

THE HEALTH NEEDS OF WOMEN WITH EXPERIENCES OF INTIMATE PARTNER VIOLENCE LIVING IN URBAN SLUMS IN KAMPALA, UGANDA

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ABSTRACT

Although intimate partner violence affects women from various walks of life, empirical evidence suggests a greater incidence among women of low socioeconomic status. Intimate partner violence is a major problem among women of child-bearing age in Uganda. There is a lack of knowledge about these women's healthcare needs as they are neither accessing health care nor sharing their experiences and health care needs related to intimate partner violence. This study explored intimate partner violence experiences of women living within urban slums and their resultant health impacts in order to inform health care strategies aimed at responding to intimate partner violence. A cross-sectional exploratory study using a qualitative approach was implemented with a purposive sample of 48 female participants aged between 20–45 years and living within Kabalagala slums, Kampala, Uganda. The purposively sampled participants had a history of intimate



partner violence. The qualitative data was collected using in-depth interviews and coded utilising a thematic content analysis process. Two major themes emerged from the data: firstly, physical care and treatment needs resulting from scars of life, disability, disfigurement, and diminished physical functioning, and sexual and reproductive health complications; and secondly, psychosocial health and support needs reflected in the terror of unpredictability, the shame of being me and delayed access to health care. The psychosocial consequences of intimate partner violence resulted in delayed access to health care and potential exacerbation for physical ill-health. More assertive outreach by health care professionals in these high risk areas is required. Policy to support primary and secondary prevention of intimate partner violence must be developed and its implementation integrated into general health care settings specifically breaking the cycle of violence through provision of empowering psychosocial support to women who have experienced intimate partner violence.

Keywords: intimate partner violence, women's health needs, Uganda

INTRODUCTION AND BACKGROUND

Intimate partner violence (IPV) is a form of interpersonal violence by a spouse or life partner. Typically, this is interpersonal violence perpetuated by a male to a female (Murthy, Upadhyay, & Nwadinobi, 2010:11; United Nations Population Fund (UNFPA), 2010:13; WHO, 2014:10). IPV reflects the societal context that underpins and encourages discriminatory attitudes and behaviour against women through negative gender stereotypes and the view that IPV is a domestic issue is dominant (ActionAid, 2015:1). Research reports serious short-term and long-term bio-psychosocial health consequences for women who experience intimate partner violence who are at increased risk of ill-health and disability (UNFPA, 2010:13). While IPV affects many women of various walks of life, empirical evidence suggests a greater incidence among women of low socioeconomic status (Murthy *et al.*, 2010:12). In 2013 global statistics estimated that male partners were responsible for approximately 38% of female homicides and that 10% to 69% of women have experienced IPV (Murthy *et al.*, 2010:11; WHO, 2014:10). Within the African region the prevalence of IPV is estimated at 36.6% (WHO, 2014:14). Women experience injuries, specifically genitourinary, that include cuts and bruises, and burns, and can result in death (Murthy *et al.*, 2010:18). In addition to the physical outcomes for victims of IPV, negative mental health outcomes such as shame, guilt, depression and suicidal behaviour, anxiety disorders (post-traumatic stress, panic and phobias), eating and sleep disorders, and psychosomatic disorders are reported (Murthy *et al.*, 2010:18). Specific behaviour changes of women who have experienced IPV are reported to include self-harm, substance abuse, unsafe sexual behaviour, and sexual dysfunction (Murthy *et al.*, 2010:18). In addition, other long-term specific health consequences of victims of IPV can include sexually transmitted infections such as HIV, and undesirable pregnancy outcomes (Kouyoumdjian *et al.*, 2013:1335).

According to the 2011 Uganda Demographic and Health Survey (UDHS, 2012:239), 59% of married women had experienced IPV, and of these 37% had sustained physical injuries. Ofosu-Kwakye (2013:1) reports that the problem of IPV in Uganda continues to grow. Kampala, Kaye, Mirembe *et al.* (2006:97) report that among 942 women seeking post-abortion care in Mulago Hospital in Kampala, domestic violence, including intimate partner violence, was strongly associated with unwanted pregnancy and or induced abortion. Researchers agree that women who suffer IPV experience poor health outcomes, although they can delay accessing healthcare they do ultimately access health services more than other women, and are most likely to report their present health status as poor or very poor (UNFPA, 2010:13; Garcia-Moreno *et al.*, 2015a:1567).

