



## Intimate Partners Violence in Sub-Saharan Africa: Review of Risk Factors and Impacts

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### Authors' contributions

This work was carried out in collaboration between both authors. The researcher worked out the study conception, design, and synthesis of the selected articles. Author NRG contributed to the discussion and review of the draft manuscript. Both authors read and approved the final manuscript.

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### ABSTRACT

**Background:** Intimate Partner Violence (IPV) against women is one of the most known public health concerns. The depth of the problem varies across regions and different settings. The purpose of this scoping review is to assess the overall prevalence and risk factors of IPV in the context of Sub-Saharan Africa (SSA).

**Methods:** The review was conducted based on 24 articles selected from PubMed and google search. The selection considered only those conducted in SSA based on a representative sample size of women of reproductive age (15-49), published in peer-reviewed journals in the last ten years, and those having resemblance in study design and conceptualization of IPV.

**Results:** While slight methodological variations exist among the individual studies, nearly all the reported prevalence of IPV were unacceptably high. The lifetime experience of IPV ranged from about 20% in some societies to more than 75% in other settings. Physical and emotional violence were the most frequently reported type of IPV. One common feature of all studies reviewed is that they all recognized the important role of women's attitude (acceptance) towards their experience of IPV. Good proportion (ranging between 33-57%) of women justified IPV more often than men do.

The studies further documented a wide range of risk factors associated with IPV, more importantly, low maternal and paternal education, partner's alcohol drinking behavior, childhood experience of domestic violence, and certain household and community/cultural factors.

**Conclusion:** Given considerable proportion of women experienced one or more forms of IPV in most settings in SSA, national and local governments have a long way to go in preventing or reducing its occurrence in their geographic areas if they must meet SDG 3 (i.e., better health of children and women). Since IPV is embedded in most cultures; concerned authorities should establish appropriate norms, enhance women's status, and ensure proper implementation of policies and laws on abuse. Community reflections, mass education/ behavioral change communications are essential in this endeavor.

*Keywords: DHS; domestic violence; intimate partners' violence; Sub-Saharan Africa.*

## 1. BACKGROUND

Intimate Partners Violence (IPV), as one form of domestic violence, is both human right violation and public health concerns [1]. A victim of spousal violence is susceptible to both short and long-lasting physical, emotional, and financial consequences. These effects are not confined only to the victim, but also stretch to the victim's family, friends and the society at large [2,3]. In its broader spectrum, IPV also impacts the social and economic development of countries [4].

Worldwide, about 35% of women were estimated to experience either sexual or physical violence perpetrated by an intimate partner [5]. The prevalence is even worse in Sub-Saharan Africa (SSA) where women face a wide range of violence both at home and community levels. About 45.6% of the women in this African region have experienced at least one IPV form in their lifetime [5]. For instance, the 2016 Demographic and Health Survey (DHS) of Malawi indicated that 42% of women experienced at least one form of IPV in their lives [6]. Similarly, close to a third of women in Ethiopia faced at least one form of domestic violence during a reference period of 12 months (CSA and Macro, 2016). Generally, domestic violence against women occurs in all social and economic classes, but women living in poverty are more likely to experience abuse.

Approval of partner violence and its psychosocial consequences have been recognized [7]. Most studies demonstrated that the rate of justification and approval of domestic physical violence against wives in many countries is relatively high. Moreover, these studies found that women tended to approve of IPV (including physical violence) faster than men. The factors reflecting lower socio-economic status are associated with typically higher acceptance of IPV [8]. Patriarchy reflects social norms and attitudes around

women's role regarding men as a source of partner violence. The power of male dominance, as reflected in studies, revealed that large percentages of both women and men believe that male violence against women is acceptable under different circumstances [9,8].

An increasing body of research has recognized a range of adverse reproductive health consequences arising from women's experiences of IPV, which includes unplanned pregnancy, maternal morbidity, fetal loss, mortality, and increased vulnerability to sexually transmitted infections, including HIV [10,11]. In Ghana, women's experience of IPV was associated with increased risk of contracting HIV and depression [12]. In some studies, conducted in SSA over the last few years, the effects of IPV on the wellbeing of both women and their children were reported. For instance, in a recent longitudinal study conducted in Tanzania, Neamah and others [13] found significant association between women's sexual/ physical IPV and cognitive development, child stunting and delayed motor skills (Neamah et al., 2018). Another study in Tanzania found that IPV against women was a risk factor for child morbidity [14]. Given these severe effects on maternal and child health, continued research on the subject in SSA is critically essential. Public health and social work engagement is needed to continue to build knowledge and effective response in this area.

While increasing number of researchers are interested in conducting multicounty analysis of IPV, there is little cross-national country-level evidence [1]. This scoping review attempts to synthesize the findings reported by research conducted in SSA assessing the factors associated with IPV and its impacts on selected domains of individual and household wellbeing based on studies conducted over the last few years.

## 2. METHODS

### 2.1 Sources of Information and Searching Strategy

Studies conducted on IPV in SSA are increasing and are made available in open access. Thus, this scoping review was based on searching through the electronic database (PubMed and Google scholar). Since the available studies vary in scope and methodology used, the present review primarily focused on those which examined the determinants, risk factors and impacts in Sub-Saharan Africa countries. In searching and locating studies, we used five keywords: domestic violence, the prevalence of IPV, determinants, impacts, and sub-Saharan Africa. In the first round of searching, we extracted 131 publications from PubMed and Google scholar. The total number of articles retained, after removing duplicates, was 82. The second stage of selection and extraction involved screening titles and abstracts for relevance, scope, and study approaches employed by individual studies. At this stage, we excluded some published materials. Finally 24 full texts were included for review. Thus, the selected articles were all published in peer-reviewed journals in the last ten years. As the main objective was not estimating prevalence, we did not do a quality assessment of the included studies.

