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Factors Associated With Attitudes Toward Intimate Partner Violence: A Study of Women in Zambia

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Demographic, social, and empowerment factors associated with attitudes toward intimate partner violence (IPV) were investigated in a random sample of women ($n = 5{,}029$) aged 15–49 years in Zambia. Data was retrieved from the *Zambia Demographic and Health Survey 2001–2002* (2003). The findings indicated demographic, social, and structural differences in attitudes toward IPV. Married/previously married and less educated women, employees in the agricultural sector, and women with a history of IPV were more likely to tolerate IPV. In addition, structurally disempowered women (i.e., women lacking access to information and autonomy in household decisions) were more likely to justify IPV than more-empowered peers. Most variables remained significant even when possible confounding was adjusted for using a logistic regression. The findings are discussed and implications for prevention as well as methodological issues considered.

Keywords: attitudes toward violence; intimate partner violence; predictors; women; Zambia

Domestic violence, particularly against women and children, is receiving increased recognition in policy and research in developing countries. It is now agreed that such abuse constitutes a setback on the drive toward sustainable national development (National Council for Population and Development [NCPD], 2000, World Development Report [WDR], 2004). Intimate partner violence (IPV) is the most prevalent form of domestic violence. Recent data based on nationally representative and community samples of women in developing nations suggest a lifetime prevalence of IPV of between 11% and 52% and a yearly prevalence of 4%–29% (Ellsberg, Pena, Herrera, Liljestrand, & Winkvist, 2000; Gage, 2005; Jewkes, Levin, & Penn-Kekana, 2002; Kishor & Johnson, 2004; Koenig et al., 2003; Mwenesi, Buluma, Kong'ani, & Nyarunda, 2004), with variations due to differences in sample characteristics, definitions of violence, and willingness of respondents to report abuse.

The health consequences of IPV have been widely acknowledged in the research. Besides injury following physical abuse, victimized women stand at heightened risk of somatic complaints (Campbell, 2002; Kramer, Lorenzon, & Mueller, 2004; McNutt, Carlson, Persuad, & Postmus, 2002; Plitcha & Falik, 2001) and psychological symptoms manifested in depression, anxiety, post-traumatic stress disorder, and suicidal ideation (Aidoo & Hapham, 2001; Campbell, 2002; Golding, 1999; Mayeya et al., 2004; Petersen, Gazmararian, & Clark, 2001; Tolman & Rosen, 2001). Moreover, women experiencing IPV risk infertility (Heise, Ellsberg, & Gottemoeller, 1999), morbidity, and mortality (Campbell, 2002) to a higher degree than their nonvictimized counterparts.

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The extent, nature, and health implications of IPV have prompted increased research to understand its risk and eliciting factors. In this regard, research indicates that having been victimized or witnessing abuse during childhood (Bensley, Eenwyk, & Simmons, 2003; Gage, 2005; Jewkes, 2002; Jewkes et al., 2002; Jeyaseelan et al., 2004; Lipsky, Caetano, Field, & Larkin, 2005), belonging to socially and economically marginalized groups (Ellsberg et al., 2000; Hoffman, Demo, & Edwards, 1994; Jewkes, 2002; Krishnan, 2005; Levinson, 1989; Malcoe, Duran, & Montgomery, 2004; Ratner 1993), and belonging to societies with a high grade of patriarchal norms (Jewkes, 2002) may be associated with increased vulnerability.

A factor that has received some attention in the literature as a risk factor of IPV is the victim's attitude toward IPV. A recent study indicated that tolerant attitudes toward violence may have a stronger predictive power of IPV greater than the significance of other strong correlates like unemployment, low education, and poverty (Faramarzi, Esmailzadeh, & Mosavi, 2005). The strength of association found by Faramarzi et al. could be explained by multiple associations between attitudes toward IPV and established IPV risk factors such as witnessing abuse in childhood, empowerment, and social status. It could also be explained by reverse causality, however; that is, IPV leading to tolerant attitudes toward violence.

Owing to the fact that attitudes toward IPV may vary depending on the societal context, it is warranted to study such attitudes in different societies. Moreover, it is not certain that women with a history of violence may be more likely to consider abuse as acceptable in all societies. At times, this may be a pragmatic decision based, among other things, on the victim's economic dependence on her husband, her limited options, and autonomy.