Research problem and purpose

There is a lack of knowledge about the bio-psychosocial health care needs of women experiencing intimate partner violence. In essence they are somewhat a 'hidden' group. To design and implement meaningful interventions, a detailed understanding is needed as less well understood are the IPV experiences and the health needs of women who have experiences of IPV. The study aimed at exploring IPV experiences and women's health needs in Kabalagala slums in Kampala and recommends practical interventions for improving access to quality health and other supportive services in Uganda.

RESEARCH DESIGN

The study was a cross-sectional exploratory study employing qualitative methods (Creswell, 2013:234). The study employed purposive sampling using health care records achieved through collaboration with a community service organisation to enable the researcher to access participants with experiences on IPV (Green & Thorogood, 2009:118). The researcher used a grand tour question followed by probing questions to enable participants to share their multiple experiences in detail and through this qualitative method, provided greater insight into the effects of IPV on women's health (Testa, Livingston & VanZile-Tamsen, 2011:242).

METHODS

Population and sampling

In Kampala, slums lack running water and electricity (World Vision, 2011:2). While there is a free health policy for all, many people do not have access to health facilities. The Kabalagala area comprises low income residents from various cultural backgrounds and it is two kilometres from Kampala City centre. Residents live in makeshift homes made of mud and pole and some of brick. Most of the people are engaged in petty trades,

such as hawking, and some work as casual labourers. Kabalagala is popular for its bars and commercial sex work is common among young women. Women have unique experiences negotiating relationships and life due to structural and gendered realities of living in the urban slums. The population included women aged 20 to 45 years living in slum areas, and these living conditions and age group are reported to result in the greatest risk of IPV (UDHS, 2012:239). Kamwanyi and Kikubamutwe slums in the Kabalagala area in Kampala, Uganda, were purposively sampled. The total target population was not known but was estimated at 10 000, the sample frame based on district data suggested an estimated 2 500 women within the target age group. Participants with rich IPV experiences were identified through collaboration with a community agency that runs a non-paying clinic assisting women reporting health problems due to IPV. The final purposive sample determined by saturation included forty-eight women. The average age of the participants was 31.75 years and the minimum age was 20 with a maximum of 45 years. Of the participants, thirty-one (64.6%) were married, nine (18.8%) were single, and eight (16.7%) were widowed. All the participants had children, with an average of four children and a maximum of seven children. Of the participants, twenty-two (45.8%) reported hawking as their work, six (12.5%) reported cleaning, three (6.3%) indicated shop-keeping, and two (4.2%) owned a salon. The participants' average stay at their current residence was 6.2 years with a minimum of 2 years and maximum of 20 years. Most of the participants, thirty-one (64.6%), reported that they were still living with their violent partners. The average duration of stay with the violent partner was 7.95 years with a minimum of half a year and a maximum of 30 years.

Data collection

Data was collected using qualitative in-depth interviews from a sample of forty-eight women with experiences of intimate partner violence. The researcher used a grand tour question (Creswell, 2013:227): 'What are your experiences of intimate partner violence and how has this affected you?', followed by probing questions, to obtain rich data on multiple realities and to allow the participants to adequately describe their own experiences of IPV (Green & Thorogood, 2009:80). The qualitative interviews were conducted personally by the researcher. The researcher collected the data in Luganda and ensured that the data collected was of high quality, and that the questions were asked in a clear manner. In order to collect accurate data on the participants' realities, the researcher used tape recorders to record interviews, took field notes and recorded observations on non-verbal cues. Each interview lasted about an hour and the interviews were conducted until data saturation was achieved at 48 interviews at which point no new themes emerged. The qualitative data was collected over a period of four months from August to December 2014.

Data analysis

All transcripts were translated from Luganda to English and back translated to avoid loss of meaning in translation. The qualitative data was then coded utilising thematic content analysis (Green & Thorogood, 2009:198). Each interview was structured into an individual table highlighting key themes. The researcher checked for authenticity of codes, divergent cases and confirmed the emergent themes by categorising the data tables in order to find patterns and processes (Mason, 2010:1). The researcher then developed a theme codebook consisting of themes and sub-themes with numerical codes attached to each theme and sub-theme.