### 2.2 Summary of Study Designs

Nearly all the reviewed studies (n=23) employed a cross-sectional research design with quantitative approaches. While seventeen of them have drawn data from a specific country, seven employed multi-country analysis. In most of the selected studies, married women of reproductive age (15-49) with infant and young children, and female and male adults have been used as respondents. The sample size of each quantitative survey was determined using one of the probability sampling methods. Most studies used a survey questionnaire as their primary data collection instrument.

### 2.3 Strategy for the Synthesis

The analysis has primarily focused on assessing two critical aspects of IPV: risk factors and impacts on individual women, children's health and other household livelihood domains. The

study undertook both quantitative and qualitative summaries and synthesis.

## 3. RESULTS

Table 2 summarizes the prevalence of intimate partner violence reported by the individual studies. It is noted that the prevalence are exceptionally high in some of the countries than others. The reported prevalence varies according to the nature of measurements used. For instance, some of the studies used a reference period of 12 months while others measured lifetime experiences of IPV (see Table 2).

Table 3 presents main study domains (i.e., the outcome variable), the explanatory variables, and a summary of findings for each study. Overall, most of the studies examined the prevalence and determinants/risk factors at the individual, household, and community levels and the effects on women and household livelihood (such as women's health, nutrition, children's well-being, household wealth, and income). It is noted that the measurement of violence against women varies slightly from one study to another. In some of the studies, IPV was understood in its broader sense and includes dimensions of violence at household and community levels. In others, IPV is defined as sexual, physical, and verbal abuse experienced by wives from their husbands. Few of the outcome variables tried to measure the level of attitudes/acceptance/justification of violence at home.

The framework presented in Fig. 1 below was developed based on the risk factors identified in the reviewed articles. The framework resembles the Social Ecological Model (SEM) developed in 1970's. This model identified core assumptions that underpin the SEM such as the influences individuals have on their environment, the influence of others, and the environment on the individual [15].

The framework provides a simplistic model in understanding the primary pathways through which individual and household level predisposing factors influence IPV and its subsequent impacts. Predisposing factors are the combination of socio-economic characteristics such as individual variables (age, education, alcohol intake...etc.), household/familial variables (household size, husband-wife communication, household assets...etc.), community variables (norms, religion, services, groups membership,

community attitudes...etc.) and societal/ macro level factors (such as legislation, policy, governance...etc.). These factors, either individually or in combination, determine the likelihood of a woman experiencing IPV. Most of these factors, which are not directly measurable, shape the individual/ household level predisposing factors and lead to IPV and its ultimate outcome variable i.e. impacts on women, children, and household wellbeing.

#### 4. DISCUSSION

Given the significant impacts of IPV on women's lives and household livelihood, the current study has primarily aimed to understand the overall prevalence, risk factors, and effects of IPV in Sub-Saharan African countries. The review included studies on power at the individual, household, and community levels.

The review witnessed that women in SSA experienced unacceptably high prevalence of Intimate Partners Violence (IPV) ranging from verbal remarks to physical and sexual violence. The prevalence of IPV varied across studies depending on the study settings and slight variations in methodology employed. Looking at the summary results presented above, it turns out that the reported variations could be due to the reference periods (ever versus current/recent) used in measuring the reported occurrence of IPV. Those measuring the lifetime occurrence of IPV reported a much higher prevalence of the event. For instance, in the Tanzanian study (n=1,278), almost 40% of women reported having experienced physical or sexual violence in their life, whereas the most recent (last one year) prevalence was 33% [16]. In the study conducted in Uganda (n=1,318) and in Cote d'Ivoire (n=981), women reported experiencing physical or sexual violence at least once in their lifetime [17,18]. On the other hand, when the reference period of observation is limited to 12 months, the reported prevalence of IPV becomes modest. For instance, in the study of the 11,698 women in Malawi, only about 18% of women reported moderate to severe violence in 12 months preceding the survey date [19]. The overall prevalence of recent exposure to spousal sexual violence for 22 SSA countries (n=37,915

women) was only 9.6% [20]. Similarly, only about 20% prevalence of IPV was reported in other studies included in this review [21,22]. The overall observations of the findings indicate that emotional and physical violence were most frequently reported types [22,23].

Sub-regional analyses found that Eastern Africa (42%), including Ethiopia and Uganda, were the most affected by all forms of IPV [24] [25], followed by Western Africa (41.7%). Other findings also confirmed that the two regions experienced high prevalence rates of IPV compared to other areas in Africa [26]. The prevalence also varies across countries. The survey from South Africa found a relatively higher (71.3%) proportion of women experiencing physical violence by their husbands. This finding is slightly higher than the average prevalence of physical IPV among women's general population in SSA [27]. However, studies in Nigeria, Zimbabwe, Kenya, Mozambique, and Cameroun measured the prevalence of violence (sexual, physical, and emotional) as 30.5%, 43.4%, and 45.3%, 53.9%, and 57.6%, respectively [28]. The most widespread forms of physical IPV against women were slapping and pushing. The prevalence in the South African study was also significantly higher compared to studies conducted in Ghana (39%), Rwanda (56%), and Uganda (57%), which are considered high in the SSA region [29].