The current study sought to investigate factors possibly affecting attitudes toward IPV among women in Zambia. More specifically, the paper examined the relationship between attitudes toward IPV and history of IPV abuse, demographic, and social-status variables (e.g., education levels and occupational status), and empowerment indicators (e.g., access to information and shared power in the domestic domain).

DOMESTIC VIOLENCE IN ZAMBIA

Recent statistics based on the *Zambia Demographic and Health Survey 2001–2002* (*ZDHS 2001–2002;* Central Statistical Office [Zambia], Central Board of Health [Zambia], and ORC Macro, 2003) indicate that more than 53% of Zambian women have, since the age of 15 years, experienced some form of physical victimization, with about 24% reporting such abuse during the past 12 months. The same source indicates that such abuse is more prevalent among women older than 20 years, married, living in urban settings, and with high education levels (Kazungu & Chewe, 2003).

Regarding risk factors, studies evolving from developing countries seem rather inconsistent concerning the correlation between social factors and vulnerability to IPV, on the one hand, and attitudes toward violence, on the other. A multicountry study of domestic violence based on representative samples of married women from Zambia, Rwanda, and Tanzania suggested that social indicators such as household wealth, female education, and earnings were weak predictors of domestic violence but strong predictors of attitudes toward violence (Gonzalez-Brenes, 2004), suggesting social differences in attitudes toward IPV but not exposure to IPV itself. Data emerging from other countries, on the other hand,

indicate a social gradient in exposure to IPV (Ellsberg et al., 2000; Hoffman et al., 1994; Krishnan, 2005; Levinson, 1989; Malcoe et al., 2004; Ratner 1993). Thus, further research assessing the relationship between violence and social status is warranted.

Though data on intimate partner violence and its determinants in Zambia and other parts of the world is rather extensive, women's attitudes toward IPV and its determinants have not received equivocal recognition. Moreover, inconsistencies with regard to the association between violence, social status, and structural empowerment seem evident, indicating that further scrutiny may be useful. Using the *ZDHS 2001–2002,* the current study sought to investigate possible factors affecting attitudes toward violence in a random sample of women of reproductive age in Zambia.

METHODS

Demographic and Health Surveys

The demographic and health surveys (DHS) are carried out in several developing countries and receive main funding from the United States Agency for International Development (USAID). The key objective of the DHS is to assist participating countries in monitoring their demographic and health situation on a five-year basis. The participating countries have the main responsibility for its implementation. At a broad level, the DHS provide detailed data on fertility, marriage, awareness/utility of family planning methods, nutritional status of women and children, awareness regarding sexually transmitted illnesses including HIV, maternal and child health, and mortality. The survey procedure (e.g., organization and sampling methods) and instruments used have received ethical approval from the Institutional Review Board of Opinion Research Corporation (ORC) Macro International, Incorporated.

The *ZDHS 2001–2002* is a comprehensive, nationally representative survey implemented by the Central Statistics Office in partnership with the Central Board of Health. Like most other DHS surveys, the *ZDHS 2001–2002* is mainly funded by the USAID. Additional funding, however, has been obtained from the Japanese government, United Nations Population Fund (UNFPA), and the Danish International Development Agency (DANIDA). Over time, the DHS have been modified, and a new feature for the *ZDHS 2001–2002* is the domestic violence module.

Sample Design

The *ZDHS 2001–2002* used the list of Standard Enumeration Areas prepared for the population census of 2000 in Zambia as a frame for data sampling. Based on this list, a stratified two-stage sampling procedure was utilized. Zambia has a total of nine provinces. Once the number of households was allocated to each combination of province by urban and rural areas, the number of clusters (i.e., 320 clusters, 100 in urban areas and 220 in rural areas) was calculated based on an average sample take of 25 completed interviews among women 15–49 years old. In each urban or rural area in a given province, clusters were selected systematically with a probability proportional to the number of households in each cluster. Within the 320 clusters, households were selected to achieve a self-weighted sampling fraction in each province (Dzekedzeke & Mulenga, 2003). These procedures resulted in a probability sample of 8,050 households. A more detailed description of the sampling procedure is reported in Dzekedzeke and Mulenga (2003).