Measures to ensure trustworthiness

The researcher improved the credibility of the data by using qualitative research techniques and allowing participants to reflect on their personal lives and experiences privately without fear or embarrassment. The researcher made sure that the results of this study could be confirmed by others by documenting the procedures for checking and re-checking the data throughout the study. All translations were cross-checked to ensure that the data was highly credible and trustworthy. A description of the context also enhanced the credibility of this research (Drew, Hardman & Hart, 1996:169–171). The researcher pre-tested the grand tour question with five participants to identify and correct possible problems such as ambiguity and difficult language. Dependability of the research findings was increased by ensuring that the research processes were consistent in the study design, data collection, interpretation and reporting (Polit & Beck 2008:539). All processes were explained and presented clearly, taking into account the dynamic study context and how it affected the research processes. The researcher had an increased awareness of any undesirable negative occurrences that dispute previous observations. In addition, at the end of the data collection and analysis, the researcher reviewed the research processes and established any potential bias. To ensure transferability of the results, the researcher provided a thick description of the research context and key research assumptions (Polit & Beck, 2008:539), enabling others who desire to transfer to make their judgment about the study findings.

ETHICAL CONSIDERATIONS

The researcher obtained ethical approval and permission to conduct the study from the Research and Ethics Committee of the Department of Health Studies, University of South Africa. Ethical approval and permission were also obtained from the Uganda National Council of Science and Technology (UNCST) and Office of the President. The researcher explained the purpose and significance of the study, risks and benefits of participation, emphasised that participation was free and voluntary, and treated the participants with respect (Polit & Beck, 2013:141). This information enabled the

participants to make an informed decision about participating and seek any clarification about the study. There was a risk of psychological discomfort due to the sensitive nature of the topic but participants were made to feel comfortable through good rapport and they were assured of maximum confidentiality. In case any of the participants needed further support, professional counselling support was available from a community service agency. There was also a minimal risk of loss of confidentiality but this was addressed by use of pseudonyms to protect the identities and maintain confidentiality of the participants.

RESULTS

Two major themes emerged from the data: firstly, physical care and treatment needs that include the following categories: scars of life, disability, disfigurement, and diminished physical functioning, and sexual and reproductive health complications; and, secondly, psychosocial health and support needs reflected in the terror of unpredictability, the shame of being 'me' and delayed access to health care. Direct quotes from the participants provide a description of the findings and are discussed in relation to the literature.

Theme 1: Physical care and treatment

The participants' narratives revealed physical care and treatment needs arising from health conditions and complications directly linked to IPV, and inflicted through beating, burning, kicking and cutting using weapons such as knives. Physical impacts of IPV as described by the participants ranged from injuries, disability, disfigurement, chronic headaches and backaches, and HIV infection. The descriptions of the mechanisms by which IPV occurred and the resulting physical health complications increased understanding of the participants' health needs.

Scars of life

Many of the participants reported that they had scars on their bodies and physical injuries as a result of violence. One participant was nursing a broken nose during the time of the interview while two reported losing an ear through IPV. The participants reported that their health was poor because of IPV and consequently their bodies felt battered all the time. Some participants described how they had to go to the health facilities to have their injuries treated. When the researcher mentioned health needs, the participants were quick to point to the different scars that they sustained:

I have a lot of scars on my body (P19).

You see here where he cut me (showed a big scar on her leg) He is the one who cut me. I went home to my parents and they looked after me (P4).

He cut me with some knife that is used with the gun. So he pulled it from the gun and cut me (P8).

This study brings to light the negative physical health impacts of IPV as highlighted in the literature, including injuries from beating, burning, pushing, and weapon assault by partners (UNFPA, 2010:13).

Disability, disfigurement and diminished physical functioning

Besides sustaining injuries, some participants had to endure chronic pain, disability, experienced diminished physical functioning or had undergone surgical operations as a result of the physical violence, including kicking and beating, from their partners:

He wanted to cut off the whole ear but it only got one part of the ear (P8).

[H]e broke my tooth, you see? My teeth became weak; indeed, they are not strong, and they are shaky. So I went and told the health workers and they gave me some medicine (P12).

They found that the kidney was damaged and they removed it in the hospital. The doctors treated me and removed it. But again the chest, I got complications, I can't carry something heavy like carrying a jerry can of water ... (P32).

Other participants reported body weakness as a result of IPV through regular beatings. As a result of body weakness, they could not lift heavy items:

I have a lot of chest and backache pains due to broken ribs and this means I can't do heavy duty jobs (P41).