The reported figures agree with studies conducted in other parts of the world [30]. For example, the research conducted by Kim et al. [31] showed that one-quarter of women had experienced both sexual and physical violence from an intimate partner in their lifetime. Among those reporting ever having experienced such violence, 71.3% had experienced physical violence and 19.1% experienced physical and sexual power; only 9.6% said sexual violence alone. In both the reviewed studies and other literature worldwide, some women reported that their partners' violence act is justified [32]. Interestingly, however, a considerable number of women reported that their partners' behavior violated their wishes and welfare, a signal that all wives do not fully accept these cultural norms, a finding that deserves further studies.

**Table 1. Summary of sampling and study designs for each selected study, SSA**

<b>Study</b>	<b>Country</b>	<b>Approaches</b>	<b>Design</b>	<b>Sample (n)</b>	<b>Data and year</b>
Sardinha et al., 2018 [1]	Sub-Saharan Africa and South East Asian	Quantitative	Cross- sectional	1,174,108 women aged 15-49 and men aged 15-59 years	49 DHS 2005-2017
Felb et al., 2014 [18]	Cote d'Ivoire	Quantitative	Cross- sectional	981 women (aged above 18)	National Data
Guracho & Biftu [33]	Ethiopia	Quantitative	Systematic review	15 Articles	Pub-Med and Google
Adjah and Agbemafle [34]	Ghana	Quantitative	Cross- sectional	1524 married women	GDHS 2008
Doku and Asante [35]	Ghana	Quantitative	Cross- sectional	10,607 women aged 15 - 49 years	GDHS 2003-2008
Mandal & Hindin (2012)	Malawi	Quantitative	Cross- sectional	11,698 Women ages 15-49 and men 3,261 ages 15-59	MDHS 2004
Titilayo et al. [23]	Nigeria	Quantitative	Cross sectional	26,997 ever married women age 25-39	NDHS 2013
Bola [21]	Nigeria	Quantitative	Cross- sectional	21,196 women ever married and 6,423 unmarried women	NDHS 2013
Benebo et al. [36]	Nigeria	Quantitative	Cross- sectional	20,802 ever-partnered women of age (15-49 year)	NDHS 2013
Solanke [22]	Nigeria	Quantitative	Cross- sectional	19, 925 women ages (15-49) years	NDHS 2013
Thomson et al. [37]	Rwanda	Quantitative	Cross sectional	4, 338 couples	RDHS 2005 and 2010
Kim et al., 2007 [31]	South Africa	Quantitative	Cross-sectional	40,000 eligible loan recipients and control participants	IMAGE study between 2001-2005
Bamiwuye and Odimegwu [28]	Cameron, Kenya, Mozambique, Nigeria, Zambia, and Zimbabwe	Quantitative	Cross-sectional	Women aged 15-49 from Cameroun (3961), Kenya (4336), Mozambique (5610), Nigeria(16,763) Zambia (3,010) and Zimbabwe (5,016)	DHS data of each country
Epstein et al. [38]	19 Countries in Sub-Saharan Africa	Quantitative	Cross-sectional	83 990 partnered women aged (15-49) years	DHS 2010-2018
Hung et al. [39]	11 Countries in Sub-Saharan Africa	Quantitative	Cross-sectional	11,730 women aged 15-49 years	DHS 2008
Upadhyay and Karasek +[40]	4 Sub-Saharan African countries: Guinea, Mali,	Quantitative	Cross-sectional	724 in Guinea, 805 in Mali, 303 in Namibia and 945 in Zambia.(married women	DHS Guinea (2005), Mali (2006), Namibia (2006-2007), and

<b>Study</b>	<b>Country</b>	<b>Approaches</b>	<b>Design</b>	<b>Sample (n)</b>	<b>Data and year</b>
Muchomba [20]	Namibia, and Zambia. 22 Sub-Saharan African countries	Quantitative	Cross-sectional	aged 15-49 37,915 women aged 15-49	Zambia (2007). DHS 2016
Uthman et al. [41]	17 Sub-Saharan African countries	Quantitative	Cross-sectional	5,000 and 15,000 household, women aged (15-49) and men aged (15-59)	DHS between 2003-2007
Ali et al. [42]	Kassala, eastern Sudan	Quantitative	Cross-sectional	440,491 women of reproductive age	National data from March to June 2014
Vyas and Jansen [16]	Tanzania	Quantitative	Cross-sectional	1,278 married and cohabiting couples	TDHS 2005
Wandera et al. [43]	Uganda	Quantitative	Cross-sectional	1,307 married women	UDHS 2011
Kwagala et al. [44]	Uganda	Quantitative	Cross-sectional	857 women in Union age (15-49)	UDHS 2011
Speizer [17]	Uganda	Quantitative	Cross-sectional	1,318 ever-married or in union men age 15-59 years and 1,598 ever-married or in union women age 15-49 years.	UDHS 2006 (UBOS & Marco International Inc., 2007)
Muarry et al. [45]	Zambia	Qualitative	Cross-sectional	25 HIV women across the age range of 18-40	Key Informants Interview (KI)