Participants

All women aged 15–49 years and resident/visitors at the sampled households at the time of the survey were eligible for participation in the women's interviews; that is, a total of 7,944 women. Of those eligible, 7,658 were interviewed, constituting a response rate of 96.4%. The domestic violence module, however, was administered to only one woman in the household, randomly chosen, in compliance with the World Health Organization's (WHO's) ethical and safety recommendations for research on domestic violence (WHO, 2001). A total of 5,466 women were selected for the domestic violence module, of which 5,029 were interviewed, constituting 92% of those eligible for the domestic violence module. Thus, this paper is based on the 5,029 respondents to the domestic violence module.

Questionnaire

A comprehensive questionnaire covering demographic and health issues was administered to the eligible women. The questionnaire covered women and husband's social status, empowerment indicators (e.g., access to information and power in the domestic arena), reproductive history, utility of family planning methods, fertility preferences, antenatal and delivery care, child care and nutrition, child mortality, adult mortality, awareness of and precaution against sexually transmitted diseases, marriage and sexual behavior, and domestic violence. For the current article, the questions concerning attitudes toward intimate partner violence, history of domestic violence, demographics, social status, and empowerment indicators were of primary interest.

MEASURES

Dependent Variable

Attitudes toward IPV was assessed by asking participating women if they would justify partner abuse for one or several of the following reasons: if she burns the food, if she argues with him, if she goes out without telling him, if she neglects the children, and if she denied him sexual relationship. The possible outcomes for these questions were "yes," "no," or "don't know." In the logistic regression, attitude toward violence was transformed into a dichotomous variable and used as the dependent variable. Women who responded "no" on all of the attitudes toward IPV questions (i.e., firm negative attitude) formed one group of the dichotomy, whereas those who responded in the affirmative on one or several of the attitudes toward IPV questions were considered to be the risk group of the dichotomy.

Independent Variables

History of IPV was assessed using part of the Conflict Tactic Scale (CTS; Strauss, 1990), which assesses whether participants have, since the age of 15 years, experienced physical abuse perpetrated by primary family (mother, father, brother, sister, daughter, son), extended family (e.g., stepparents and other relatives), and ex- or late partners. In this study, IPV is limited to physical abuse by current, ex-, or late husband (i.e., among ever-married women). The response was in "yes/no" format. Physical abuse was defined as slapping, hitting, kicking, throwing things at her, or doing anything to physically hurt her.

The questions concerning history of abuse were administered only to one randomly selected woman in the household. The rationale behind this approach is to ensure confidentiality and security that may be threatened if information leaks to other family members. Interviewers were also instructed to discontinue the interview if they sensed or confirmed the presence of other members in the household. These precautions are in line the WHO's ethical recommendations for collecting data on domestic violence (WHO, 2001). Thus, a subsample of 5,029 women was eligible for this module.

Demographic/social status was assessed using the following indicators: age, urban/rural resident, marital status, highest educational achievement, and occupational status. Because of too many categories in the occupational status variables (many of them containing only a few women), the variable was transformed to include only 3 categories: *not working, agriculture employee,* and *others,* comprising professionals, technicians, managers, clerical, sales, service, and manual workers.

Empowerment was assessed using the following indicators, which were dichotomized to allow for meaningful statistical analysis: (1) access to information measured via questions on frequency of watching television, listening to radio and reading newspapers/magazines (the response levels "less than once a week," "at least once a week," and "almost every day" formed one group of the dichotomy, and response level "not at all" formed the other group of the dichotomy); (2) literacy level measured as ability to read (being "able to read whole sentence" formed one group of the dichotomy, and being "able to read part of sentence" and "unable to read" formed the other group of the dichotomy); (3) autonomy in domestic decisions regarding how to spend money, health care, and visiting relatives/friends (response options "respondent alone" and "respondent and other person in household" formed one group of the dichotomy, and the option "Other person in household" formed the other group of the dichotomy).

History of IPV, demographic, social-status, and empowerment variables were used as independent variables in the logistic regressions model.

