

2015-01-01

An Ethnic Comparison Of Intimate Partner Violence Among Ecuadorian Women Of Reproductive-Age

Marlene Lara

University of Texas at El Paso, marleneshytown23@yahoo.com

Follow this and additional works at: https://digitalcommons.utep.edu/open_etd



Part of the [Public Health Education and Promotion Commons](#)

Recommended Citation

Lara, Marlene, "An Ethnic Comparison Of Intimate Partner Violence Among Ecuadorian Women Of Reproductive-Age" (2015). *Open Access Theses & Dissertations*. 1084.

https://digitalcommons.utep.edu/open_etd/1084

This is brought to you for free and open access by DigitalCommons@UTEP. It has been accepted for inclusion in Open Access Theses & Dissertations by an authorized administrator of DigitalCommons@UTEP. For more information, please contact lweber@utep.edu.

AN ETHNIC COMPARISON OF INTIMATE PARTNER VIOLENCE AMONG
ECUADORIAN WOMEN OF REPRODUCTIVE-AGE

MARLENE LARA

Master's Program in Public Health Sciences

APPROVED:

Oralia Loza, Ph.D., Chair

Thenral D. Mangadu, Ph.D.

Mark W. Lusk, Ed.D.

Charles Ambler, Ph.D.
Dean of the Graduate School

Copyright ©

by

Marlene Lara

2015

AN ETHNIC COMPARISON OF INTIMATE PARTNER VIOLENCE AMONG
ECUADORIAN WOMEN OF REPRODUCTIVE-AGE

by

MARLENE LARA, B.S.

THESIS

Presented to the Faculty of the Graduate School of
The University of Texas at El Paso
in Partial Fulfillment
of the Requirements
for the Degree of

MASTER OF PUBLIC HEALTH

Master's Program in Public Health Sciences

THE UNIVERSITY OF TEXAS AT EL PASO

December 2015

Abstract

Background: Afro-Ecuadorian and Indigenous women in Ecuador are ethnic minorities that may be at a greater risk of intimate partner violence (IPV) and adverse physical, sexual, and psychological health outcomes compared to Mestizo/White majority women. Prior studies have suggested factors such as SES, age, marriage, marital status, prior history of abuse and violence, attitudes regarding IPV, and alcohol and/or drug use are associated to IPV. **Aims:** The aim of this secondary analysis was to compare IPV prevalence and sociodemographic and health-related correlates by ethnicity (minority versus majority) among Ecuadorian women. **Methods:** A total of 10,730 Mestizo/White, Indigenous, and Afro-Ecuadorian Ecuadorian women included in the large nationally representative database of ENDEMAIN 2004 (aged 15-49 years) and responded to Mujer de Edad Fértil (MEF), a subsample questionnaire concerning violence against women. Measures collected included ethnicity and other demographic characteristics and the following IPV related measures: past year and lifetime IPV (physical, sexual and psychological), IPV support services, IPV-related injuries, and early life exposure to violence. Descriptive statistics of all categorical measures included frequency and percent. Ethnic differences in measures for IPV were determined with bivariate tests of Pearson's Chi-Square (χ^2) and Likelihood Ratio tests then adjusted for demographic characteristics using of multinomial logistic regression with Mestizo/White as a referent category. **Results:** Among the sample of Ecuadorian women, Mestizo/White (86.7%), Indigenous (9.7%), and Afro-Ecuadorian (3.6%) women observed parent psychological, physical, and both IPV (35%, 32.3% 37.2%) and were mistreated (22.1%, 25.1%, 27.7%) before age 15. Women reported psychological, physical, and sexual IPV in their lifetime (30.8%, 21.7%, 7.8%) and in the past 12 months (11.8%, 7.5%, 2.7%). The adjusted results indicate that, compared to White/Mestizo women, Indigenous minority women had higher rates of psychological ($p=0.081$; $p=0.004$) and physical ($p=0.031$; $p<0.001$) early life exposure

and mistreatment to IPV. Physical lifetime ($p=0.042$; $p=0.001$) and recent ($p=0.061$; $p=0.002$) IPV among Indigenous and Afro-Ecuadorian minority women was higher compared to majority Mestizo/White women. Afro-Ecuadorian minority women showed statistically higher rates for injuries ($p=0.010$) and help-seeking ($p=0.001$) behaviors compared to majority Mestizo/White women. **Discussion:** Minority women experience more IPV, IPV-related injuries and less help-seeking behaviors compared to Mestizo/White majority women. The findings of this study suggest that there is a need for integrated educational preventive intervention programs, supporting healthcare systems and law enforcement to identify IPV victims to help reduce underreporting of IPV, press charges, and treat injuries. Thus, outreach to these communities through interventions and prevention programs and decreasing barriers of help-seeking services maybe an important factor to further allow a more effective approach towards IPV affected minorities in Ecuador.

