



# Marital violence and sexually transmitted infections among women in post-revolution Egypt



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## ARTICLE INFO

### Article history:

Received 14 February 2017

Revised 15 May 2017

Accepted 16 June 2017

### Keywords:

Sexually transmitted infections

Partner violence

Egypt

## ABSTRACT

**Objectives:** To explore the relationship between past year physical or sexual partner violence against women and women's self-report of sexually transmitted infection (STI) symptoms in post-revolution Egypt; and to examine the effects of men's and women's risky sexual behavioural characteristics and structural dimensions of poverty and gender inequality on this relationship.

**Study design:** This study uses the nationally representative cross-sectional demographic and health survey data conducted in 2014. Multivariate logistic regression was used to assess the relationship between past year partner violence and self-report of STI symptoms among currently married women.

**Main outcome measures:** women's self-report of STI was based on their responses to three questions; whether in the past year they had: got a disease through sexual contact?, a genital sore or ulcer?, or a bad smelling abnormal genital discharge? Women who gave an affirmative response to one or more of these questions were assumed to self-report STI.

**Results:** Almost one-third of women self-reported symptoms of STI. Fourteen percent of women reported they had experienced physical or sexual violence by a male partner in the past 12 months. Abused women had a 2.76 times higher odds of self-reported STI symptoms (95% CI 2.25–3.38). The significant relationship between self-reported STI and past year partner violence against women did not alter when adjusting for men's and women's behavioural characteristics and factors related to poverty and gender inequality.

**Conclusions:** Public health interventions that address women's sexual and reproductive health need to consider violence response and prevention strategies.

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## Introduction

Partner violence against women is associated with wide-ranging physical, mental and sexual and reproductive health problems in women [1–3]. Among the myriad of adverse sexual health outcomes, abused women are at increased risk of sexually transmitted infections (STI) when compared with non-abused women [1–3]. Moreover, violence against women (VAW) serves as a barrier to women's sexual and reproductive health rights, a barrier that is elevated during conflicts and crises [4]. This is because such settings are typically characterised by political unrest and a worsening economic situation that disadvantage women, thus hindering their access to legal, social and economic protection [4]. For example, in Liberia, its history of conflict and scarce resources shaped an environment for high rates of physical or sexual partner violence and STI [5].

## Pathways to STI risk

Several pathways have been proposed where physical or sexual partner violence is hypothesised to increase women's risk of STI. Direct pathways highlight STI transmission through sexual activity, including coercive or physically forced sex, that exposes women to sexual infections [2,3]. VAW is also hypothesised to elevate risk of sexual infection if induced stress from repeated abuse lowers STI exposed women's immunity [1,3].

Indirect pathways tie partner violence with sexual risk taking behaviours (both men's and women's) that are further mediated by structural dimensions of gender inequality and poverty [6–8].

Studies have found that among women high-risk behaviours include having sex with 'high-risk' male partners (men who are living with HIV, who inject drugs or who are non-monogamous); having multiple sexual partners; alcohol abuse; and trading sex for money, drugs and housing or other support [1,7,9–11]. Women's age at first sexual intercourse has also been found to be associated with STI. The younger the age at sexual initiation the greater the

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risk of STI, because younger age is a marker for more lifetime sexual partners and because of women's longer exposure to STI [9,12,13].

Abusive men are more likely to engage in high-risk behaviours that increase not only the likelihood of their acquisition of STI, but also that they infect their female partners [1,14–16]. A study among 428 men reporting multiple sexual partners, in Cape Town, South Africa, found men's report of STI symptoms and engagement in transactional sex were associated with their perpetration of physical and sexual partner violence, and alcohol consumption or substance abuse and inconsistent condom use were associated with their perpetration of physical partner violence [15].

A second set of pathways link structural factors with partner violence and STI risk. Fear instilled by partner violence impairs women's ability to assess risk and interacts with their sexual decision making processes [2,6,9,17,18]. Violence reduces women's ability to engage in safe sexual practices such as being able to refuse sex or to negotiate condom use, and this is particularly so in societies where high gender inequalities and social disadvantage exist [5,7,8,19,20]. Further, factors such as poverty and barriers to education and employment opportunities, both reinforce and are reinforced by gender inequalities and serve to keep women and girls dependent upon their male partners [8,20]. For example, a population-based study from Liberia used attitudes towards gender roles as a marker of men's dominant position within society and found women possessing attitudes tolerant of wife beating were significantly more likely to report STI symptoms; a relationship that persisted even when controlling for physical or sexual partner violence [5].