Statistical Analysis

Descriptive statistics were used to study demographic and other relevant characteristics of the participants. Many of the independent variables were transformed to reduce the number of categories because some of the categories lacked enough women to enable meaningful statistical analysis. The transformations, however, remain logical. Differences in the dependent variable (i.e., attitudes toward violence) between participants in different categories of the independent variables were assessed using the chi-square test. A t test was used to study the association between age and attitudes toward IPV. To assess the independent contribution of demographic, social status, empowerment indicators, and history of abuse in determining attitudes toward IPV, logistic regression was run. Demographic, social-status, and empowerment indicators that were statistically significant in the bivariate analyses ($p < .05$) were all entered in the regression model in a single block to control for possible confounding between them. The magnitude and direction of association were expressed in the adjusted odds ratios and significant levels expressed as p-values. Statistical significance was assumed at $p < .05$. The Statistical Package for the Social Sciences (SPSS) version 13.0 was used for all analyses.

To account for differences in probability due to clustering in the sampling design of DHS surveys in general, sample weights are usually recommended and provided in DHS data. The results (with regard to statistical significance) based on the weighted sample did

not differ from those based on actual unweighted data in the current work, however, indicating that weighting may be unnecessary. It has also been argued by DHS experts that if a study aims primarily at investigating associations between variables, weighted data are inappropriate (Rutstein & Rojas, 2003). Owing to these reasons, results presented here are based on the actual observations.

RESULTS

Attitudes Toward Violence and History of Violence

Significant proportions of the 5,029 participating women would justify IPV if the woman went out without telling her husband (80%), neglected the children (63%), argued with her husband (55%), refused to have sex with her husband (51%), or burned the food (48%). Eighty-five percent would justify IPV for at least one of the given reasons.

In addition, 35% had experienced physical abuse at the hands of a husband since the age of 15 years. Twenty-five percent had experienced physical violence perpetrated by others, including relatives (parents, children, brothers, sisters, and in-laws), and ex- or current boyfriends. Among ever-married women in the sample ($n = 4{,}147$), 44% had previously been physically abused by their current, ex-, or late husband.

Proportion of Women With Tolerant Attitudes Toward IPV by Demographics, Social Status, and Empowerment Indicators

A significant proportion of participants (regardless of demographic and social position) reported tolerant attitudes toward violence (Table 1). Significantly higher proportions with tolerant attitudes, however, were observed among formally/currently married women, women lacking a postsecondary education, rural residents, agricultural employees, and illiterate women. In addition, women lacking access to newspaper, radio, and television and without autonomy in household decisions (i.e., autonomy in purchase, visiting, and health decisions) were more likely to express tolerant attitudes toward IPV. Finally, women with a history of IPV were more likely to express tolerant attitudes toward IPV when contrasted with peers who had never experienced such abuse. All Table 1 variables reached statistical significance ($p < .05$) using a chi-square test. Attitudes toward IPV did not vary depending on age.

Demographics, Social Status, and Empowerment as Predictors of Attitudes Toward IPV

Taking into consideration the contribution of other potential predictors in the logistic regression model (adjusted odds ratios), urban residents exhibited a higher risk of justifying IPV than peers resident in rural settings (Table 2). Similarly, less-educated women were at higher likelihood of tolerating IPV when contrasted with peers having a postsecondary education. On the other hand, women without a job were less likely to justify IPV when contrasted with peers employed in other sectors, particularly agriculture. Women with access to newspaper and those having some autonomy on health decisions in the domestic arena stood at a lower likelihood of tolerating IPV than peers lacking such resources/liberties. Finally, women with a history of IPV exposure were at higher risk of tolerating it than never-abused peers.

TABLE 1. Proportion of Participants With Tolerant Attitudes Toward Violence by Demographic, Social Status, and Empowerment Indicators

Variables	Number Within Category[a]	% With Tolerant Attitudes Towards IPV
Marital status		
Never married	814	84
Currently married	3,470	89
Formally married	656	90
Residential area		
Urban	1,508	85
Rural	3,432	89
Education		
No education	710	87
Primary education	3,029	92
Secondary education	1,079	84
Postsecondary education	122	45
Occupational status		
Not working	1,887	83
Agriculture	1,992	96
Other	1,057	83
Read newspaper/magazine		
Not at all	4,052	90
Yes	877	78
Listen to radio		
Not at all	2,350	91
Yes	2,589	86
Watch TV		
Not at all	3,823	90
Yes	1,115	82
Literacy level		
Cannot read/cannot read fully	2,617	91
Can read fully	2,277	45
Final say on health issues		
Not at all	2,728	91
Full or partial say	2,196	85
Final say on visiting		
Not at all	2,621	90
Full or partial say	2,279	86
Final say on household purchases		
Not at all	3,014	90
Full or partial say	1,848	85
History of IPV		
No	2,310	87
Yes	1,812	92
Total	4,940	88

[a]Actual number of those with a "yes" or "no" response on any of the attitudes questions. The totals within each variable may differ because singular data may have been lost due to nonresponse to some questions.