**Table 2. Prevalence/volumes of the problem as reported by different studies**

<b>Study</b>	<b>Assessing the prevalence/volume of the problem as reported by different studies</b>
Sardinha et al., [1]	The prevalence of domestic violence supportive attitudes ranked within and between regions. Over one in three people (36.40%) across 49 countries justified domestic violence in at least one circumstance [1]
Falb et al., 2014 [18]	One in five women reported lifetime partner –perpetrated reproductive coercion (18.6%). Nearly half (49.8%) of women reported experiencing physical or sexual violence from the partner at some point in their lifetime, signifying that IPV is commonplace in the region, regardless of marital status [18].
Guracho and Biffu, [33]	The pooled prevalence of women's attitudes towards justifying domestic violence was 57% (95% CI; 47.0-67.2%). The reason for explaining was burning food, argues with their husband, goes out without telling, neglects children, refuses sex, unfaithful, disobeys, and suspected infidelity [33].
Adjal and Agemafle, [34]	Of 1524 ever-married women in the study, 33.6 % had ever experienced domestic violence. The risk of increasingly experiencing domestic violence was 35 % for women who reside in urban areas. The risk of domestic violence was 41 % higher for women whose husbands ever experienced their father beating their mother. Women whose mothers ever abused their father were three times more likely to experience domestic violence than women whose mother did not hit their father. The risk of domestic violence was 48 % less likely for women whose husbands had higher than secondary education than women whose partner never had formal education. Women whose husbands consume alcohol were 2.5 times more likely to experience domestic violence than women whose husbands do not drink alcohol [34]
Doku and Asante, [35]	The prevalence of approving at least one form of domestic violence against wives was 39% [35]
Mandal and Hindin, [19]	About 18% of women reported moderate-severe violence, and 1% experienced very severe violence in 12 months. Factors significantly associated with women's physical violence experience included women who reported intimating physical violence against their partners, women's work status, partners' lower education level, and husbands' alcohol intake. Women with a controlling partner were at increased risk of experiencing physical violence in the past year [19]
Titilayo et al., [23]	More women experienced emotional violence (19.7%), followed by those who experienced physical violence (15.1%), and the least experience was among those who reported ever to have been exposed to sexual abuse (4.6%) [23]
Bola et al., [21]	Overall, 19.9% of women experienced at least one type of spousal violence, and 13.8% of the women had experienced at least on pregnancy termination [21]
Benebo et al. [36]	In this study, 5224 (23.5%) ever-partnered women aged 15-49 reported experiencing at least one form of IPV (physical, sexual, and emotional) at some point in their life. This prevalence was lower than the global lifetime prevalence of 30% from the WHO global and regional estimate of violence against women [36]
Solanke, [22]	Overall, one-fifth of respondents had experienced at least one type of intimate partner violence. Women who were exposed to interpersonal violence compare with non-exposed women had a high prevalence of at least one kind of partner physical violence (25.4% vs. 8.1%), partner sexual violence (10.4% vs. 3.1%), partner emotional violence (40.3% vs. 13.8%) and at list one type of IPV (44.3% vs. 17.4%) [22]
Thomson et al., [37]	Women who self-reported in household surveys ever-experiencing intimate partner violence (IPV) increased from 34% in 2005

<b>Study</b>	<b>Assessing the prevalence/volume of the problem as reported by different studies</b>
	to 56% in 2010 in Rwanda [37]
Kim et al., [31]	The study revealed that one-quarter of women experienced physical and sexual violence from an intimate partner in their lifetime. With those reporting ever having experienced such violence, 71.3% had experienced physical violence, and 19.1% experienced physical and sexual power; only 9.6% said sexual violence alone [31]
Bamiwuye and Odimegwu [28]	The prevalence of violence (physical, sexual, and emotional) ranges from 30.5% in Nigeria to 43.4 % in Zimbabwe; 45.3% in Kenya; 45.5% in Mozambique; 53.9% in Zambia; and 57.6% in Cameroun [28]
Epstein et al., [38]	The study found a correlation between drought and several manifestations of IPV in pooled analyses. Women in mild/moderate drought were at a similar risk of physical violence to those in severe drought, with 0.7% point and 0.8%-point marginal RDs, respectively [38]
Hung et al., [39]	Among the 46,697 women in the sample, 11 730 (25.1%) reported a personal history of physical violence, and 4 935 (10.6%) reported a personal account of sexual violence [39]
Upadhay and Karasek, [40]	In four countries, being in a couple in which the husband's ideal number of children was higher than the wife's was associated with greater odds nearly 12 times as great in Mali having had more children than excellent (odds ratios, 2.2-11.9). In two countries, Guinea and Mali, the risk also increased when a woman's husband give numeric response 3.2 and 9.1, respectively). Guinea and Zambia women's odds of having more children than ideal increased slightly with increasing age (1.1 each) [40]
Muchomba, [20]	The overall prevalence of recent exposure to spousal sexual violence was 9.6%, with 8.2% of respondents reporting spousal force sexual intercourse in the past year [20]
Uthman et al., [41]	The meta-analyses on sex differences in attitudes towards IPVAW brought together evidence from 17 countries in Sub-Saharan Africa. The findings revealed that women are more likely to justify IPVAW than men in most countries studied [41]
Ali et al., [42]	Out of 1009 women in eastern Sudan, 33.5% (338) reported recent physical violence, and of these 338 women, 179 (53%) and 159 (47%) reported moderate and severe physical violence forms. The prevalence of sexual coercion, verbal insult, and psychological violence was 17% (172\1009), 30.1% (304\1009), and 47.6% (480\1009), respectively. For verbal insult, 20.1% (203/480) and 27.5% (277/480) reported shouting and yelling, respectively. Once more, 251 (24.9%) and 270 (26.8%) women said they experienced divorce threats and second marriage threats, respectively [42]
Vyas and Jansen, [16]	Almost 40% of women in this sample reported that they had experienced physical or sexual violence through an intimate partner in their life and past-year prevalence was 33% [16]
Wandera et al., [43]	Significant predictors of current MCU (25.3%) among women were: women's reported ability to ask a partner to use a condom, several living children, and wealth index [43]
Kwagala et al., [44]	The prevalence of skilled birth attendance among rural women, 55%, is lower than the national majority of 58% and the 63% estimate for developing countries [44]
Speizer, [17]	More than half of women (57%) reported that they have ever experienced physical or sexual violence [17]
Murray et al., [45]	45% of children cited parental fighting as poorly affecting the children and community, and 15% particularly said interpersonal violence (man beating his wife) was a problem for children. 45% of children said dying parents and mourning are complicated, and 25% said that adult alcohol abuse was a big problem cited by children and women [45]



