1.50	1.01 2.23
Woman used alcohol during pregnancy (<i>vs.</i> no alcohol)	2.26	1.41 3.63	2.24	1.39 3.6					2.37	1.33 4.24	2.32	1.29 4.16	2.18	1.20 3.97
Partner's problem drinking during pregnancy (<i>vs.</i> no)									2.04	1.36 3.05	2.01	1.33 3.02	1.98	1.31 3.00

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Table 5 (continued)

Variable	Physical and/or sexual violence during pregnancy						Severe physical and/or sexual violence during pregnancy								
	Stage 1		Stage 2		Stage 3		Stage 1		Stage 2		Stage 3		Stage 4		
	AOR	LCI	UCI	AOR	LCI	UCI	AOR	LCI	UCI	AOR	LCI	UCI	AOR	LCI	UCI
Endorsing 3–6 sexual abuse attitudes (<i>vs.</i> 0–2 attitudes)	1.32	1.03	1.69	1.32	1.03	1.7									
Endorsing 1–2 wife-beating attitudes (<i>vs.</i> non-attitudes)							1.25	0.84	1.88	1.24	0.82	1.86	1.19	0.79	1.80
Endorsing 3–6 wife-beating attitudes							1.79	1.00	3.18	1.83	1.02	3.28	1.84	1.02	3.31
Experiencing 1–2 controlling behaviours (<i>vs.</i> none)	1.23	0.92	1.63	1.25	0.94	1.67	1.44	0.82	2.55	1.40	0.79	2.46	1.41	0.79	2.50
Experiencing 3–6 controlling behaviours (<i>vs.</i> none)	1.71	1.19	2.44	1.78	1.24	2.55	1.96	1.07	3.59	1.83	1.00	3.37	1.84	1.00	3.38
Quarrel sometimes (<i>vs.</i> rarely)	1.47	1.12	1.94	1.48	1.12	1.95	1.81	1.21	2.73	1.81	1.20	2.74	1.84	1.21	2.80
Quarrel often (<i>vs.</i> rarely)	1.63	0.82	3.23	1.56	0.79	3.10	5.60	2.88	10.89	4.68	2.34	9.37	4.56	2.27	9.16
Partner ever fought with another man (<i>vs.</i> no fighting)	1.67	1.21	2.3	1.73	1.25	2.40	1.84	1.21	2.80	1.78	1.17	2.72	1.76	1.15	2.69
Woman ever injured by partner (<i>vs.</i> not injured)	2.69	1.57	4.62	2.80	1.62	4.82	3.68	2.26	6.01	3.33	2.01	5.51	3.26	1.97	5.39

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Table 5 (continued)

Variable	Physical and/or sexual violence during pregnancy						Severe physical and/or sexual violence during pregnancy													
	Stage 1		Stage 2		Stage 3		Stage 1		Stage 2		Stage 3		Stage 4							
	AOR	LCI	UCI	AOR	LCI	UCI	AOR	LCI	UCI	AOR	LCI	UCI	AOR	LCI	UCI					
HIV risk factors Partner knows own HIV status (<i>vs.</i> partner does not know)																		0.62	0.42	0.93

AOR, adjusted odds ratio; LCI, lower confidence interval; UCI, upper confidence interval.
N = 2042.

ing violence in one region (Watts *et al.* 1998) and in 2005 when the violence module was added to the DHS (CSO and Macro 2007). Although direct comparisons cannot be made due to different study designs, these studies reported only physical IPV during pregnancy that was 8.3% (CSO and Macro 2007) and 9.9% (Watts *et al.* 1998), which are considerably lower than what we found (15.9%). Similarly, our study reported a prevalence of physical and/or sexual violence of 46.2%, which is much higher than 13.5% reported in a review based on data from 19 DHS and International Violence Against Women Surveys (Devries *et al.* 2010).

