Journal of Adolescent Health 55 (2014) S58–S67

ELSEVIER

JOURNAL OF ADOLESCENT HEALTH

www.jahonline.org

Original article

Prevalence and Health Impact of Intimate Partner Violence and Non-partner Sexual Violence Among Female Adolescents Aged 15–19 Years in Vulnerable Urban Environments: A Multi-Country Study

Michele R. Decker, Sc.D., M.P.H. [a,*], Sarah Peitzmeier, M.S.P.H. [a], Adesola Olumide, M.B.B.S., M.P.H. [b], Rajib Acharya, M.Sc., M.P.S., Ph.D. [c], Oladosu Ojengbede, B.Sc., M.B.B.S. [d], Laura Covarrubias, M.S.P.H. [a], Ersheng Gao, M.D., M.P.H. [e], Yan Cheng, Ph.D. [e], Sinead Delany-Moretlwe, M.D., Ph.D. [f], and Heena Brahmbhatt, Ph.D. [a]

[a] *Department of Population, Family and Reproductive Health, Johns Hopkins Bloomberg School of Public Health, Baltimore, Maryland*
[b] *Institute of Child Health, College of Medicine, University of Ibadan/University College Hospital, Ibadan, Oyo State, Nigeria*
[c] *Population Council, New Delhi, India*
[d] *Department of Obstetrics and Gynecology, College of Medicine, University of Ibadan/University College Hospital, Ibadan, Oyo State, Nigeria*
[e] *Shanghai Institute of Planned Parenthood Research, Shanghai, China*
[f] *Wits Reproductive Health & HIV Institute, School of Clinical Medicine, University of the Witwatersrand, Johannesburg*

Article history: Received May 14, 2014; Accepted August 20, 2014
Keywords: Adolescent; Intimate partner violence; Sexual violence

A B S T R A C T

Purpose: Globally, adolescent women are at risk for gender-based violence (GBV) including sexual violence and intimate partner violence (IPV). Those in economically distressed settings are considered uniquely vulnerable.
Methods: Female adolescents aged 15–19 from Baltimore, Maryland, USA; New Delhi, India; Ibadan, Nigeria; Johannesburg, South Africa; and Shanghai, China (n = 1,112) were recruited via respondent-driven sampling to participate in a cross-sectional survey. We describe the prevalence of past-year physical and sexual IPV, and lifetime and past-year non-partner sexual violence. Logistic regression models evaluated associations of GBV with substance use, sexual and reproductive health, mental health, and self-rated health.
Results: Among ever-partnered women, past-year IPV prevalence ranged from 10.2% in Shanghai to 36.6% in Johannesburg. Lifetime non-partner sexual violence ranged from 1.2% in Shanghai to 12.6% in Johannesburg. Where sufficient cases allowed additional analyses (Baltimore and Johannesburg), both IPV and non-partner sexual violence were associated with poor health across domains of substance use, sexual and reproductive health, mental health, and self-rated health; associations varied across study sites.
Conclusions: Significant heterogeneity was observed in the prevalence of IPV and non-partner sexual violence among adolescent women in economically distressed urban settings, with upwards of 25% of ever-partnered women experiencing past-year IPV in Baltimore, Ibadan, and Johannesburg, and more than 10% of adolescent women in Baltimore and Johannesburg reporting non-partner sexual violence. Findings affirm the negative health influence of GBV even in

IMPLICATIONS AND CONTRIBUTION

Gender-based violence varies significantly by setting among adolescent women in economically distressed urban environments. In these settings, the association of gender-based violence with primary health threats to youth demonstrates the need for broad-based prevention and support.

Conflicts of Interest: The authors declare no conflicts of interest.
Disclaimer: Publication of this article was supported by the Young Health Programme, a partnership between AstraZeneca, Johns Hopkins Bloomberg School of Public Health, and Plan International. The opinions or views expressed in this article are those of the author and do not necessarily represent the official position of the funders.

* Address correspondence to: Michele R. Decker, Sc.D., M.P.H., Assistant Professor, Johns Hopkins Bloomberg School of Public Health, 615 N. Wolfe St., E4142, Baltimore, MD 21205.
E-mail address: mdecker@jhsph.edu (M.R. Decker).

http://dx.doi.org/10.1016/j.jadohealth.2014.08.022

disadvantaged urban settings that present a range of competing health threats. A multisectoral response is needed to prevent GBV against young women, mitigate its health impact, and hold perpetrators accountable.