Table of Contents

Abstract.....	iv
Table of Contents.....	vi
List of Tables.....	viii
List of Figures.....	ix
Chapter 1: Background and Significance.....	1
Intimate Partner Violence Overview.....	1
Factors that Promote or Protect Against IPV.....	2
Ethnicity/Race.....	2
Education.....	3
Employment Status.....	4
Household Socioeconomic Status and Income.....	4
Age.....	5
Marital Union Characteristics.....	5
Childhood Exposure to IPV or Violence.....	6
Cultural Norms and Attitudes.....	6
Alcohol and Other Drug Use.....	7
Health-Related Consequences of IPV.....	8
Physical Health Symptoms.....	8
Adverse Physical Health Outcomes.....	9
Adverse Mental Health Outcomes.....	10
Reproductive and Sexual Health.....	12
Health-Seeking for IPV.....	14
Overview of Intimate Partner Violence in Ecuador.....	15
Chapter 2: Study Objectives and Hypothesis.....	17

Chapter 3: Methods.....	19
Source of Study Data	19
Study Design and Sample.....	19
Data Collection.....	19
Measures.....	20
Sociodemographic Characteristics.....	20
Intimate Partner Violence Measures.....	21
Data Analysis.....	22
Database Management.....	22
Statistical Analysis.....	22
Chapter 4: Results.....	24
Descriptive Statistics.....	24
Sociodemographic Characteristics.....	24
Intimate Partner Violence Measures.....	24
Bivariate Analysis for Ethnic Differences.....	25
Multivariate Analysis for Adjusted Ethnic Differences.....	25
Chapter 5: Discussion.....	28
Strengths.....	31
Limitations.....	31
Chapter 6: Conclusion.....	33
References.....	34
Tables.....	42
Figures.....	52
Appendix: ENDEMAIN 2004 (selected questions).....	53
Curriculum Vita.....	58

List of Tables

Table 1. Descriptive statistics of sociodemographic characteristics and measures for IPV among Ecuadorian women (n=10,730).....	42
Table 2. Ethnic Differences in Early Life Observed Exposure to IPV.....	46
Table 3. Ethnic Differences in Early Life Mistreatment.....	47
Table 4. Ethnic Differences in Lifetime Experience of IPV.....	48
Table 5. Ethnic Differences in Recent IPV.....	49
Table 6. Ethnic Differences in Recent IPV-related Injuries.....	50
Table 7. Ethnic Differences in Recent Help Seeking for IPV.....	51

List of Figures

Figure 1. Prevalence of Physical or Sexual Partner Violence, Ever and in the Past 12 Months, among women aged 15-49 in the Latin America & Caribbean Region.....	52
---	----

Chapter 1: Background and Significance

Intimate Partner Violence Overview

Violence against women is an important global public health issue (Devries et al., 2013). The most common form of domestic violence that women experience is intimate partner violence (IPV). Intimate partner violence is defined as physical, emotional, psychological, verbal, and/or sexual abuse that occurs between two persons who are currently or were previously engaged in a romantic relationship (CDC, 2008). It has been estimated that one in three women worldwide have in the past or will experience IPV in their lifetime (Devries et al., 2013; Chibber & Krishnan, 2011). However, the prevalence of IPV varies between and among populations. The prevalence of lifetime physical or sexual IPV in the Americas 17% to 53.3% (Figure 1) (Bott, Guedes, Goodwin, & Mendoza, 2012). Intimate partner violence has been linked to multiple adverse physical and psychological illnesses, premature mortality and disability for individuals (Cummings et al., 2013; Chibber & Krishnan, 2011; other refs). It also has been associated with significant adverse economic and social consequences for families, local communities, and the larger society (Devries et al., 2013, other refs). In addition, it is associated with high direct and indirect healthcare and related costs. For example, IPV-associated costs were reported to exceed the equivalent of 20 billion dollars annually in the United Kingdom (Devries et al., 2013). Similarly, the CDC has estimated that IPV-associated costs for the U.S. health care system around \$4.1 billion/year including medical care and mental health services (CDC, 2003). Other studies have reported that the need for hospital services and health care by IPV-affected women may last as long as five years after IPV has ceased (Chibber & Krishnan, 2011). In low and middle-income countries, out-of-pocket expenses for health care

associated with IPV are estimated to be as high as 75% of household weekly income (Chibber & Krishnan, 2011).

Factors that Promote or Protect Against IPV

A number of individual, interpersonal, community factors are reported to be associated with IPV risk in women. The identification of potential risk and protective factors is an important topic of research that can inform policy makers and assist public health authorities, social workers, and other health professionals in the design of more effective IPV prevention and amelioration programs (PAHO 2012; WHO, 2013; CDC, 2013).

Risk factors identified in prior studies as associated with IPV include low SES, alcohol abuse, younger age, male cultural attitudes supportive of IPV, having multiple sexual partners, and a positive history for childhood abuse, domestic violence, or other forms of violence (Abramsky et al., 2011). In contrast, sociodemographic factors identified as protective factors for IPV include a secondary education, high socioeconomic status (SES), and being legally married (Abramsky et al., 2011).