**Table 3. Summary of reported findings/ conclusions made by the individual studies, SSA**

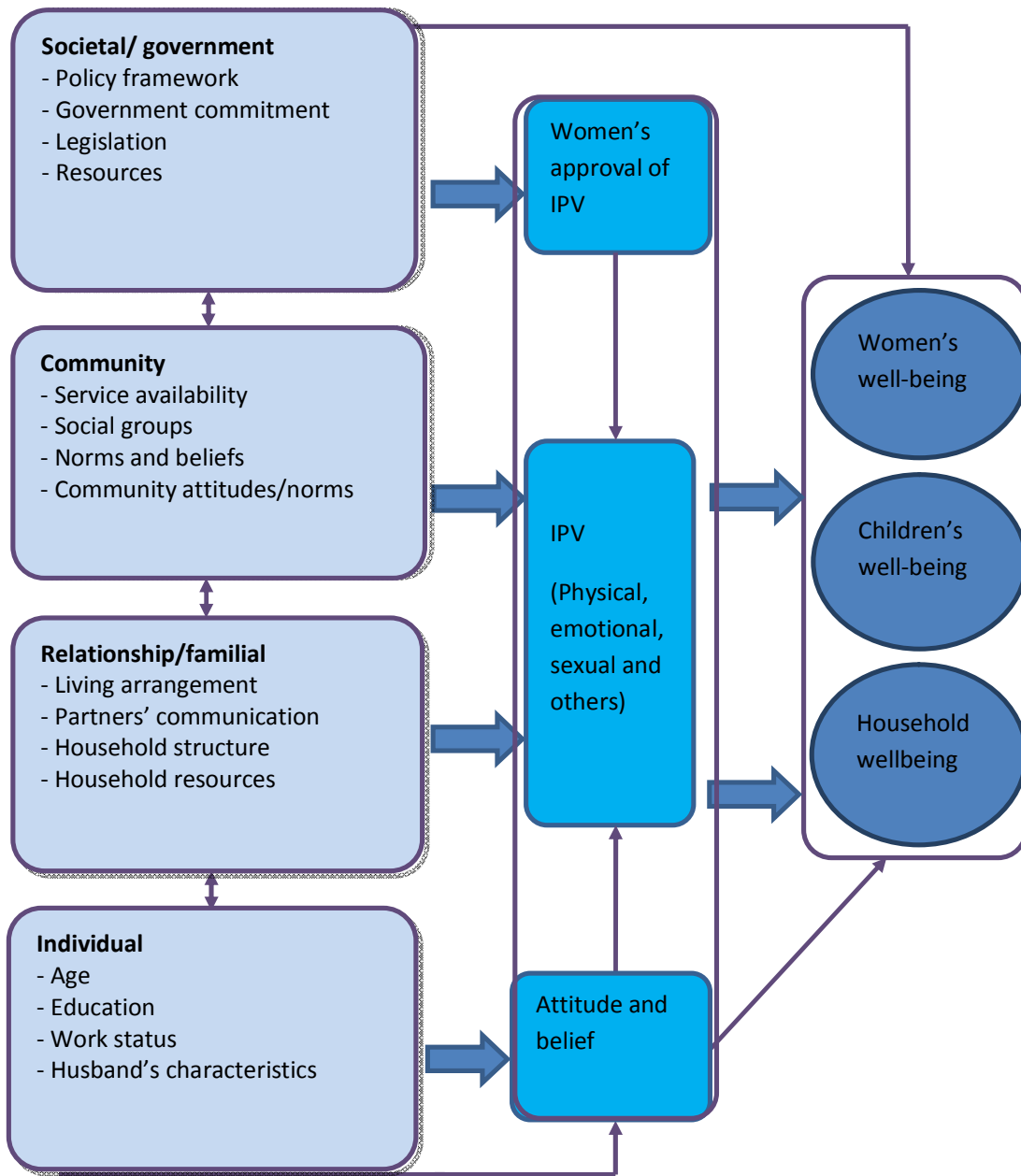
<b>Study</b>	<b>Outcome variable</b>	<b>Explanatory variables</b>	<b>Reported findings/ conclusion made</b>
Sardinha et al., [1]	DHS measured attitudes towards DV using five items	A vigorous household –level multidimensional deprivation index was constructed in line with Sustainable Development Goals using DHS data on housing material, access to primary health care, sanitation, safe drinking water, and primary education [1]	The study reported economic factors, education, and poverty, in particular, had a more significant influence on the societal acceptance of domestic violence amongst women [1]
Falb et al., 2014 [18]	Lifetime physical and Sexual IPV	To determine pregnancy pressure and birth control devastation, women were asked if their partner has ever (1) told you to use birth control; (2) leave you if you did not get pregnant; (3) he would have a baby with someone if you didn't get pregnant; (4) force or pressure you to become pregnant; (5) taken off a condom while having sexual intercourse (6) make holes in the condom so you would get pregnant; (7) taken birth control away from you; and (8) have sex without a condom [18]	The study found a significant relationship between IPV and reported experiences of partner perpetrated reproductive coercion. Notably, women with experiences of IPV were more likely to report reproductive pressure than their counterparts who did not report IPV [18]
Guracho and Bifttu, [33]	Women's attitude towards wife-beating	WHO multi-country assessment device with six items: in your view, does a man have enough reason to abuse or beat his wife if: (1) does not complete her household core to his pleasure? (2) Does she disobey him? (3) refuses to have sexual relations with him? (4) she asks him whether he has other girlfriends?, (5) he suspects that she is unfaithful? and (6) he finds out that she has been cheating? [33]	The study reported that more than half of women and girls accepted domestic violence; the most commonly identified reasons for the acceptance of domestic violence were: burning food, argues with husband, goes without telling, neglects children, refuses sex, unfaithful, does not complete house-work, disobeys husband suspects infidelity, if the wife asks her husband about other women and considering of wife-beating as a sign of love [33]
Adjal and Agemafle, [34]	Domestic violence	These seven (7) questions were used to make variables for physical violence: Did your (last) husband /partner ever i. Slapped you? ii. Twisted your arm or pulled your hair? iii. Push you, shook you, or threw something at you? iv. Punch you? With something that could harm you? v. Kicked, dragged	This study found positive relationships between past exposures to violence in terms of the father abusing mother or vice versa and a women's current status of ever experiencing domestic violence [34]