The higher rates reported could be because our study was clinic based, using a different sample from population studies, but more importantly, we referred to the most recent pregnancy, and interviews were conducted within 10 days to 6 weeks of giving birth, which potentially reduces recall bias. Previous studies in Zimbabwe measured violence in any pregnancy a woman ever had (Watts *et al.* 1998; CSO & Macro 2007). A similar difference between an antenatal-based study and a DHS in South Africa despite them having identical questions has been reported (Dunkle *et al.* 2004). The antenatal health setting in our study may also have allowed greater disclosure of violence compared to the home where the perpetrator may hinder disclosure (Covington *et al.* 2002; Dunkle *et al.* 2004; Alhabib *et al.* 2010). Much lower prevalence was also reported in a global review with between 1.3% and 12.6% of physical, sexual and/or emotional violence during pregnancy but up to 36% were reported in developing countries (Taillieu & Brownridge 2010) compared to our estimate of 63%. Very high gender inequalities reported in this study could be influencing higher IPV rates.

The higher prevalence of IPV reported in our study could have been due to this study measuring IPV that took place in the entire pregnancy period. Most other studies collected data in the 1st or 2nd trimester (Leung *et al.* 1999; Johnson *et al.* 2003; Fawole *et al.* 2008). The importance of including the full period of pregnancy was demonstrated to us during the formative qualitative study when reports of sexual and emotional violence during the third trimester were very prominent in women's accounts of their experiences (Shamu *et al.* 2012).

The measurements of past IPV (12 months before pregnancy) allowed us to compare violence in pregnancy and outside pregnancy. We found no difference contrary to studies that reported more past physical and/or sexual violence before pregnancy than during pregnancy (Guo *et al.* 2004). Although physical violence decreased (from 21.3% [95% CI 19.5–23.1] to 15.9% [95% CI 14.3–17.5]), reports of emotional violence (40.3% [95% CI

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38.1–42.3] to 44.0% [95% CI 41.8–46.1]) and sexual violence (35.6% [95% CI 33.5–37.7] to 38.9% [95% CI 36.8–41.0]) suggest increasing though not statistically significant trends; that pregnancy may be associated with increasing non-physical forms of violence. The lower rates of physical violence may be an indication of men reducing this type of abuse during pregnancy because of the value they place on the unborn child whilst forcing sex and emotional abuse are not perceived in the same way. Reasons for increased sexual violence during pregnancy – particularly in the last trimester – were reported in the formative study (Shamu *et al.* 2012), where women reported that men fail to understand the physical and emotional changes pregnancy brings about and wanted frequent sexual intercourse as before the pregnancy, whilst women were less willing to have sex, finding positions more difficult or uncomfortable. Such excuses were often not accepted or understood by their partners resulting in conflict and forced sex. These experiences confirm the continued male dominance, control and entitlement to sex that is still common in many African cultures and have been described as the extension of the transfer of a woman's sexuality rights from her father to a husband through traditional marriage payments (Ansell 2001).

Socio-demographic and behavioural risk factors

Although our study was conducted in a poor community where most respondents were unemployed (70%) and economically dependent on their partners who were un/semi-skilled employees, which could have increased their likelihood of experiencing violence, none of the poverty indicators such as low education and unemployment were significantly associated with experiencing IPV during pregnancy. This is inconsistent with findings from studies conducted in similarly less industrialised, less educated and poor communities, which found lower socio-economic status as a risk factor for IPV in Peru (Perales *et al.* 2009), Pakistan (Farid *et al.* 2008) and among poor Black Americans (Shumway *et al.* 1999; Covington *et al.* 2002). The lack of an association with poverty indicators in our study may be a result of the endemic poverty in Zimbabwe and may also reflect the current economic and political crisis. It is also possible that the lack of variability in our measure of poverty resulted in an apparent lack of effect. Our sample reported high levels of formal education, suggesting that current poverty may not reflect multidimensional or lifetime deprivation. The only demographic factor associated with violence during pregnancy was partner's age; younger men were more likely to abuse their partners, which is consistent with findings

from IPV studies conducted in South Africa (Jewkes *et al.* 2002, 2006b). This association between young men and violence may be due to young men lacking experience in handling misunderstandings and conflicts in a marriage.

This study provides evidence on how unequal gender norms promote violence. We found all gender inequity factors (women's sexual abuse attitudes, wife-beating attitudes and partner's controlling behaviours) associated with both forms of IPV that we measured. The finding confirms what has been reported in studies performed with pregnant and non-pregnant women (Jewkes *et al.* 2002, 2006a,b; García-Moreno *et al.* 2005; Clark *et al.* 2009) as well as perpetration studies where men's use of violence against partners was associated with greater gender inequality (Jewkes *et al.* 2011) and partner violence is part of a broader control of women by men (Dunkle *et al.* 2004). IPV could potentially alter gender norms (Jewkes 2010) and ultimately forcing abused women to endorse attitudes towards wife-beating, sexual abuse and controlling behaviours. An intervention to improve relationship communication has been developed and tested with a study in SA among young men and women showing a decrease in IPV (Jewkes *et al.* 2010). Continued development and testing of such interventions are urgently needed.