Ethnicity and Race

The prevalence of IPV is reported to vary among different ethnic/racial groups. In the United States, the prevalence of IPV among Hispanic women is reported to be higher compared to other ethnic groups (Caetano, Field, Ramisetty-Mikler, & McGrath, 2005). For example, in a large national study of cohabitating couples, the prevalence of IPV among Hispanic couples was 14% versus 6% among non-Hispanic White couples ($p < 0.05$) (Caetano et al., 2005). A higher IPV recurrence rate was also reported for Hispanics (58%) compared to non-Hispanic Black (52%) and White couples (37%) (Caetano et al., 2005).

Documentation of intimate partner violence is not only limited to the United States. Many Latin American countries, such as Ecuador, are greatly affected by IPV. It is estimated that 7 out of every 10 Ecuadorian women have been victims of domestic violence in their lifetimes (Valdivierzo, 2004). The Ecuadorian Center for the Promotion and Action for Women (CEPAM) reported that the legal services of the Women and Family Commissaries (WFC) served close to 600,000 cases of IPV between 1995 and 2006 (CEPAM, 2009). Among Hispanics in the United States, other factors associated with IPV include young age, low income, unemployment, traditional gender norm roles, perceived/actual isolation, acculturation level, language barriers, and use of alcohol and other drugs (Cummings, Gonzalez-Guarda, & Sandoval, 2013). Hispanic women also are reported to be more likely to experience adverse IPV-associated mental and physical health consequences compared to non-Hispanic women (Bonomi, Anderson, Cannon, Slesnick, & Rodriguez, 2009).

Education

Among women, educational attainment is reported to be an important negative correlate of IPV. The findings from several past studies indicate that the risk for IPV is reduced when both the female and male partner have a secondary education or higher (Abramsky et al., 2011). Data from the *National Survey on Families and Households* indicate college graduates were significantly less likely to report IPV compared to those with only a high school education (AOR= 0.68; 95% CI [0.47 - 0.98]) (Sorenson et al., 1996). The report also suggested that women with less than a high school were more likely to report IPV than those who had graduated from high school (AOR= 1.41; 95% CI [1.02 - 1.96]) (Sorenson, Upchurch, & Shen, 1996). Findings from a study by Abramsky and colleagues (2011) also suggested that women whose male partner has a higher education level, increases her risk for experiencing IPV (11%)

(AOR=1.6, 95% CI: [0.83, 2.9] however the results were not significant. Quigley and colleagues (1996) did not find significant association between women's educational attainment and IPV.

Employment Status

Employment status is another factor that has been linked to IPV among women. For example, Abramsky and colleagues (2011) reported that when both partners had paid employment, IPV was less likely compared when either one or both partners were unemployed. This suggests that better economic status associated with both incomes or a better support network, especially for women, could reduce vulnerability to IPV. Male occupation type may also influence IPV risk. A population-based survey from the 1975 *National Family Violence* found that among men working in manual labor jobs, these men had an annual partner assault rate that was almost twice that of those working in white collar office occupations (9.2% vs. 5.4%) (Straus, 1990). However, since occupation is also closely linked to both education and income, it could be a proxy for either of those documented risk factors. In some instances, where a woman works and with whom could also influence her IPV risk. Devries and colleagues (2013) have reported that women who work outside the home and/or whose job entails working with other males can be more at-risk for experiencing IPV due to partner jealousy in some societies or sub-cultures.

Household Socioeconomic Status and Income

The socioeconomic status and annual income of a household is reported to have a strong influence on women's risk for IPV. In a study conducted in 15 countries, high SES among women is with associated with reduced IPV prevalence (Abramsky et al., 2011). Americas women whose annual household incomes of less than \$15,000 were 1.5 times more likely to report experiencing IPV (AOR: 1.49; CI 95% [1.02, 2.18]) compared to those with higher

incomes (\$25,000-\$39,999) (Sorenson et al., 1996). Likewise, a similar association has been reported, findings from a longitudinal study conducted by Magdol and colleagues (1997) confirmed that low-income males who also had limited formal education and/or who were unemployed (13.59%) were significantly more likely to engage in IPV compared to other males (2.14%).

Age

It has been reported that younger women are more likely to experience physical and emotional abuse by their partners compared to their older counterparts (Chibber & Krishnan, 2011). However, the results of another study conducted by Volpe and colleagues (2013) examined age differences between adolescent girls and their older male partners indicated that age did not appear to be associated with relationship power and/or the severity of either physical or psychological IPV. However, adolescent girls with older male partners were found to be at greater risk for experiencing poorer sexual health outcomes compared to those whose partners were younger.