The participants clearly sustained injuries because of IPV and while some of the women interfaced with the health system, the health workers did not play an active role in preventing or in responding to IPV beyond treating the health impacts.

I went to a health facility and they treated me, okay I felt some relief, only that the headaches return every year (P46).

So I went and told the health workers and they gave me some medicine (P12).

The role of health workers was absently glaring and this may also reflect the social context where IPV may be considered a personal issue. Yet, the health workers have an opportunity to screen for IPV and support women who experience intimate partner violence (Bott, Guedes, Claramunt & Guezmes, 2010:109).

Sexual and reproductive health risks and vulnerability

Participants also stated that their experiences of IPV had resulted in contracting STIs, including HIV infection. Some partners did not even disclose their HIV-positive status to the participants, and intentionally infected them. Some participants found out that

they were HIV-positive when they were pregnant and sought antenatal care services or when their children were sickly and tested HIV-positive. A participant stated that her partner had been tested and known that he was HIV-positive and was already on medication. He used to hide the medication from her until one day when she discovered it herself. The experience of being infected intentionally by a partner through his failure to disclose could in itself be considered a form of violence

For him he already knew, because I investigated him. So I went and did my own search at home. There is one chair he used to sit, that's where he was keeping his book and identity card for The AIDS Service Organization [commonly referred to as TASO in Uganda], because for me I read through he had enrolled in TASO before we got married. Because even the record book for taking medicine I got it. So as I didn't know how ARVs looked like, that tablet I had seen it before, he used to tell me that it's for kabotongo (STI) (P43).

A participant also reported that she found out that she had sero-converted to HIV-positive status when she was tested during an antenatal visit during her fourth pregnancy.

At the fourth child, because I went and tested for HIV during that pregnancy and I was found with the disease. So since then, my life, I started to shrink up to now (P2).

The vulnerability of women who experience IPV to HIV infection has been documented (Kouyoumdjian *et al.*, 2013:1336) and they were 1.5 times more likely to acquire HIV infection in a study among pregnant women.

The study showed that a variety of health needs resulted from the participants' IPV experiences. Other authors have also suggested that the availability of health care support especially targeted and tailored at IPV has potential for yield in improving secondary prevention of IPV (Olayanju *et al.*, 2013:111).

Theme 2: Psychosocial health care and support

The participants reported that the major effects of IPV on their lives were stress and fear of death, shame and embarrassment that seemed to inform their decisions to 'self-treat' and resulted in delayed access to healthcare. Participants reported caring for their own injuries and/or symptoms until they were not able to manage the complications of the injuries. Self-stigma featured due to scars and injuries that participants believed marked them as women who have experienced intimate partner violence.

The terror of unpredictability

Women who survive IPV endure mental 'torture' as a result of their experiences of violence. For one participant, the mental torment was due to the fact that the man had the financial capacity to offer financial support but refused to offer it. The partner had what she wanted but intentionally deprived her of money to buy the necessities for the children and family leading to immense struggle.

[H]e would show me that he has money because he would pull it out of his pocket and say, “have you seen this money? I will not give it to you.” He would carry it and take it to other women. That’s the torture of someone (P23).

He came while I was trying to prepare food. It was during the day, I was sick, and I was from the hospital, so I was going to serve food. He lifted a whole saucepan of beans I was cooking and poured it over me. From May to September, I was sick. Here is the scar where he poured hot sauce on me (showed a big scar on her arm) (P3).

A participant reported losing her baby after undergoing a caesarean section following IPV experiences. This participant described difficulties of coping with the psychological torture of losing a child through the violence of the same partner who had made her pregnant.

He would not beat my face; he would just beat the ribs. Even when you are pregnant for him, he doesn’t want to know. There was a time I was operated for one child but the child died (P17).

This finding of undesirable maternal and child health outcomes due to IPV in pregnancy is supported by the literature where violence during pregnancy was found to put women at a higher risk of complications during birth that could result in death of the mother and the baby (Shamu *et al.*, 2011:1; Garcia-Moreno *et al.*, 2015b:1686). Other participants stated that they did not feel happy with life as they were full of sorrow and misery. They reported that they were usually tense and fearful in anticipation of violence from their partners. Participants described how IPV had impacted the way they perceived themselves. They lead a life where they hate themselves, have low self-esteem and question their self-worth in life:

It has affected me a lot in my life, I did not enjoy my life the way I would have. I realise I was in a lot of sorrow, every time miserable, crying. I hated myself because I would not even eat; I would just sit there and look on like a mad person (P9).