The explanation of why women under 20 years of age at first pregnancy were less likely to be abused may be further evidence of the role of gender inequality as these women may have learned to be submissive to their partners and may therefore avoid abuse by their compliance. The association between IPV and being in a polygamous relationship was previously reported in Zimbabwe (Nyamayemombe *et al.* 2010), and although this has not been explored and is not fully understood – economic demands of a pregnant wife could increase her vulnerability to violence by a husband. Violence between co-wives because of competition for limited resources, including attention of the husband, has been anecdotally reported.

Our results suggest that abuse during pregnancy is not an isolated incident in a woman's life but appears to be part of a lifetime process. The association with abuse before age 15, forced first sexual intercourse and ever being injured has been reported in both IPV during pregnancy studies (Ntaganira *et al.* 2008) and general IPV studies (Jewkes *et al.* 2002) in Africa. Violence prevention interventions should start during childhood because targeting the pregnancy period is too late as women learn to accept violence as a means to punish misbehaviour from childhood (Dunkle *et al.* 2004). The frequency of abuse during pregnancy also indicates that violence is not a once-off event during the pregnancy with one in ten women experiencing more than six events during their

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pregnancy. We do not know of other studies that report frequency of violence during pregnancy. Such persistent violence may have chronic health problems to the woman and negative consequences to the unborn child.

It is a concern that alcohol use during pregnancy by the women and partners was found associated with abuse. This, however, has been reported in many studies of IPV during pregnancy (Dunkle *et al.* 2004; Fawole *et al.* 2008; Ntaganira *et al.* 2008, 2009; Olagbuji *et al.* 2010; Eaton *et al.* 2012). The relationship between IPV and alcohol use is complex because it can be bidirectional with alcohol drinking leading to IPV or IPV leading to alcohol drinking (Bacchus *et al.* 2006; Widom *et al.* 2006) or it may involve both partners (Pallitto & O'Campo 2004).

Pregnancy-related risk factors

Many studies in the past decade assessed the association between pregnancy intention or unplanned pregnancy and IPV during pregnancy without defining whose intention it was to become pregnant (Goodwin *et al.* 2000; Pallitto & O'Campo 2004; Silverman *et al.* 2007; Cripe *et al.* 2008; Fanslow *et al.* 2008). In our study, we analysed whose intention (both, woman's, partner's or unintended) it was to become pregnant as well as the willingness for the pregnancy. We found that if a woman decided on her own to become pregnant, she was at greater risk to experience IPV during the pregnancy. We also found that if the partner wanted her to become pregnant, she was protected from experiencing violence. It is possible that being victimised by a partner leads to a pervasive sense of 'everyday violence' that undermines women's self-efficacy, which predisposes them to believe that they themselves desire children when in fact they are simply mirroring their abusive partners' desires or leads to less reproductive control and unintended pregnancy (Tsai & Subramanian 2012). This relation between pregnancy decision-making and violence links to the central role male domination has in women's sexuality and reproductive health issues as discussed earlier. The increase in vulnerability of women may be explained in Zimbabwean economic context where women's decisions to have children are in conflict with men's roles of being providers. Men's traditional role of deciding how many children a couple could have including when to have another pregnancy could be related to the economic hardships facing people in Zimbabwe where men struggled to raise income for family upkeep during the time of study. The link between sexual and reproductive health and poverty has been reported in Zimbabwe in the context of HIV decline (Gregson *et al.* 2006; Hallett *et al.* 2006; Halperin *et al.* 2011) with men limiting their sex-