DISCUSSION

An overwhelming majority of the women in Zambia (85%) would justify IPV for at least one of the following reasons: burning food, going out without informing the partner, neglecting the children, arguing with the partner, and refusing sexual intercourse with the partner. It is, therefore, not surprising that a substantial proportion of the ever-married women had previously been exposed to IPV (44%), a figure comparable with data from other developing countries (Ellsberg et al., 2000; Gage, 2005; Kishor & Johnson, 2004; Koenig et al., 2003; Mwenesi et al., 2004). Though policy to manage violence has been enacted in several sub-Saharan countries, including Zambia (Kwaramba, 2001; Mwenesi et al., 2004), the current data indicate that legislation on its own may not be enough. There is a need for a change in public opinion on this issue. The fact that 8 out of 10 women in a nationally representative sample justified IPV supports this view. Therefore, identifying factors associated with women's attitudes toward IPV may prove paramount not only in highlighting priority groups to target with regard to prevention but also in identifying possible channels/obstacles to such interventions.

Women having a history of IPV were at higher risk of justifying IPV than peers without IPV experience. Growing up in violent surroundings is likely to implant during youth an attitude that violence is motivated, and such attitudes are likely to follow into adulthood. Indeed, the data presented here suggest that tolerant attitudes toward IPV seem to be evenly distributed across the entire age span. Little evidence exists of change in attitudes toward violence across generations, and the current work seems to point in that direction. These findings warrant a need for concerted awareness-raising and interventions to change attitudes about acceptability of IPV across the entire age span.

The results of the current work suggest a social gradient in attitudes toward violence among Zambian women. Uneducated and low-educated women were more likely to report tolerant attitudes toward violence than peers with postsecondary education. In addition, employees in the agriculture sector seemed more tolerant toward IPV than peers within other sectors and unemployed peers, this in line with recent work based on data from other developing countries (Gonzalez-Brenes, 2004). Though not pertaining to attitudes toward IPV per se, the status inconsistence theory suggests a U-shape in the relationship between exposure to IPV and women's status (Yllo, 1983). It is purported, on the one hand, that women in the lower bracket of the socioeconomic hierarchy are likely to experience violence because of their limited resources (e.g., education and poverty). On the other hand, high status among women is likely to conflict with patriarchal norms of male dominance, thereby increasing the likelihood of IPV (Yllo, 1983). With regard to attitudes toward violence, however, a social gradient seems apparent; that is, socially disadvantaged women risk tolerating violence to a higher degree than their more advantaged peers, and this perhaps can be explained by the limited resources and possibilities theory.

The results regarding the association between rural/urban residency and attitudes toward IPV are difficult to reconcile when based only on this data. Although the bivariate analysis revealed a slightly higher proportion with tolerant attitudes among rural residents than among urban residents, the multivariate analysis indicated that urban residents stood at a higher likelihood of justifying violence than rural colleagues. Recent data based on a similar method (multivariate logistic regression) have indicated that IPV exposure may be more pronounced in urban than in rural areas. In their multicountry study of nine developing countries including Zambia, Kishor and Johnson (2004) demonstrated rather consistently a higher risk of IPV exposure in urban areas in most of the countries. Considering

TABLE 2. Logistic Regressions Analysis of Attitudes Toward IPV: Odds Ratios Assessing the Independent Role of Demographic, Social Status, Empowerment Variables, and History of IPV