Marital Union Characteristics

Women cohabiting with a male partner in a common law union are reported to be at higher risk for experiencing IPV compared to non-cohabiting women (Abramsky et al., 2011). These authors also reported that women involved in a legal martial union of less than five years duration appear to be at higher risk for IPV compared to those women in longer-term relationships (Abramsky et al., 2011). Moreover, 87% of women who first experienced IPV in their lifetime reported IPV abuse during the first 5 years of their marriage (Chibber & Krishnan, 2011). Increased choice in a martial union in women has been linked to decreased IPV compared to women who had forced or arranged marriages (Abramsky et al., 2011). It has also been

reported that women who gave birth to children from other male partners often can experience increased tensions and disturbances in their relationships, which can increase IPV risk (Abramsky et al., 2011). Women who have multiple male partners are more likely than others to experience IPV (Raj, Silverman, & Amaro, 2004) and in particular, physical IPV (Collins, Ellickson, Orlando, & Klein, 2005) as well as to experience more severe physical health consequences resulting from IPV (Parish, Wang, Laumann, Pan, & Luo, 2004).

Childhood Exposure to IPV or Violence

Exposure to violence in childhood and/or perpetration of violence is a well-documented risk factor for future IPV (Devries et al., 2013). Female children who experience sexual or physical abuse directed towards their own mother by a male partner are more likely to also experience IPV in the future compared to those without such a history (Abramsky et al., 2011). In addition, relationships in which both partners were abused in childhood also are reported to be associated with higher IPV risk (Abramsky et al., 2011). Furthermore, women whose male partners had fought with another male at least once during the past year were found to be more likely to experience IPV than those whose male partners did not fight during this time period (Abramsky et al., 2011).

Cultural Norms and Attitudes

Cultural norms and male and female attitudes regarding the appropriateness and acceptability of IPV appear to influence whether or not a woman will experience IPV and whether a male will perpetrate it. For example, male behaviors are often associated with traditional gender roles emphasizing masculinity and “machismo”. In many Latin American societies, *machismo* is characterized by a suite of male behaviors such as multiple female sexual partners, tight control of female partners, fighting with other men, and jealousy. These behaviors are strongly associated with the likelihood of perpetrating IPV (Abramsky et al., 2011).

Mayo and Resnick (1996) have reported that the concept of *machismo* is characterized by the domination of women, and the view that the role of women is to serve men and raise their children. *Marianismo* embodies the Latin American cultural ideal regarding women's behavior. This cultural ideal is characterized by women's subservience, faithfulness to the husband, and selflessness (Goicolea et al., 2102). Other studies have shown that males who have unsupportive attitudes regarding gender equality in personal relationships are more likely to engage in IPV because their perceptions of gender can trigger IPV reactions against increased female autonomy (Goicolea et al., 2102). It has been hypothesized that as women become more independent and gender equality occurs, machismo males are more likely to engage in IPV in their efforts to try to maintain their control over their female partners (Goicolea et al., 2102). It also has been reported that women who hold more traditional views and attitudes regarding the right of males to carry out IPV also are more likely to experience it in their own relationships, possibly because of partner self-selection in that they tend to select machismo males as partners (Abramsky et al., 2011). Furthermore, Chibber and Krishnan (2011) have reported that women from low- and middle-income countries who experience IPV rarely seek out help from legal authorities because of fear retaliation. Thus, IPV perpetrator reports and arrests are rarely carried out (Chibber and Krishnan, 2011).

Alcohol and Other Drug Use

Drug and alcohol use has an adverse impact on cognitive ability and judgment hence drug use may increase the risk for perpetrating or experiencing IPV (El-Bassel et al., 2005). The potential for IPV to occur is increased in Latin American populations where excessive alcohol consumption is customary. For example, Abramsky and colleagues (2011) have reported that IPV was more likely to occur when one or both partners engaged in drinking compared to when

neither had consumed alcohol. Specifically, it reduced inhibitions and self-control and left individuals less likely to be able to negotiate a nonviolent resolution to conflicts in their relationships (WHO, 2013). The use of tranquilizers, marijuana, cocaine, crack, and heroin has also been found to be associated with increased IPV risk among women (El-Bassel et al., 2005). Women who reported using either crack cocaine or marijuana were more likely to report IPV than those who used no drugs or heroin (El-Bassel et al., 2005). In addition, conflicts over spending money or sharing drugs lead to arguments between partners that escalated to IPV (El-Bassel et al., 2005). Many drug-dependent women in partnerships are often perceived as sexually promiscuous by their male partners which appears to promote the chances of perpetration of violence by the same (El-Bassel et al., 2005).

Health-Related Consequences of IPV

Various studies have linked IPV among women with negative physical, psychological, and sexual health consequences (Dillon et al., 2013; Fortin et al., 2009; Naved & Akhtar, 2008). Health consequences are further worsened for women when self-reporting of IPV to authorities and health care centers is low, thus not allowing for the needed help-seeking for treatment of injuries and other negative health outcomes (Ellsberg et al., 2008).