ual partners as resources to provide for them diminished. Such control of decision-making in Zimbabwean households soon after marriage has been described (Matavire 2012), and the struggle to teach women about their reproductive health rights was recognised more than a decade ago (Njovana & Watts 1996). Abused pregnant women were more likely to report being stopped from using contraception before the pregnancy or prevented from accessing antenatal care, confirming the male domination in decisions of sexual and reproductive health. Similar findings were reported in India (Koski *et al.* 2011), whilst two studies from the US reported several ways in which men exercise control over women's reproductive health (Miller *et al.* 2010; Moore *et al.* 2010). However, further research is needed to help us understand the relationship between violence and reproductive health decision-making including specific factors such as type of contraception use. Continued effort is needed to target men in reproductive health programmes to ensure sharing of reproductive health decisions in programmes such as the low-cost antenatal visit-specific short educational interventions, which was able to reduce women's odds of reporting reproductive coercion by 71% in the USA (Miller *et al.* 2011). Such interventions may be adapted in developing countries such as Zimbabwe to help women with abusive partners.

HIV and HIV-related risk factors

No HIV-related factors were found to be associated with both physical and/or sexual violence and severe physical and/or sexual violence except that a decrease in severe violence was associated with women's partners knowing their own HIV status. This finding implies that if men know their status, they would treat their partners better. It might also mean that they had communicated about HIV and testing although our study did not explore this further. The lack of association between violence and HIV infection found in this study is not surprising and is consistent with recent findings from pooled analysis of ten low-middle income countries using DHS data (OR, 1.05; CI 0.90–1.22) as well as an analysis of individual countries data including Zimbabwe (0.97 CI, 0.83–1.15) that found no significant association except for a negative association for Haiti (OR, 0.45; CI 0.23–0.90) (Harling *et al.* 2010). In a similar analysis of risk factors associated with partner violence using DHS data from Zimbabwe, HIV-positive status was not associated with increased odds of experiencing violence (OR, 1.11; CI, 0.91–1.34) (Nyamayemombe *et al.* 2010). Similarly, a study based on DHS population data in Rwanda found that HIV was only associated with severe psychological violence but not

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with physical and/or sexual IPV (Kayibanda *et al.* 2012). Although we cannot directly compare these findings because these studies were not based on IPV during pregnancy and they analysed data from either currently married (Nyamayemombe *et al.* 2010) or ever married (Harling *et al.* 2010) women – excluding single women which our study included – they do provide insight on the general epidemiology and complicatedness of the intersections between IPV and HIV in Zimbabwe and across the globe. The lack of a significant relationship between HIV-related factors and violence or severe violence could also be explained by interactions with variables we did not measure. The high prevalence of IPV and HIV may also make the association difficult to find as the two are commonly present in the population. Also, whilst IPV was experienced during pregnancy, we do not know when women were infected by HIV, and therefore, longitudinal studies are best suited to explore the relationship between IPV and HIV status disclosure.

Limitations

The cross-sectional nature of the study limits causal inferences. We could not establish the direction of causality between IPV and unequal gender norms. However, as literature suggests, the bidirectional relationship between IPV and unequal gender norms helps us to understand that intervening at one level can alter the other in a positive way. Although the study was about violence during pregnancy, it is not representative of all pregnant women in Harare because 19.4% pregnant women would not visit the clinic postnatally (Munjanja *et al.* 2009). However, interviewing women post-natally gave us an opportunity to interview women who reported being stopped from visiting prenatal care whom we could have missed if we had done interviews during pregnancy. Although we interviewed women who attended the 10 days postpartum visit – a near representative sample of recently pregnant women – we still missed women who aborted, miscarried or were in other circumstances that prevented them from attending a post-natal clinic.

Conclusions

The high rates of IPV during pregnancy among post-natal attendees in this study are among the highest ever reported. The study found IPV to be associated with a range of behavioural and pregnancy-related factors but not associated with HIV infection and most demographic factors. Primary prevention interventions are needed in form of community educational campaigns to change gender inequitable norms, beliefs and practices. Lessons

about changing gender inequitable beliefs can be learnt from successful interventions with both adults (Dunbar *et al.* 2010) and young people (Hallfors *et al.* 2011) in Zimbabwe. Secondary prevention mechanisms by midwives in antenatal and post-natal care settings should address IPV during pregnancy because these are unique opportunities to consistently contact women at risk.