My life is not at peace, I don’t love myself, I am not at ease with myself. Indeed that thing in your heart it affects you. You get into a situation where you don’t love yourself like other people and you say I wish I was also like so and so (P17).

While some of the physical scars had healed, the emotional ones were still evident. Many of the participants referred to religion (God) as their source of hope amid all the problems that they experienced in their families:

I have suffered a lot, I have seen sorrow and what can I add? You see, everything has reached my head. What I do is trust God who created me; he is the one who will help me (P19).

Some participants reported that they developed hypertension and persistent headaches because of IPV experiences.

This experience has left me with a stressful life and I usually get headaches (P5).

Our findings are synonymous with other studies that have shown that women exposed to severe emotional abuse have a high risk of hypertension (Mason, Wright, Hibert, Forman & Rich-Edwards, 2012:566). They affirm that IPV is linked to negative emotions and behaviour, including stress (Murthy *et al.*, 2010:18).

The shame of being me

The participants reported experiencing shame and embarrassment as a result of IPV. One participant described exceptionally embarrassing and shameful experiences when her partner physically and sexually abused her outside the house when the neighbours were watching:

It was one of those special days, we were in a barracks, he came drunk and he called me to “come here”. I remember I was cooking food, I had just added meat to the saucepan. It was the 25th of the month and when he called me I told him, “I am cooking on the charcoal stove; let me first finish cooking”. So he did not listen, he immediately started beating me that I don’t want to sleep with him and then he used me a lot, in that very place. Like the charcoal stove is here and he sexually used me there. That embarrassment! People were there seeing. Did I tell you that he would use me in the anal opening? And then he would rape me again, he would not even wait for the children to sleep; he wants to do it when the children are awake so that you get embarrassed. Even the neighbours, he would want them to hear, he would not mind (P9).

Another participant explained how she hid in her house for a week, afraid that her neighbours would see her swollen face and possibly ask what had happened to her.

There is a time when he beat me and my whole face got swollen. I spent like a week; I would even fear the neighbours seeing my face (P16).

Physical and sexual violence are often tied. Women who are beaten are also forced to engage in sexual intercourse with the perpetrator and cannot negotiate safe sex (Allsworth, Anand, Redding & Peipert, 2009:529). This includes marital rape, which is a form of sexual violence (Murthy *et al.*, 2010:15). There is not any law against marital rape in Uganda and the issue of conjugal rights falls in the private sphere. Under the *Domestic Violence Act* (2010:8), the partners’ conduct would be considered ‘sexual abuse’ defined as ‘any conduct of a sexual nature that abuses, humiliates, degrades or otherwise violates the dignity of that person’, and is liable to a jail term of up to two years. Public display of affection or intimacy in public is not culturally acceptable in Uganda (Otiso, 2006:101), hence the man’s behaviour is not congruent with the customs and traditions of the society. Such experiences of physical and sexual violence humiliate and denigrate women, and cause them emotional trauma.

The narratives indicate that women experience shame and make attempts to cover up their experiences of IPV. A participant mentioned how the partner would pull her braids off her head and because she did not want people to know about her experiences she began lying to people.

I used to plait my hair and he would pull it and it all gets out. That's why I gave up on the braids. Now, I don't grow my hair. So when someone meets me they say why you don't grow hair, I say I don't want it. But for me, I know the reason (P1).

This shame is particularly reflected in delayed access to healthcare. Most participants reported that they could not afford to seek healthcare due to self-stigma and perceived stigma by others. They stayed home and endured the pain first hand until they were healed, keeping their experiences a secret. A participant explained that she made attempts to self-treat due to the stigma associated with the abuse and was afraid of 'what people would say':

I wanted to go back home but I wondered what people would say so I decided to first treat myself ... (P9).

Some of the participants stated that they could not leave the violent partner since they had nowhere to run to and were locked in violent marriages because they had children whom they could not look after on their own. This impacted negatively on the self-esteem and ability to explore alternatives to free themselves from these violent unions:

He is the father of the children. I don't have anywhere to take them (P47).