Globally, one in three women experience gender-based violence (GBV) in their lifetimes [1], with 30% of ever-partnered women experiencing physical or sexual intimate partner violence (IPV) [2] and 7% experiencing non-partner sexual violence (SV) [3]. GBV research and interventions focus heavily on IPV and non-partner SV given their prevalence and health impact. Demonstrated consequences include unintended pregnancy, sexually transmitted infection (STI) and HIV, substance use and abuse, mental health issues [4–12], and injury and homicide [13]. IPV and non-partner SV are assessed distinctly within GBV-related research [1,3,4], reflective of qualitative differences in the nature and potential health impact of abuse within an ongoing dating or marital relationship as compared with instances of SV perpetrated by non-partners. Although IPV and non-partner sexual assault are experienced by men and women alike, significant gender differences exist in the prevalence, severity and nature of such abuse [14,15]. For example, a recent global review found that intimate partners are responsible for more than 35% of women's homicides, relative to 6% of men's [13].

Adolescents are at high risk for both IPV and non-partner SV; in turn, GBV prevention is highlighted among research priorities for adolescent sexual and reproductive health in low- and middle-income countries [16]. Adolescents' young age and relative inexperience can limit their power in relationships and incur risk, particularly for females involved with older men [6,17–19]. Violence during adolescence imparts risks similar to those observed among adults; prospective research links abuse during this period with subsequent health issues including depression, suicidal ideation, and chronic inflammation [20,21]. Abuse can set young women on a trajectory for future violence [21,22] and sexual risk behavior [10]. Moreover, GBV experiences and fear of such abuse undermine gender equity for adolescent women, both by conveying the notion that they are not valued and by constraining their engagement in education, employment, and general mobility in society based on fears for safety [23,24].

Women who are homeless, unstably housed, and living in distressed urban settings are also considered an at-risk population for GBV [25–27]. High levels of IPV and SV have been identified in urban settings and among homeless women [27–29], reflecting a cascade of accumulated and interacting social vulnerabilities, which include stigma and limited access to social and health resources that accompany both individual-level poverty as well as residence in neglected settings of entrenched urban poverty. Some evidence suggests that GBV can be concentrated at the neighborhood level, with poverty and other dimensions of disadvantage heightening risk in some settings [30-32]. Disadvantaged urban settings can exacerbate underlying gender-based power disparities, with young women subject to intensive gender-based harassment, pressure for early sexual activity, and a pervasive threat of physical and SV [24,27]. Adverse economic conditions may prompt violence perpetration by men seeking to reclaim power and may also strain the couple's relationship, prompting discord that leads to violence [33]. Broader neighborhood factors including weak social ties, low collective efficacy, and constrained police protection can also impart IPV risk [34].

Developing evidence-based GBV policy and programming requires clarity on the prevalence, risk correlates, and health impact of both IPV and non-partner SV. Global GBV surveillance has improved tremendously during the past decade. After the landmark 2005 World Health Organization Multi-Country Study on Women's Health and Domestic Violence Against Women [4], the Demographic and Health Survey system integrated a domestic violence module to monitor and compare trends globally. However, its IPV assessment is limited to ever-married or cohabitating women, limiting our ability to generate internationally comparable estimates on the partner violence that can also occur in the context of dating or other casual partnerships, particularly among youth. The household-based Demographic and Health Survey sampling frame enables population-level estimates, yet risks overlooking youth who may be unstably housed.

Against this backdrop, we describe the prevalence and correlates of both IPV and non-partner SV, and evaluate their associations with key health outcomes across domains of substance use, sexual and reproductive health, and mental health among young females aged 15–19 years in five cities across the globe.

Methods

Sample and study design

Our cross-sectional study was conducted in 2013 with adolescents aged 15–19 years recruited via respondent-driven sampling (RDS). This multicountry study was conducted in five sites selected based on having sizable disadvantaged neighborhoods within large urban settings, research capacity, and geographic diversity: Baltimore, Maryland, USA; New Delhi, India; Ibadan, Nigeria; Johannesburg, South Africa; and Shanghai, China. Our formative research [35] identified geographically bound, economically distressed areas at each site to serve as target communities. RDS was selected because of the challenges in developing sampling frames in most study sites (i.e., housing instability and out-of-school youth). See further details of methodology and site characteristics elsewhere [35,36].

Eligible seeds (Baltimore n = 8; New Delhi n = 7; Ibadan n = 10; Johannesburg n = 14; and Shanghai n = 5) and participants were male and female adolescents ages 15–19 and residing, or spending a majority of their time, in the study sites. Youth from Shanghai were limited to migrants as they constitute a particularly vulnerable population in this setting. After determination of eligibility and informed consent, including parental consent for minors, seed participants and subsequent recruits completed a survey. Consistent with RDS methods [37], seeds and subsequent recruits were provided with up to three recruitment coupons to recruit additional adolescents until the desired sample size was