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References

- Abramsky T, Watts C, Garcia-Moreno C *et al.* (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.
- Alhabib S, Nur U & Jones R (2010) Domestic violence against women: systematic review of prevalence studies. *Journal of Family Violence* **25**, 369–382.
- Ansell N (2001) 'Because it's Our Culture!' (Re)negotiating the Meaning of Lobola in Southern African Secondary Schools. *Journal of Southern African Studies* **27**, 697–716.
- Auerbach JD, Parkhurst JO & Cáceres CF (2011) Addressing social drivers of HIV/AIDS for the long-term response: conceptual and methodological considerations. *Global Public Health* **6**(Suppl. 3), 293–309.
- Bacchus L, Mezey G & Bewley S (2006) A qualitative exploration of the nature of domestic violence in pregnancy. *Violence Against Women* **12**, 588–604.
- Campbell JC (2002) Health consequences of intimate partner violence. *The Lancet* **359**, 1331–1336.

S. Shamu *et al.* **Intimate partner violence during pregnancy**

- Campbell JC, Baty ML, Ghandour RM, Stockman JK, Francisco L & Wagman J (2008) The intersection of intimate partner violence against women and HIV/AIDS: a review. *International Journal of Injury Control and Safety Promotion* **15**, 221–231.
- Clark CJ, DE Bloom, Hill AG & Silverman JG (2009) Prevalence estimate of intimate partner violence in Jordan. *Eastern Mediterranean Health Journal* **15**, 880–889.
- Covington DL, Hage M, Hall T & Mathis M (2002) Preterm delivery and the severity of violence during pregnancy. *Obstetrical & Gynecological Survey* **57**, 329–330.
- Cripe SM, Sanchez SE, Perales MT, Lam N, Garcia P & Williams MA (2008) Association of intimate partner physical and sexual violence with unintended pregnancy among pregnant women in Peru. *International Journal of Gynecology and Obstetrics* **100**, 104–108.
- CSO and Macro (2007) Zimbabwe Demographic and Health Survey 2005–2006 CSO and Macro International Inc., Calverton, MD.
- Devries KM, Kishor S, Johnson H, Stöckl H, Bacchus LJ, Garcia-Moreno C & Watts C (2010) Intimate partner violence during pregnancy: analysis of prevalence data from 19 countries. *Reproductive Health Matters* **18**, 158–170.
- Dunbar MS, Maternowska MC, Kang M-SJ, Laver SM, Mudekunya-Mahaka I & Padian NS (2010) Findings from SHAZ!: a feasibility study of a microcredit and life-skills HIV prevention intervention to reduce risk among adolescent female orphans in Zimbabwe. *Journal of Prevention and Intervention in the Community* **38**, 147–161.
- Dunkle KL, Jewkes RK, Brown HC, Gray GE, McIntyre JA & Harlow SD (2004) Gender-based violence, relationship power, and risk of HIV infection in women attending antenatal clinics in South Africa. *The Lancet* **363**, 1415–1421.
- Eaton L, Kalichman S, Sikkema K, Skinner D, Watt M, Pieterse D & Pitpitan E (2012) Pregnancy, alcohol intake, and intimate partner violence among men and women attending drinking establishments in a Cape Town, South Africa township. *Journal of Community Health* **37**, 208–216.
- Fanslow J, Silva M, Robinson E & Whitehead A (2008) Violence during pregnancy: associations with pregnancy intendedness, pregnancy-related care, and alcohol and tobacco use among a representative sample of New Zealand women. *Australian and New Zealand Journal of Obstetrics and Gynaecology* **48**, 398–404.
- Farid M, Saleem S, Karim MS & Hatcher J (2008) Spousal abuse during pregnancy in Karachi, Pakistan. *International Journal of Gynecology and Obstetrics* **101**, 141–145.