Variables	Odds Ratio (OR)	Confidence Interval of OR	*p*-Value
Residential area			
Rural	1.00		
Urban	1.98	1.48 – 2.64	0.0001
Education			
Postsecondary education	1.00		
Secondary education	5.03	3.03 – 8.35	0.0001
Primary education	5.55	3.19 – 9.65	0.0001
No education	3.07	1.62 – 5.82	0.001
Occupational status			
Not working	1.00		
Agriculture	5.59	4.20 – 7.44	0.0001
Other	1.38	1.05 – 1.81	0.022
Read newspaper/magazine			
Not at all	1.00		
Yes	0.67	0.48 – 0.94	0.019
Listen to radio			
Not at all	1.00		
Yes	0.89	0.70 – 1.14	0.362
Watch TV			
Not at all	1.00		
Yes	0.79	0.57 – 1.08	0.141
Literacy level			
Cannot read/cannot read fully	1.00		
Can read fully	0.93	0.69 – 1.27	0.657
Final say on health issues			
Not at all	1.00		
Full or partial say	0.75	0.59 – 0.94	0.015
Final say on visiting relatives/friends			
Not at all	1.00		
Full or partial say	0.84	0.65 – 1.08	0.172
Final say on household purchases			
Not at all	1.00		
Full or partial say	0.84	0.66 – 1.08	0.180
History of IPV			
No	1.00		
Yes	1.66	1.34 – 2.07	0.0001

Note. Only variables that were significantly associated with attitudes toward IPV in the bivariate analyses were entered into the regression model. Because history of IPV was only assessed among ever-married women, however, marital status could not be included in the regression model.

the strong correlation between IPV vulnerability and attitudes toward IPV in the current and other studies (e.g., Faramarzi et al., 2005), it is reasonable to expect more tolerant attitudes among urban settlers. Further insight on attitude differences and their determinants in urban versus rural areas is warranted in future studies.

The proportion of women with tolerant attitudes toward IPV reduced as accessibility to information and autonomy in household decisions increased. The multivariate analysis confirmed to some measure (i.e., some variables showing statistical significance and others at the margin of a statistical trend) a higher likelihood of tolerating violence among structurally disempowered women. These findings underscore the importance of structural empowerment of women in shaping their attitudes toward violence. Similar results have previously been reported with regard to IPV exposure (Kishor & Johnson, 2004). Thus, structural changes may be necessary alongside other interventions to change attitudes toward IPV and reduce exposure.

The DHS have some important advantages when compared with other surveys. First, they are often nationally representative, allowing for conclusions that cover the entire nation. Second, the sampling methodology and instruments used adhere to ethical standards for research as approved by the Institutional Review Board of Opinion Research Corporation (ORC) Macro International, Incorporated. In addition, data collectors are trained to adhere to regulations for interview completion in line with the WHO's recommendations for safety precautions for collection of domestic violence data. These factors notwithstanding, weaknesses of the DHS domestic violence module deserve some acknowledgement. Research evolving from Nicaragua and Colombia suggest that despite the listed attempts to improve validity, the DHS surveys still underestimate the extent of IPV when compared with other surveys, such as the WHO's multicountry survey on gender-based violence and other specialized violence surveys (Ellsberg et al., 2001; Morrison & Orlando, 2004). In that case, the frequencies reported here may represent an underestimation. Second, the validity of the attitude toward IPV measure could be challenged, considering that the questions used are limited in scope to capture women's normative roles in the domestic arena. Other issues, such as motivation of partner abuse because of nondomestic factors like woman's financial superiority/inferiority, employment position, education, husband's drunkenness, and so on, were not included in the measure of attitudes toward IPV. Yet the significance of such variables in explaining IPV has been demonstrated (Hoffman et al., 1994; Krishnan, 2005; Malcoe et al., 2004).

Another important issue not addressed in the DHS domestic violence module is the length of time the victim has been in an abusive relationship. Attitudes toward violence are likely to change or evolve over time, depending, among other things, on the victim's choice to remain in or leave an abusive relationship. For these reasons, the results reported here and in similar studies must be interpreted in light of these limitations.

Finally, the current work has some implications for interventions to manage IPV. It is apparent that, despite increasing legislation against IPV in developing countries, public opinion on the issue is discouraging. A nationwide campaign of cognitive restructuring is necessary, possibly channeled via educational interventions, demonstrating that violence is unmotivated regardless of the underlying cause and emphasizing its detrimental effects on development and health, particularly among socially and structurally disadvantaged women of all age groups. A significant hinder to this process, however, is that almost half of the women were illiterate or could not access information via media that would enhance mass coverage (e.g., newspaper, radio, and television), suggesting that structural changes

are needed alongside nationwide educational campaigns to change women's distorted attitudes toward violence.

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