**Extended Abstract**

# The Interlink between Domestic Violence and Fertility: Partner Asymmetry and Gender Inequality

Sasha Frade[1] and Clifford Odimegwu[1]

[1] Demography and Population Studies Programme, University of the Witwatersrand, 1 Jan Smuts Avenue, Braamfontein, 2000, Johannesburg, South Africa

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**Corresponding Author:** sasha.frade@wits.ac.za

# 1. Background

Domestic Violence (DV), which emanates as a severe consequence of gender inequality in society, is the most pervasive form of GBV as the vast majority of abuse is perpetrated by intimate partners and has major sexual and reproductive health consequences for women; such as high parity, inconsistent and lower levels of contraceptive use, unintended pregnancies, and adverse pregnancy outcomes (Nalwadda et al, 2010). Studies have found links between DV and unintended pregnancy, postulating that women in abusive relationships have a limited ability to control their fertility (Pallitto et al., 2005). The more control a woman has over her reproductive health; the more likely she is to use contraceptives and therefore decrease the number of children ever born. Thus, one of the most important factors that Kalipeni (1995) and Handwerker (1991) attribute to declining fertility rates is the upliftment in the status of women.

Despite concerted efforts by African governments, fertility levels in the region remain high. Africa is the region that has been least responsive to family planning programmes. Furthermore, according to Principle 4 of the ICPD PoA: "Advancing gender equality and equity and the empowerment of women, and the elimination of all kinds of violence against women, and ensuring women's ability to control their own fertility, are cornerstones of population and development-related programmes…" (UNFPA, 1994).

# 2. Data and Methods

This study investigated the relationship between DV and fertility in Uganda – a country with persistently high fertility rates as well as high rates of DV, using the Ugandan Demographic and Health Survey of 2011. Adult women of reproductive ages (15-49) that were included in the domestic violence module of the individual recode, were included in this study. Children ever born was selected as the fertility outcome variable, and three forms of DV (Emotional, Physical and Sexual) were the main independent variables. Socio-demographic and women's empowerment variables included in the analysis were selected from a review of the literature, as well as from the conceptual model based on Bongaarts' Proximate Determinants Model and the Social-Ecological Model for Violence Prevention. These included highest educational level attained, employment status, type of place of residence, age at first cohabitation, household decision making, attitude to wife beating, number of dead children, current type of contraceptive method, and ever had a stillbirth, miscarriage or abortion. Unfortunately, due to the illegality and, therefore, sensitive nature of abortion in Uganda the last variable included stillbirths, miscarriages and abortions in one variable. Given that women included in the domestic violence module were married or cohabiting marital status was not included. Furthermore, due to a high correlation with children ever born, age was another demographic characteristic not included in the analysis.

Univariate analysis conducted included percentage distributions of the outcome, DV and independent variables. Bivariate analysis, whereby cross-tabulations were done and chi-square tests were performed to test for associations between the independent and dependent variables [not shown in extended abstract] as well as the overall mean CEB for those that experienced and did not experience each of the forms of DV were included. The final part of the analysis was the unadjusted [not shown in extended abstract] and adjusted Poisson Regression models, showing both coefficients and Incidence Risk Ratios (IRR) for children ever born and the different forms of DV, as well as the socio-demographic and women's empowerment variables.

## 3. Preliminary Results

Uganda does indeed have high fertility as over a third of women have between 3 and 6 children, whereas almost one in five women have 7 or more children. While around 43% of women of reproductive age in Uganda report having experienced emotional and physical DV in their lifetime, over a quarter of women of reproductive age in Uganda have experienced sexual DV as well.

Women whom have experienced any form of DV in their lifetime have a higher mean number of children ever born than those that have not. Those whom have experienced emotional DV have an average of 4.66 children, compared to 3.85 children amongst those who have never experienced emotional DV. Furthermore, women whom have ever experienced physical DV have an average of 4.62 children, compared to 3.88 amongst those whom have never experienced this form of DV. Although the difference is far smaller, women whom have ever experienced sexual DV have an average of 4.51 children compared to 4.08 children amongst those whom have never experienced sexual DV.

The results of the adjusted models show that there is a significant associative relationship between children ever born, and each of the forms of DV, even when the effects of the socio-demographic and women's empowerment variables are included. Women whom experience emotional DV have 12% more children than women who do not experience emotional DV; whilst it was 8% for physical DV and 7% for sexual DV. Educational level and type of place of residence are also significant predictors of fertility – whereby with each increasing level of education, women have a lower percentage of children ever born to them, whilst those living in rural areas have around 13% - 14% more children born to them (Models 1, 2 and 3).

Furthermore, the younger the age at first cohabitation, the higher the percentage of children ever born. Surprisingly, however, the composite index of household decision-making showed that if women were solely or in part responsible for key decisions in the household (big household purchases, going to the clinic on their own, and visiting family and friends) increased the children ever born by 21%-22%, depending on the model and DV form included. However, this could be explained by the high cultural value

placed on children in Uganda. This variable also has the limitation that this information is self-reported, and women may be over-stating their involvement in key household decisions. Attitude to wife-beating, another indicator of women's empowerment and deep-set cultural values, shows that women whom believed that wife-beating was justified on certain occasions have between 2% and 3% more children than those whom believed that it was never justified.

Having had a child die, increases the number of children ever born. Those whom had one child die had 42%-46% more children and those whom had 2 or more children die have between 97% and 2 times more children compared to those whom had not experienced the death of a child – depending on the DV form included in the model.

## 4. Conclusion

Although the current work is still in progress, preliminary results show that there is in fact a relationship between DV and fertility. Both bivariate and multivariate analyses show a strong association between both these pervasive health problematics; and may therefore be one of the unexplained proximate determinants of persistently high fertility in countries such as Uganda. These results have important implications for understanding both the fertility transition in Uganda, but also for programmes and policies addressing unwanted pregnancies and unmet need for contraception that is driving fertility up, and DV amongst women which we know from previous work has severe reproductive health outcomes but which we have now identified is a contributor to high fertility as well. DV could be, in part, a factor that explains the low uptake of family planning programmes in Uganda. Empowering women in general, and having programmes and policies that directly talk to the value and quality of children (as opposed to the quantity of children), increasing female education, and behaviour change programmes that work around the issue of the value and respect of women in society may go a long way in not only decreasing the incidence of DV but, therefore, decrease fertility overall and thus increasing the opportunity to benefit from the demographic dividend and increase levels of development and economic growth. This, however, needs to be complimented with children's health and immunisation programmes – to ensure that children survive – given that an increased number of children whom have died increases the likelihood of having subsequent children. This is very likely since once a woman has experienced the death of one or more children, there is a fear that other children might die as well. Research is ongoing to identify the direct and indirect pathways in which DV acts on reproductive proximate determinants, and the total effect (indirect and direct combined) that DV has on fertility rates in Uganda.