- Fawole AO, Hunyinbo KI & Fawole OI (2008) Prevalence of violence against pregnant women in Abeokuta, Nigeria. *Australian and New Zealand Journal of Obstetrics and Gynaecology* **48**, 405–414.
- García-Moreno CJ, Jansen HAFM, Ellsberg M, Heise L & Watts C (2005) WHO Multi-country Study on Women's Health and Domestic Violence Against Women: Initial Results on Prevalence, Health Outcomes and Women's Responses. WHO, Editor, Geneva.
- Gilbert L, El-Bassel N, Wu E & Chang M (2007) Intimate partner violence and HIV risks: a longitudinal study of men on methadone. *Journal of Urban Health: Bulletin of the New York Academy of Medicine* **84**, 667–680.
- Goodwin MM *et al.* (2000) Pregnancy intendedness and physical abuse around the time of pregnancy: findings from the pregnancy risk assessment monitoring system, 1996–1997. *Maternal and Child Health Journal* **4**, 85–92.
- Gregson S, Garnett GP & Nyamukapa CA *et al.* (2006) HIV decline associated with behavior change in eastern Zimbabwe. *Science* **311**, 664–666.
- Guo SF, Wu JL, Qu CY & Yan RY (2004) Physical and sexual abuse of women before, during, and after pregnancy. *International Journal of Gynecology and Obstetrics* **84**, 281–286.
- Hallett TB, Aberle-Grasse J & Bello G *et al.* (2006) Declines in HIV prevalence can be associated with changing sexual behaviour in Uganda, urban Kenya, Zimbabwe, and urban Haiti. *Sexually Transmitted Infections* **82**(Suppl. 1), i1–i8.
- Hallfors D, Cho H, Rusakaniko S, Iritani B, Mapfumo J & Halpern C (2011) Supporting adolescent orphan girls to stay in school as HIV risk prevention: evidence from a randomized controlled trial in Zimbabwe. *American Journal of Public Health* **101**, 1082–1088.
- Halperin DT, Mugurungi O & Hallett TB (2011) A surprising prevention success: why did the HIV epidemic decline in Zimbabwe? *PLoS Med* **8**, e1000414.
- Harling G, Msisha W & Subramanian SV (2010) No association between HIV and intimate partner violence among women in 10 developing countries. *PLoS ONE* **5**, e14257.
- Heise L (1998) Violence against women: an integrated, ecological framework. *Violence Against Women* **4**, 262–290.
- Heise L, Ellsberg M & Gottmoeller M (2002) A global overview of gender-based violence. *International Journal of Gynecology and Obstetrics* **78**(Suppl. 1), S5–S14.
- Jewkes R (2002) Intimate partner violence: causes and prevention. *The Lancet* **359**, 1423–1429.
- Jewkes R (2010) Gender inequalities must be addressed in HIV prevention. *Science* **329**, 145–147.
- Jewkes RK, Dunkle K, Nduna M & Shai N (2010) Intimate partner violence, relationship power inequity, and incidence of HIV infection in young women in South Africa: a cohort study. *The Lancet* **376**, 41–48.
- Jewkes R, Levin J & Penn-Kekana L (2002) Risk factors for domestic violence: findings from a South African cross-sectional study. *Social Science Medicine* **55**, 1603–1617.
- Jewkes R, Dunkle K & Nduna M *et al.* (2006a) Factors associated with HIV sero-status in young rural South African women: connections between intimate partner violence and HIV. *International Journal of Epidemiology* **35**, 1461–1468.
- Jewkes R, Dunkle K, Koss MP, Levin JB, Nduna M, Jama N & Sikweyiya Y (2006b) Rape perpetration by young, rural South African men: prevalence, patterns and risk factors. *Social Science Medicine* **63**, 2949–2961.
- Jewkes R, Sikweyiya Y, Morrell R & Dunkle K (2011) The relationship between intimate partner violence, rape and HIV amongst South African men: a cross-sectional study. *PLoS ONE* **6**, e24256.