The narratives show how women who experience intimate partner violence may often hide their experiences from their families and neighbours due to feelings of shame and embarrassment. Our study findings are supported by evidence that suggests that for some women, it is unheard of to speak openly about their experiences of violence and they feel ashamed and blame themselves for the violence (Payne and Wermeling, 2009:180). In other instances, there is a lack of confidentiality and women fear further violence from their partners if they are found to have disclosed, and consequently they suffer in silence (UNFPA, 2010:40). The literature suggests that in some settings women who suffer IPV access health services more than other women (Garcia-Moreno *et al.*, 2015a:1567), however, our study indicates that women who experience IPV in this context may not necessarily use health services more due to the complexities brought about by the perceived social stigma. Consequently, any interventions must not ignore such emotional and psychological needs of women who have experienced IPV.

CONCLUSION AND RECOMMENDATIONS

IPV impacts the well-being of women and affects their ability to live healthy and productive lives. The health impacts of IPV in this study were intricately linked and in some cases participants reported a combination of physical and psychosocial health consequences. Women who have experienced IPV in this study reported physical health complications, resulting in psychological distress, while in some cases the psychological distress led to physical health complications. The identified health needs should inform health care strategies aimed at responding to intimate partner violence, mainly in the

domain of physical health and psychosocial support for women who have experienced IPV as has also been indicated in some studies (Murthy *et al.*, 2010:20; UNFPA, 2010:13). The experiences of women in this study show that IPV affected the women's agency to seek timely access to health care and their dignity to extricate themselves from the violence perpetrated by their partners.

More assertive outreach by health care professionals in these high risk areas is required (Bott, Guedes, Claramunt & Guezmes, 2010:109; Murthy *et al.*, 2010:21). Health workers should be trained to professionally ask and identify women who need further support by integrating this in the health services package offered. In Zimbabwe, Shamu *et al.* (2013:520) found that health workers had limited ability to identify and respond to IPV. Policy to support secondary prevention of IPV must be developed and implemented (Murthy *et al.*, 2010:21). It is crucial to improve the social and institutional support, including training of health workers to identify and support women experiencing IPV. Efforts should be heightened to break the continued cycle of IPV for women as this study's findings indicate that the average duration of stay in a relationship with a violent partner is relatively long at about eight years. Therefore, the need to intervene is important when it is known that IPV is happening. Specifically, women require bio-psychosocial support to empower them to be their own drivers of change.

LIMITATIONS

The study was restricted only to women aged 20–45 years living in Kabalagala urban slums in Kampala, Uganda, and therefore may not mirror the circumstances and experiences of all women in the country. The researcher acquired deeper insight into the experiences and understanding of the occurrence of IPV and consequent health needs among the participants. Intimate relationships, however, involve two individuals although the results of this study only represent the participants' experiences and perceptions. The men's perspectives were beyond the scope of this study.

REFERENCES

- ActionAid. 2015. The Marriage and Divorce Bill coalition minimum position. Retrieved from <http://www.actionaid.org/uganda/2015/05/marriage-and-divorce-bill-coalition-minimum-position> (Accessed 14 March 2016).
- Allsworth, J. E., Anand, M., Redding, C. A. & Peipert, J.F. 2009. Physical and sexual violence and incident sexually transmitted infections. *Journal of Women's Health*, 18(4):529–534.
- Bott, S., Guedes, A., Claramunt, M. C. & Guezmes, A. 2010. Improving the health sector response to gender-based violence: a resource manual for health care professionals in developing countries. Western Hemisphere Region: IPPF. Available from http://www.ipfwhr.org/sites/default/files/GBV_cdbookletANDmanual_FA_FINAL.pdf (Accessed 10 March 2014).
- Campbell, T. & Campbell, A. 2007. Emerging disease burdens and the poor in cities of the developing world. *Journal of Urban Health* 84(Suppl 3):54–64.