Physical Health Symptoms

Pain caused by physical injuries and somatization is common among women with IPV (Loxton, Schofield, Hussain, & Mishra, 2006). Women with a positive history for IPV were reported as more likely to identify chronic pain as a significant problem for them including chronic back ache, neck pain, headache, and pain from stomach cramping (Vives-Cases, Ruiz-Cantero, Escribà-Agüir, & Miralles, 2011). Findings from another study indicate that women who experienced IPV were more likely to report pain in multiple body locations; 43.2% reported

swollen and painful joints (Wuest et al., 2008). In a study on medication use among women with a positive IPV history, common complaints of chronic pain included back pain, headaches, and swollen joints (Wuest et al., 2007). Women with a positive IPV history who were affected by chronic pain were less likely to be taking over-the-counter anti-inflammatory drugs and analgesics than women without any IPV history despite having more pain (Wuest et al., 2007).

A Norwegian study found that the physical health of women who experienced injuries from IPV with pain continued to be affected even after abuse had stopped 12 months or more months earlier (Alsaker, Moen, & Kristoffersen, 2008). Most studies have noted that women with any type of history of IPV had overall lower levels of physical functioning compared to those with a negative IPV history (Dillon, Hussain, Loxton, & Rahman, 2013). In contrast to the aforementioned studies, the findings from two others suggests that even though physical functioning may be reduced among women with IPV, the prevalence of physical symptoms or the degree of symptom severity does not differ from those of women who have no history of IPV (Chen et al., 2009; Helfrich et al., 2008).

Adverse Physical Health Outcomes

In addition to physical injuries, a positive IPV history has been frequently reported as associated with an increased risk for various chronic illnesses such as cardiovascular and circulatory problems (e.g., heart attack, heart disease, hypertension, thrombosis, stroke, diabetes), respiratory problems (e.g., asthma, allergies, emphysema, bronchitis), musculoskeletal conditions (e.g., osteoporosis, arthritis, and other joint problems) and gastrointestinal conditions, auditory and visual problems, and fatigue (Dillon et al., 2013; Loxton et al., 2006). Undernutrition (e.g., low BMI) and iron-deficiency anemia are also reported to be more common among women with a positive IPV history (Ackerson & Subramanian, 2008). Moreover, poor

sleep quality and sleep disorders also are reported to be more common among women who have experienced IPV compared to others (Dillon et al., 2013).

Adverse Mental Health Outcomes

In addition to its reported physical effects, IPV has been reported to adversely affect women's mental health. For example, the results of a study conducted by Fortin and colleagues (2012) indicated that women who had experienced IPV had significantly reduced overall mental health and social functioning scores on the SF-36 Health-Related Quality of Life Scale compared to those without such a history. Likewise, women with a positive history of mental or physical IPV were more likely to report greater psychological and emotional distress than women who had never experienced IPV (Fortin et al., 2009; Dillon et al., 2013). Chronic exposure to IPV is also reported to be a risk factor for depression, anxiety, post-traumatic stress disorder (PTSD), and suicide among women (Chibber & Krishnan, 2011). In a study conducted by Vos et al., (2006), as much as one-third (34.7%) of the total IPV-related burden of disease was attributable to depression and its health consequence while 27.3% was attributable to anxiety.

The type and severity of IPV experienced also appears to influence the risk for depression in women. For example, findings from a study by Chen and colleagues (2009) indicated that depression was more common among U.S. Hispanic women who had experienced any form of IPV than those with a negative IPV history. However, the risk for developing depression was especially significantly higher among women who had experienced IPV-related sexual abuse (83.3% vs. 66.7%) but also significantly higher for those with a history of physical (80% vs. 50%) and psychological abuse (64.5% vs. 45.2%). The results of other studies have confirmed that depression is positively associated with IPV severity and chronicity (Bonomi et al., 2006; Chen et al., 2009).

In contrast, other authors have reported that post-IPV stress is more closely associated with depression symptoms than IPV severity or frequency (Martinez-Torteya, Bogat, von Eye, Levendosky, & Davidson 2009). Similar to depression, Ludermir and colleagues (2008) have reported finding that as IPV severity and chronicity increase so does the severity of anxiety among women. Yet, other reports have suggested that among women with a positive IPV history, anxiety often occurs as a comorbid condition along with depression (Dillon et al., 2013). In addition, Pico Alfonso and colleagues (2006) reported that as the severity of anxiety increased among women with IPV, they also showed evidence of increased depressive symptoms.

A number of study results also have confirmed that women with a positive IPV history are at a higher risk for post-traumatic stress disorder (PTSD) symptoms and clinically diagnosed PTSD. A study conducted by O'Campo and co-authors (2006) estimated that women with a history of IPV were more than twice as likely to develop PTSD (30.9%) compared to women without such a history (13.7%). Similarly, another study published by Fedovskiy and colleagues (2008) confirmed that women with a history of IPV were approximately three times as likely to meet conditions for a PTSD diagnosis compared to women with no IPV history. Similar to the relationship between IPV and clinical depression, PTSD symptoms were reported to be greater in women who experienced more severe and chronic abuse and in cases of more than one type of physical, sexual, or psychological and emotional IPV (Houry, Kemball, Rhodes, & Kaslow, 2006).