#### *VAW in Egypt*

Egypt was one of several countries to experience a political uprising that swept the Arab region in 2011. Eighteen days of protests and demonstrations led to the eventual deposition of the then government. The demonstrations, particularly in Tahrir square, that symbolised the Egyptian revolution were, however, marred by reports of increased incidents of sexual harassment against women—a consequence that continues to feature in many women's lives [21,22]. While this form of VAW has received much public attention, other forms remain endemic. The vast majority (over 90%) of women, ages 15–49, have undergone some form of female genital mutilation (FGM); and slightly over one-in-four ever-married women have experienced physical or sexual partner violence by a male partner in their lifetime (in 2014) [23].

Very few studies on the sexual and reproductive health effects of partner violence exist from Egypt or even the Arab region. An early study (in 1995) from Egypt explored the reproductive health effects of women's lifetime exposure to physical partner violence. The study found that ever-beaten women were less likely to use a female contraceptive method or to have received ante-natal care for their most recent child [24]. Although Egypt ranks as a low HIV prevalence country (less than <0.1% of the adult population, ages 15–49, are estimated to be living with HIV) [25], awareness on how infection can be reduced is low [23]. Against a backdrop of poor access to health services, including sexual and reproductive health care [21,26], understanding the factors associated with STI is important.

The aims of this study are firstly, to explore the relationship between women's self-report of STI and partner violence against women, and secondly, to assess whether any relationship (between STI and partner violence) holds when controlling for women's and men's behavioural characteristics and structural dimensions of gender inequality and poverty.

#### **Methods**

The nationally representative 2014 Egypt Demographic and Health Survey (DHS) data were used for this study. Sampling took place in 25 of the country's 27 governorates (North and South Sinai were excluded) and each governorate was stratified by urban and rural areas (except Cairo; Port Said and Suez which are entirely urban) [23].

A multi-stage sampling strategy was used with shiakh/towns (in urban areas) and villages (in rural areas) as the primary sampling units (PSU). A total of 481 shiakh/towns and 445 villages were selected in the initial stage with sampling proportional to population size. Each PSU was sub-divided into equal size “parts” of 5000 population, with 3 parts selected from towns or villages with a population of 100,000 or more, 2 parts selected from towns or villages with populations between 20,000–100,000, and 1 part selected in towns/villages with fewer than 20,000 people. Each part was further divided into segments, and within each PSU 2–3 segments were selected for sampling. Within each selected segment a complete household listing was obtained and households were randomly selected for interview. A total of 29,471 households were selected for inclusion in the study from which interviews were completed in 28,175 households [23].

A household questionnaire was first administered with the purpose to document the sex, ages and educational attainment of all residing household members. Household characteristics such as asset ownership and type of infrastructure were also recorded.

An individual woman's questionnaire was then administered to all ever-married women, ages 15–49, considered resident in the household, yielding a sample of 21,762 women. Informed consent was obtained from all individual participants included in the study.<sup>1</sup> A module on domestic violence was administered in a sub-sample of 6693 households, and in order to adhere to ethical and safety guidelines on researching VAW, only one randomly selected woman received the module [27]. Guidelines used by DHS were adapted from the World Health Organization's ethical and safety recommendations that aim to ensure respondent confidentiality and safety, and to maximise violence disclosure [28]. Recommendations followed for all DHS implementing the domestic violence module include: special interviewer training to ensure interviews are conducted in private; dealing with crisis situations/stopping interviews if privacy is compromised; reiterating informed consent; and offering support/referral information to any woman who requests it [27].

#### *Presence/symptoms of STI*

Self-reported STI in the past year was measured using information from the following questions: in the past 12 months have you had a (1) disease which you got through sexual contact?, (2) genital sore or ulcer? and (3) bad smelling abnormal genital discharge? Participants who responded ‘yes’ to one or more question were considered to self-report STI within the past year.

#### *Past year physical or sexual partner violence*

Respondents were asked seven questions on physical violence and three questions on sexual violence: does/did your (last) husband/partner ever (a) push you, shake you, or throw something at you?; (b) slap you?; (c) twist your arm or pull your hair?; (d) punch you with his fist or with something that could hurt you?; (e) kick you or drag you or beat you up?; (f) try to choke you or burn you on purpose?; (g) threaten or attack you with a knife,

<sup>1</sup> <http://dhsprogram.com/What-We-Do/Protecting-the-Privacy-of-DHS-Survey-Respondents.cfm>.

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