S. Shamu *et al.* Intimate partner violence during pregnancy

- Jewkes R, Nduna M, Jama Shai N & Dunkle K (2012) Prospective study of rape perpetration by young South African men: incidence risk factors. *PLoS ONE* 7, e38210.
- Johnson JK, Haider F, Ellis K, Hay DM & Lindow SW (2003) The prevalence of domestic violence in pregnant women. *BJOG: An International Journal of Obstetrics & Gynaecology* 110, 272–275.
- Kayibanda JF, Bitera R & Alary M (2012) Violence toward women, men's sexual risk factors, and HIV infection among women: findings from a national household survey in Rwanda. *JAIDS Journal of Acquired Immune Deficiency Syndromes* 59, 300–307.
- 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.
- Leung WC, Leung TW, Lam YYJ & Ho PC (1999) The prevalence of domestic violence against pregnant women in a Chinese community. *International Journal of Gynecology and Obstetrics* 66, 23–30.
- Matavire M (2012) Interrogating the Zimbabwean traditional jurisprudence and the position of women in conflict resolution. A case of the Shona Tribes in Muzarabani District. *International Journal of Humanities and Social Science* 2, 218–223.
- Miller E, Decker MR & McCauley HL *et al.* (2010) Pregnancy coercion, intimate partner violence and unintended pregnancy. *Contraception* 81, 316–322.
- Miller E, Decker MR & McCauley HL *et al.* (2011) A family planning clinic partner violence intervention to reduce risk associated with reproductive coercion. *Contraception* 83, 274–280.
- Moore AM, Frohvirh L & Miller E (2010) Male reproductive control of women who have experienced intimate partner violence in the United States. *Social Science Medicine* 70, 1737–1744.
- Munjanja SP, Nystrom L, Nyandoro M & Magwali T (2009) Maternal and Perinatal Mortality Study 2007. Ministry of Health and Child Welfare, Harare, Zimbabwe. http://www.unicef.org/zimbabwe/ZMPMS_report.pdf (accessed 20 June 2012).
- Njovana E & Watts C (1996) Gender violence in Zimbabwe: a need for collaborative action. *Reproductive Health Matters* 4, 46–55.
- Ntaganira J, Muula AS, Masaisa F, Dusabeyezu F, Siziya S & Rudatsikira E (2008) Intimate partner violence among pregnant women in Rwanda. *BMC Women's Health* 8, 17.
- Ntaganira J, Muula AS, Siziya S, Stoskopf C & Rudatsikira E (2009) Factors associated with intimate partner violence among pregnant rural women in Rwanda. *Remote and Rural Health* 9, 1153.
- Nyamayemombe C, Mishra V, Rusakaniko S, Benedikt C, Gwazane M & Mukweza P (2010) The association between Violence against Women and HIV: evidence from a National Population-Based Survey in Zimbabwe, in Zimbabwe Working Papers No. 42010: Calverton, Maryland.
- Olagbuji B, Ezeanochie M, Ande A & Ekaete E (2010) Trends and determinants of pregnancy-related domestic violence in a referral center in southern Nigeria. *International Journal of Gynecology and Obstetrics* 108, 101–103.
- Pallitto CC & O'Campo P (2004) The relationship between intimate partner violence and unintended pregnancy: analysis of a national sample from Colombia. *International Family Planning Perspectives* 30, 165–173.
- Perales MT, Cripe SM, Lam N, Sanchez SE, Sanchez E & Williams MA (2009) Prevalence, types, and pattern of intimate partner violence among pregnant women in Lima, Peru. *Violence Against Women* 15, 224–250.
- Rabin RF, Jennings JM, Campbell JC & Bair-Merritt MH (2009) Intimate partner violence screening tools: a systematic review. *American Journal of Preventive Medicine* 36, 439–445.
- 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 health* 19, 2017–2031.
- 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, e17591.
- Shamu S, Abrahams N, Temmerman M, Shefer T & Zarowsky C (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, e43148.
- Shumba A (2001) Epidemiology and etiology of reported cases of child physical abuse in Zimbabwean primary schools. *Child Abuse & Neglect* 25, 265–277.
- Shumway J, O'Campo P, Gielen A, Witter FR, Khouzami AN & Blakemore KJ (1999) Preterm labor, placental abruption, and premature rupture of membranes in relation to maternal violence or verbal abuse. *The Journal of Maternal-Fetal Medicine* 8, 76–80.
- Silverman JG, Gupta J, Decker MR, Kapur N & Raj A (2007) Intimate partner violence and unwanted pregnancy, miscarriage, induced abortion, and stillbirth among a national sample of Bangladeshi women. *BJOG: An International Journal of Obstetrics & Gynaecology* 114, 1246–1252.
- StataCorp (2009) Stata Statistical Software, in Release 11. StataCorp LP, College Station, TX.
- Taillieu TL & Brownridge DA (2010) Violence against pregnant women: prevalence, patterns, risk factors, theories, and directions for future research. *Aggression and Violent Behavior* 15, 14–35.
- Tsai AC & Subramanian SV (2012) Proximate context of gender-unequal norms and women's HIV risk in sub-Saharan Africa. *AIDS* 26, 381–386.
- Watts C, Keogh E, Ndlovu M & Kwaramba R (1998) Withholding of sex and forced sex: dimensions of violence against Zimbabwean women. *Reproductive Health Matters* 6, 57–65.
- 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.

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