Intimate-partner violence has been closely linked to an increased risk for suicidal thoughts and suicide attempts in women. For instance, it has been reported that suicidal ideation is often used as a coping mechanism by IPV-affected women to help them deal with painful emotions or as a way out of painful situations when they are no longer able to endure the abuse

(Wong, Wang, Meng, & Phillips, 2011). Women who reported partner violence at least once in their life reported significantly more emotional distress, suicidal thoughts (47%), than non-abused women (20%) (Ellsberg, Jansen, Heise, Watts, & Garcia-Moreno, 2008). In a study of IPV among immigrant women in the U.S., abused women were seven times more likely to report suicidal thoughts than non-abused women (Himelfarb Hurwitz, Gupta, Liu, Silverman, & Raj, 2006). A study by Naved and Akhtar (2008) reported that emotional and severe physical violence were major predictors of suicidal thoughts among women who experienced IPV. The findings also suggested that as the amount of types of violence (physical, sexual, and emotional) were experienced in women, the severity of abuse increased suicidal ideation (Naved & Akhtar, 2008). In another study, recent (past 12 months) physical or sexual abuse were found to be more important risk factors for suicidal thoughts among Paraguayan women than emotional abuse (Ishida, Stupp, Melian, Serbanescu, & Goodwin, 2010).

Reproductive and Sexual Health

A positive history of IPV has been consistently associated with poor sexual health and gynecological symptoms among women from diverse low-, middle-, and high-income countries (Ellsberg et al., 2008). The most common type of gynecological symptoms associated with a history for sexual IPV are bleeding after sexual intercourse, abnormal vaginal discharge, burning during urination and pain during and after intercourse (Stephenson, Koenig, & Ahmed, 2006). Moreover, IPV-affected women are reported to have poor reproductive health outcomes resulting in more frequent, use of health care services (Chibber & Krishnan, 2011).

Intimate partner violence has also been linked to reproductive health problems in women including a reduced use of modern contraceptive methods, an increased risk of sexually transmitted infections (e.g., HIV/AIDS, HPV) and cervical cancer, unplanned pregnancies and

miscarriages, and other problems (Vos et al., 2006; Chibber & Krishnan, 2011). For example, in the study conducted by Chibber and colleagues (2011), IPV-affected women were less likely to report using modern contraceptive methods and were at a higher risk for unplanned pregnancies, multiple induced abortions, and a reported loss of sexual independence compared to women who did not experience IPV. The risk for acquiring human papillomavirus (HPV) infection and cervical cancer is reported to be increased among women who experience HPV for reasons of risky sexual behaviors such as partner non-monogamy and contraceptive/protection choice (e.g., condom use), among others (Franco, Rohan, & Villa, 1999).

A study that investigated total effect of partner age differences with condom use among couples, the authors found an inverse correlation with greater partner age difference, resulting in inconsistent condom use ($p < 0.01$); age vs. condom use (Volpe et al., 2013). One explanation for this finding is that low relationship equity may be present in such relationships (Ryan et al., 2008). Alternatively, emotional manipulation by older male partners may explain inconsistent or low condom use (Teitelman et al., 2011). It also has been suggested that adolescent females dating older male partners perceive their relationship as more committed, exclusive, or serious, thus resulting in less frequent condom use (Brady, Tschann, Ellen, & Flores, 2009).

A strong positive association has been shown between the frequency of physical and sexual IPV and the risk for contracting HIV and other STIs in women. This may occur because women who have an abusive partner have less free choice in their decision-making about the timing of sexual relations and in their ability to negotiate condom use (Josephs & Abel, 2009). In a two-year study that investigated new HIV cases among South African women, the risk for contracting HIV (40.6%) was significantly increased among those with a history of physical or sexual IPV compared to other women (19.9%) ($p < 0.001$) (Jewkes, Dunkle, Nduna, & Shai,

2010). Other findings from a study conducted in Uganda, revealed that women exposed to IPV in the past year tested positive for HIV (22.2%), compared to women who did not experience IPV (13.5%) (Kouyoumdjian et al., 2013). A Rwandan study found that women who experienced any type of IPV were 1.61-3.46 times as likely to test positive for HIV and 2.14-4.11 times more likely to report an STI compared to non-abused women (Dude, 2011). Finally, Tubman and co-authors (2004) also confirmed a positive association between the number of sexual, physical, or verbal abuse episodes and the risk for contracting a STI ($F_{3,728} = 5.63, p < 0.001$).

Help-Seeking for IPV

Help-seeking specifically for IPV-related problems by women is reported to be low. For example, Thompson and colleagues (2006) reported that although the lifetime prevalence of help-seeking for medical services among IPV victims is high (44%), only 15% of women reported doing so for gynecological problems associated with IPV. In another study which assessed health-care seeking by 120 women victims of IPV, 24% required acute medical care services, only 2% women sought social or legal help by reporting to police, while 50% complained to their parents and 48% remained silent after sustaining violence (Bibi, Ashfaq, Shaikh, & Qureshi, 2014). The reasons for low help-seeking among women who experience IPV are complex. Reported barriers include fear of abuser, concerns for children, social isolation and lack of knowledge of legal systems (Yoshihama, Bybee, Dabby, & Blazeovski, 2011).