Study	Outcome variable	Explanatory variables	Reported findings/ conclusion made
		you, or beat you up? vi. Tried to choke or burn you on reason? vii. Treated or attacked you with a knife, gun, or any other weapon [34]	
Doku and Asante, [35]	Factors that influence women approval of domestic physical violence among Ghanaian women aged 15-49	The explanatory variables included residence (urban and rural) and age, marital status, religion, and household wealth, represented by wealth index (in five categories from poorest to richest) [35]	The risk of childhood mortality was higher among children of women with low decision making/DM. However, the study reported that the effects were more potent at the community than the individual level, i.e., an individually empowered woman may have limited DMI if she lives in a society where women have limited decision-making power [35]
Mandal and Hindin, [19]	Respondent, Partner, couple, and Household characteristics	The explanatory variables include age, highest education level, work status, and religion. Partner characteristics included age, highest education level, alcohol use, couples' marital status, and rural or urban residence [19]	The study found factors associated with the likelihood of approving domestic physical violence against wives, such as age, education level, residence, and religion [19]
Titilayo et al., [23]	Mother's experience of under-five mortality	The leading independent variables were family types and domestic violence. Selected variables associated with under-five death included in the analysis such as (age at marriage, educational level, household wealth, region and place of residence) [23]	The study found that a significant association between early marriage, low academic level. Middle or low wealth status, rural home, polygyny family type, and under-five children mortality. [23]
Bola et al., [21]	Pregnancy termination	Critical explanatory variables were the type of spousal violence experienced by the women in at least 12 months preceding the survey. These are physical, sexual, and emotional violence, all captured by several specific intimate partner violent acts. [21]	The study provided evidence that women's education, partner's education, partner's alcohol consumption, and childhood experience of domestic violence were among the multiple factors that predisposed women to spousal violence [21]
Benebo et al. [36]	IVP as the outcome of interest was measured as physical, sexual, and emotional violence.	Individual-level factors women's status; women's status/empowerment encompasses several dimensions of women's life socio-cultural, economic, familial/interpersonal, political, legal, individual, family/household, community, and the larger society [36]	This study showed that higher women's status was negatively associated with IPV, although the association was not conclusive for women's middle states [36]
Solanke, [22]	Intimate partner violence (IPV)	The primary explanatory variable was interpersonal violence [22]	The study further confirmed that individual relationships and community characteristics were