- Creswell, J. W. 2013. *Research design: Qualitative, quantitative, and mixed methods approaches*. 4th edition. London: Sage Publications.
- Dunkle, K. L., Jewkes, R. K., Nduna, M., Levin, J., Jama, N., Khuzwayo, N., Koss, M. P. & Duvvury, N. 2006. Perpetration of partner violence and HIV risk behaviour among young men in the rural Eastern Cape, South Africa. *AIDS*, 20(16):2107–2114.
- Garcia-Moreno, C., Hegarty, K., D'Oliveira, A. F. L., Koziol-McLain, J., Colombini, M. & Feder, G. 2015a. The health-system's response to violence against women. *Lancet*, 385:1567–1579.
- Garcia-Moreno, C., Zimmerman, C., Morris-Gehring, A., Heise, L., Amin, A., Naeemah Abrahams, N., Montoya, O., Bhate-Deosthali, P., Kilonzo, N. & Watts, C. 2015b. Addressing violence against women: a call to action. *Lancet*, 385:1685–1695.
- Green, J. & Thorogood, N. 2009. *Qualitative methods for health research*. 2nd edition. London: Sage.
- Kaye, D. K., Mirembe, F. M., Bantebya, G., Johansson, A. & Ekstrom, A. M. 2006. Domestic violence as a risk factor for unwanted pregnancy and induced abortion in Mulago Hospital, Kampala, Uganda. *Tropical Medicine and International Health*, 11(1):90–101.
- Kouyoumdjian, F.G., Calzavara, L. M., Bondy, S. J., O'Campo, P., Serwadda, D., Nalugoda, F., Kagaayi, J., Kigozi, G., Wawer, M. & Gray, R. 2013. Intimate partner violence is associated with incident HIV infection in women in Uganda. *AIDS*, 27(8):1331–1338.
- Mason, S., Wright, R., Hibert, E. D. S., Forman, J. & Rich-Edwards, J. 2012. Intimate partner violence and incidence of hypertension in women. *Annals of Epidemiology*, 22(8):562–567.
- Mason, M. 2010. Sample size and saturation in PhD studies using qualitative interviews [63 paragraphs]. *Forum Qualitative Sozialforschung / Forum: Qualitative Social Research*, 11(3): Art. 8. Available from <http://nbn-resolving.de/urn:nbn:de:0114-fqs100387> (Accessed 15 June 2013).
- Murthy, P, Upadhyay, U & Nwadinobi, E. 2010. Violence against women and girls: A silent global pandemic (Chapter 2). In P. Murthy and L. C. Smith (eds.), *Women's global health rights*. Massachusetts: Jones and Bartlett.
- Ofosu-Kwakye, A. 2013. Uganda: Women judges voice concern over domestic violence. Law Library of Congress. Available from www.loc.gov/law/foreign-news/article/uganda-women-judges-voice-concern-over-domestic-violence/ (Accessed 8 April 2016).
- Olayanju, L., Naguib, R. N. G., Nguyen, Q. T., Nguyen, Bali, R. K. and Vung, N. D. 2013. Combating intimate partner violence in Africa: Opportunities and challenges in five African countries. *Aggression and Violent Behavior*, 18(1):101–112.
- Osinde, M. O., Kaye, D. K. & Kakaire, O. 2011. Intimate partner violence among women with HIV infection in rural Uganda: Critical implications for policy and practice. *BMC Women's Health*, 11:50.
- Otiso, K. M. 2006. *Culture and customs of Uganda*. Greenwood Publishing Group.
- Payne, D. and Wermeling, L. 2009. Domestic violence and the female victim: The real reason women stay! *Journal of Multicultural, Gender and Minority Studies*, 3(1):178–185.
- Polit, D. F. & Beck, C. T. 2013. *Essentials of nursing research: Appraising evidence for nursing practice*. 8th edition. Philadelphia: Lippincott.
- Republic of Uganda. *The Domestic Violence Act, 2010* (Pages 1–20).
- Shamu, S., Abrahams, N., Temmerman, M., Zarowsky, C. 2013b. Exploring opportunities and obstacles to screening pregnant women for intimate partner violence during antenatal care in

- Zimbabwe. *Culture, Health and Sexuality: An International Journal for Research, Intervention and Care*, 15(5):511–524.
- Shamu, S., Abrahams, N., Temmerman, M., Musekiwa, A., Zarowsky, C. 2011. A systematic review of African studies on intimate partner violence against pregnant women: Prevalence and risk factors. *PLoS ONE*, 6(3):1–9.
- Testa, M., Livingston, J. A. & VanZile-Tamsen, C. 2011. Advancing the study of violence against women using mixed methods: Integrating qualitative methods into a quantitative research program. *Violence Against Women*, 17:236–250.
- UDHS. 2012. *Uganda demographic and health survey, 2011*. Kampala, Uganda: Uganda Bureau of Statistics and Calverton. Maryland: ICF International.
- United Nations Population Fund. 2010. *Addressing violence against women and girls in sexual and reproductive health services: A review of knowledge assets*. New York: United Nations Publications.
- WHO. 2014. *Global status report on violence prevention, 2014*. Geneva: WHO.