Overview of Intimate Partner Violence in Ecuador

The Republic of Ecuador is a low middle-income country in South America where 40% of the population of 14.3 million inhabitants is reported to live in poverty and 5% in extreme poverty (UNDP, 2010). The country has a diverse ethnic profile. The majority of inhabitants are Mestizos, (e.g., persons of mixed Indigenous and Spanish ancestry) but Afro-Ecuadorians (3-10%) and Quechua-speaking and other ethnic groups account (7-25%) account for a sizeable proportion of the population (Weigel & Caiza, 2013). These two major ethnic minority groups are much more likely to be more poorly educated, have low-paying jobs, be unemployed or underemployed, and live in poverty compared to their Mestizo counterparts (Ponce, 2006). Racism and racial discrimination are common (De la Torre, 2001; Rahier, 1998). Both Afro-Ecuadorian (Anselmi et al., 2003; Weigel, 2000) and Indigenous groups (Romero-Sandoval, 2007) suffer from a high burden of communicable and non-communicable health conditions.

The prevalence of IPV among women is reported to be high in the Latin American and Caribbean (LAC) region of the Americas (Bott et al., 2012). However, only limited data are available regarding the prevalence, context, and other aspects of IPV in the Ecuadorian population. Statistics reported by non-governmental organizations suggest that 70% of Ecuadorian women are subjected to at least one form of IPV at the hands of a male partner during their lifetimes (Roldos and Corso, 2013). Population-based survey data also indicates that four of every 10 Ecuadorian women experience emotional violence, three in ten experience some type of physical violence and one in ten are subjected to sexual violence (Roldos and Corso, 2013). In addition, the economic costs associated with IPV for a one-year period (2003-2004) were estimated as high as 109 million U.S. dollars (Roldos & Corso, 2013). Of this, healthcare services associated with IPV-related injuries constituted the largest single cost (Roldos & Corso,

2013). However, little else is available in the published literature. As previously noted, the two major ethnic minority groups in Ecuador are documented to suffer from a high and disproportionate burden of disease compared to Mestizos. However, it is unclear whether ethnic minority women are more likely to experience IPV than their Mestizo counterparts and if so, which risk and protective factors, if any, may differentiate these groups. Moreover, there is a lack of information documenting the short- and longer physical, mental, and reproductive health consequences of IPV in Ecuadorian women. This information is important for informing policy and planning program planning by Ecuadorian public health, social service, and legal authorities and organizations. Despite the reported high prevalence of IPV among women and a constitutional right to freedom from IPV and other forms of violence, only 3% of annual Ecuadorian governmental funding is presently directed to social welfare programs or interventions focused on the prevention of IPV or gender-based violence or discrimination (Roldos and Corsos, 2013).

Chapter 2: Study Objectives and Hypothesis

The overall goal of the study was to report IPV prevalence and health-related correlates among ethnic minority and majority women who participated in a large nationally representative reproductive health survey (ENDEMAIN 2004) of non-institutionalized Ecuadorian women of reproductive age (15-49 years). The specific aims of the study were to:

1. describe the sample's sociodemographic characteristics including ethnicity, education, age group, marital status, income quintile, residence locales, and any health insurance.
2. report rates for self-reported IPV measures including:
 - early life (<15yrs.) observed exposure to IPV
 - history of early life (<15yrs.) of mistreatment
 - lifetime experience
 - recent (past 12 months) experience
 - IPV-related injuries (past 12 months)
 - help seeking (past 12 months)
 - reasons for no help-seeking (past 12 months)
3. determine ethnic differences for all IPV measures.

The hypotheses of this study are the following:

1. Self-reported rates of IPV will differ by ethnicity.
2. Self-reported rates of IPV will be higher for minority Ecuadorian women (Indigenous and Afro-Ecuadorian) compared to the majority (Mestizo/White).

3. Self-reported rates of IPV-related injuries and help-seeking for IPV-related injuries will be lower for minority Ecuadorian women (Indigenous and Afro-Ecuadorian) compared to the majority (Mestizo/White).

Chapter 3: Methods

Source of Study Data

This study was a secondary data analysis from the Demographic, Maternal and Child Health Survey [*Encuesta Demográfica y de Salud Materna e Infantil*] (ENDEMAIN, 2004). Data collection for the ENDEMAIN 2004 was conducted by the Center for Population Studies and Social Development [*El Centro de Estudios de Población y Desarrollo Social*] (CEPAR) with assistance from the U.S. Centers for Disease Control and Prevention.

Study Design and Sample

The ENDEMAIN 2004 study used a probabilistic, multistage design to collect data from a nationally representative sample of 29,064 households, which contained a minimum of one female of reproductive age (15-49 years) in 15 provinces and two regions of Ecuador. In the *Mujer de Edad Fértil* (MEF) subsample, a total of 10,814 women (aged 15 to 49 years) responded to interview questions concerning the section of violence against women.