Study	Outcome variable	Explanatory variables	Reported findings/ conclusion made
Thomson et al., [37]	Women's knowledge of physical and sexual violence in the last 12 months	The explanatory variables for men and women included their own demographic, education, employment characteristics, perceptions of violence against women, and decisions about their health care earnings [37]	essential for explaining partner violence occurrence and prevalence [22] In Rwanda, women who self-reported in household survey experiencing intimate partner violence (IPV) increased from 34% in 2005 to 56% in 2010 [37]
Kim et al., [31]	Past years of experience of intimate partners violence	Approach recognizing an interplay between gaining internal skills and overcoming barriers, the study drew upon a conceptual framework that included "power within" (inner merits, such as self-confidence or critical thinking self-confidence skills, that add to individual agency) [31]	The study shows evidence of improved economic well-being and consistent improvements in all nine signs of women's empowerment recognized among intervention participants [31]
Bamiwuye and Odimegwu [28]	Spousal Violence	Spousal variables (measured in three dimensions i) ever experienced physical violence, ii) ever experienced sexual violence, and iii) ever experienced emotional power. Other variables include the respondent's age, level of education, residence, alcoholic intake, respondent's history of violence [28]	The findings show that a similar measurement of household poverty, wealth has produced varying relationships concerning the experience of spousal violence in Sub-Saharan Africa countries [28]
Epstein et al., [38]	Relationship between drought and Intimate partner violence	4 IPV-related outcomes: reporting a controlling partner (a risk factor for IPV) and experiencing emotional violence, physical violence, or sexual in 12 months before the survey. Other variables include the respondent's age, married, the number of live births, rural residence, partner's education level, and partner's age [38]	Findings indicate that drought is associated with IPV measures towards women, with larger positive associations among adolescent girls and unemployed women [38]
Hung et al., [39]	Women's inter-birth interval	There are two primary explanatory variables related to IPV. Lifetime exposure to IPV measured with a modified Conflict Tactics Scale, which inquired about whether the partner or husband had engaged in different acts of physical and sexual violence, ranging from being pushed or slapped to being burned or forced to have sexual intercourse [39]	The study yielded four key findings. First, the study found a statistical association between IPV and shortened inter-birth interval. Second, the evidence of these associations at the levels of both individuals and the community. Third, at both levels of individual and society, the estimated effects of more severe acts. Fourth, these

Study	Outcome variable	Explanatory variables	Reported findings/ conclusion made
			estimated associations were comparable in magnitude with known correlates of the inter-birth interval that traditionally have focused on policy and programming, such as women's education and employment status [39]
Upadhay and Karasek, [40]	Women's ideal number of children	Vital explanatory variables were the three women's empowerment from the standard DHS questionnaire: women's role in household decision-making, attitudes towards wife-beating, and attitudes towards women's right to refuse sex [40]	The findings from analyses of women's empowerment and achievement of desired family size also mixed [40]
Muchomba, [20]	Spousal sexual violence	Individual-level DHS data analyses using logistic regression examine respondent with sons only differed from those with daughters on pre-motherhood individual characteristics (i.e., age, age at first cohabitation, age at first birth, educational attainment) [20]	This study found that among women in Sub-Saharan Africa with four or more children, those with daughters only had a higher risk of spousal sexual violence than those with sons [20]
Uthman et al., [41]	Assess the degree of wife-beating by women and men	The explanatory factors include the country characteristics were percent of men practicing polygamy, gross domestic product per capita, adult female and male literacy rate, gender-related development index (GDI)( Uthman et al. [41]	The study found highly significant heterogeneity in sex differences in attitudes towards IPVAV across countries [41]
Ali et al., [42]	Polygamous marriage, a threat with divorce and second marriage	Characteristics included (age, ethnicity, and educational level residence, duration of the marriage, party, occupation, consanguinity, polygamous marriage, and number of family members, husband's age, husband's education, employment, and husband's alcohol consumption) [42]	The finding showed a significant association between domestic violence against women, husband's alcohol consumption, and polygamous marriage[42].
Vyas and Jansen, [16]	Physical and sexual partner violence	Individual-level, women's non-partner violence (sexual abuse by non-partner and witnessing violence in childhood. [16]	The findings support the assertions of violence associated with women's prior/additional abuse and men's harmful masculinity expression [16]
Wandera et al., [43]	Modern contraceptive use (MCU)	The main explanatory variables were experience of IPV, physical, sexual, or emotional violence. Other variables were age, a region of residence, residence (urban /rural), religion, current marital status (married	The finding shows that women's reproductive rights expressed by a women's reported ability to ask a partner to use a condom were significant predictors of current MCU for women in union

<b>Study</b>	<b>Outcome variable</b>	<b>Explanatory variables</b>	<b>Reported findings/ conclusion made</b>
		or cohabiting), number of living children, education level, house wealth index, and occupation [43]	[43]
Kwagala et al., [44]	Skilled birth attendance (SBA)	Other explanatory variables include women's and their partner's background factors had ANC attendance, age groups, a region of residence, wealth index, religion, educational level, household headship, and several children ever born [44]	The result of the association between women's economic empowerment measured by ownership of land or a house (individually or jointly with her partner) and SBA reveals an opposite relationship to what was expected. Ownership of land or a home reduces the odds of SBA [44]
Speizer, [17]	Intimate partner violence (IPV) attitude and experience among women and men	The dependent variable has four categories: not supportive of wife-beating/no IPV victimization; supporting of wife-beating/no IPV victimization; not supportive of wife-beating/IPV victimization; and supportive of wife-beating/IPV victimization (referred to as neither, attitude only, victimization only, and both, respectively). Speizer, [17]	This study's findings demonstrate that the main factor associated with supportive attitudes and IPV perpetration among men was witnessing the father beat the mother [17]
Murray et al., [45]	Understanding the association between HIV and Mental Health	The individual selected from diverse locations within the compound and represents women across the age span (range 18-40) with various children [45]	The study shows the local perspective of the overlap between violence and HIV [45]



**Fig. 1. An analytical framework for the determinants and impacts of Intimate Partners Violence/ IPV**

*Source: Developed by the author based on a review of the literature*

It is noted that most reviewed materials associated the high lifetime prevalence of IPV with women's attitude towards IPV i.e level of women's approval of her experience. For instance, in the analysis of 49 DHS data (n=1,174,108), about a third of the respondents (36.40%) justified domestic violence in at least one instance [1]. The same study reported that discriminatory informal social institutions such as

gender norms pose gradual acceptance of violence. Women often internalize the idea that a husband who physically punishes or verbally reprimands his wife has exercised a right that serves her interest [1]. The meta-analysis of data from four SSA countries [41] indicated that women, more than their partners, were more likely to justify IPV. About 57% of women study participants from Ethiopia justified domestic

violence [33]. Likewise, in the study of Ghanaian women (n=10,607), 39% of study participants approved at least one form of domestic violence [35].

The reviewed studies reported a wide range of variables as predisposing/risk factors of intimate domestic violence. The factors include individual characteristics (women's education, partner's education, work status, ethnicity, partner's alcohol drink, childhood experience of domestic violence), household environment, and community/cultural factors. Childhood experiences and history of abuses in the family (such as mother being abused by fathers) determines the likelihood of experiencing IPV. One of the reviewed studies pinpoints that the risk of domestic violence was 41 % higher for women whose husbands ever experienced their father beating their mother [34]. Good number of the reviewed materials concluded a significant association between the husband's alcohol intake and IPV. For instance, the study of Ghanaian women reported that women whose husbands consume alcohol were 2.5 times more likely to experience domestic violence than women whose husbands did not drink alcohol [34]. Other studies conducted around the world also reported that both men's and women's alcohol usage was an essential factor for IPV [46]. Alcohol use directly affects physical and cognitive function, reducing self-control and leaving individuals less capable of negotiating a non-violent resolution to conflicts within relationships [47]. Partner's excessive drinking can exaggerate financial problems, infidelity, child abuse, or other traumatic situations, which may increase conflicts between partners. Because alcohol dependency correlated to several health problems for drinkers, their households, and communities [48], alcohol dependency is estimated to account for 4% of worldwide disability-adjusted life years [49]. Some of the studies (such as Felb et al., 2014 [18]) reported ethnic difference as a key determinant of IPV experience. In the sample of Ivorian women, a higher prevalence of IPV was observed among women who identified as Yacouba, Guere, or Dioula [18].

Women education was reported to be a prime determinant of IPV in most studies. In the study of Ghanaian women (n=1524), the likelihood of experiencing IPV decreased by 48 % for women whose husbands had better education compared to those living with partners having no formal education [34]. Education of a woman and her

partner usually determines the level of autonomy and control practiced at household level. Women with a controlling partner were at increased risk of experiencing physical violence in the past year [19].

The review indicated that women with partners who had extramarital sexual affairs were at greater risk of psychological, and physical violence than women who reported that their partners did not have affairs. The finding is in line with the SSA study that found that men's marital infidelity was a significant trigger of IPV against women [9].

With regards to the reported impacts of IPV, experiences of IPV has been correlated with a wide range of diverse physical health outcomes such as acute injuries, chronic pain, gastrointestinal illness, gynecological problems, depression, and substance abuse [50]. This review found that IPV increases a woman's risk of experiencing depression two- to three-fold [51]. In one study, it was reported that survivors of violence were 2.3 times more liable to have alcohol use disorders [52]. The findings (such as the Nigerian study) confirm that women who experienced spousal violence had an imminent risk of pregnancy termination. For example, the study found a 5.8% and 3.8% prevalence among women who experienced and never experienced pregnancy termination [11]. The study based on the Ethiopian 2005 and 2011 national data indicated reverse association, showing that women living in a community with a higher percentage of women opposing domestic violence were more likely to use maternal healthcare services even after women's attitudes toward domestic violence and other individual-level and community-level characteristics were controlled. The authors argued that Ethiopia's social and family networks are generally tight knit, making the effect of community norms on individual behavior exceed that of personal attitudes or preferences [53]. Thus, most of the studies strongly highlighted the importance of cultural context when studying the influence of gender variables on health or another livelihood domains.

This scoping review is not without limitations. First, the number of reviewed studies, in no way, are representative of the pool of IPV studies in SSA as the selection excluded several local studies conducted based on small sample size. The selected research articles solely focused on IPV regarding health care decision-making and

did not cover other livelihood dimensions due to absence of such studies in the search engine. Finally, because of the cross-sectional nature of all the studies reviewed, none of the studies were able to draw causal inferences between women's autonomy and the respective outcome variables. Despite these limitations, the present synthesis could be useful in providing some insights to policy makers and program managers in their effort of integrating IPV in reproductive health intervention programs, including comprehensive IPV screening.

## 5. CONCLUSION

While slight methodological variations exist among the individual studies, nearly all the reported prevalence of IPV were unacceptably high. The studies further documented a wide range of risk factors associated with IPV, more importantly, low maternal and paternal education, partner's alcohol drinking behavior, childhood experience of domestic violence, and certain household and community/cultural factors. The studies further reported the significant psychosocial and economic impacts of IPV on women, children, and other household members.

The overall findings suggest that national and local governments have a long way to go in preventing and reducing the high prevalence of IPV in their geographic areas if they must meet the SDG3 (improve women's health and well-being and children). As IPV is embedded in the respective culture; concerned authorities should establish appropriate norms, enhance women's status, and ensuring proper implementation of policies and laws on abuse. Community reflections, mass education/ behavioral change communications are essential in this endeavor.

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## COMPETING INTERESTS

Authors have declared that no competing interests exist.

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