Data Collection

The ENDEMAIN 2004 utilized the 2001 Ecuadorian National Census as the sampling frame for selecting households within census sectors. The selection was independent for 17 levels of insular and Amazon regions, including 10 provinces in the Sierra and 5 of the Coast. At the national level, the sample consisted of 692 segments: 372 in urban areas and 320 in rural areas. Information was collected in 42 households in each segment: 24 households to implement the MEF questionnaire and 18 to fill the home questionnaire. For the province of Pichincha, 101 segments including: 72 urban and 29 rural areas were selected. All results are representative at the provincial level and for the city of Quito. The selected segments were from the following locations: *Quito* - Pichincha, Esmeraldas, Carchi, Sucumbios, Napo, Orellana, Imbabura,

Bolivar, Chimborazo, Cotopaxi, Tungurahua and Pastaza (345 segments), *Cuenca* - Azuay, Canar, Loja, Morona Santiago and Zamora Chinchipe (114 segments), *Guayaquil* - Guayas, Manabi, Los Ríos and El Oro (215 segments) and *Puerto Ayora* - Galapagos (18 segments). Data collection took place from July 5, 2004 to October 8, 2004. The survey had a 78% response rate. For logistical reasons, the ENDEMAIN 2004 survey administered separate questionnaires to two different randomly selected sub-samples (CEPAR 2005a; CEPAR 2005b).

Measures

The MEF questionnaire included questions on anthropometry, demographics, reproductive history, child health services associated with maternal health, family planning, reproductive preferences, young adult, marriage, violence against women, sexually transmitted infections STIs, HIV, AIDS, maternal mortality, school attendance, household characteristics, expenses and consumption. Our data analysis contained data from the MEF subsample questionnaire of sociodemographic, IPV, and health data from one reproductive-aged female respondent (15-49 years) living in each household.

Sociodemographic Characteristics

For this analysis, sociodemographic characteristics used from the MEF subsample questionnaire consisted of ethnicity (Mestizo/White, Indigenous, Afro-Ecuadorian), education (none, primary, secondary, tertiary ages, postgraduate, literacy center), age group (15-24 years, 25-34 years, 35-49 years), marital status (common law marriage, legally married, widowed, divorced/separated, single), income quintile (1-5), residence locales (urban, rural), and having any health insurance (public, private, combination of public & private, none, don't know).

Intimate Partner Violence Measures

The MEF subsample concerning the violence against women section questionnaire consisted of three main aspects of violence. Under this section, first aspect was called *history of family violence*, which focused on women experiences, up to 14 years of age. IPV measures used from the two main themes was “Early life (<15 yrs.) Observed Exposure to IPV”, which consisted of women observing their parents engaging in any psychological, physical, or both physical/psychological violence before the age of 15 and “History of Early Life (<15yrs.) Mistreatment” which consisted of any psychological, physical, or both physical/psychological violence directed towards them before the age of 15 during IPV among parents.

The second aspect was called *forced sex (rape) and sexual abuse* and focused on three different themes violence. Only the third theme of violence was used, which focused only on women ever married or cohabiting, and was defined as a violation committed by a spouse, partner, ex-husbands or ex-partners. This type of IPV may have occurred between married couples in a current or past relationship (ex- husbands or ex-partners) and boyfriends or lovers of single women. IPV measures used from the third theme named “Lifetime Exposure to IPV” and “Recent IPV Experience” consisted of psychological, physical, and sexual violence in the past 12 months.

The third aspect was called *violence against couples* and was defined as intimate partner violence (IPV). All three main themes focused only on women who experienced recent IPV or IPV in the past 12 months. The main themes consisted of “IPV-related Injuries (past 12 months)”, “Help-Seeking for IPV (past 12 months)”, and “Primary Reason for No Help-Seeking for IPV (past 12 months)”. The measures for “IPV-related Injuries (past 12 months)” consisted of women’s injuries due to recent IPV. The types of IPV-related injuries reported by the study

respondents ranged from psychological/emotional injuries to permanent physical injuries and included any of the following choices: bruises, body-aches/headaches, injuries in parts of body, disabled/paralyzed, anxiety/fear, and/or fear of re-attack.

The measures for “Help-Seeking for IPV (past 12 months)” consisted of whether women sought help after recent IPV with any of the following choices: her family, his (perpetrator) family, police station, federal women’s commission, women’s organization, church, health establishment and/or other. Lastly the measures for “Primary Reason for No Help-Seeking for IPV (past 12 months)” consisted of women’s most important reason as to why they did not seek help for recent IPV, with her answer choice being one of the following: afraid of retaliation, felt embarrassed, didn’t know where to go for help, thought could solve problem alone, thought authorities wouldn’t help, thought that he wouldn’t do it again/would change, thought she didn’t need help, didn’t want to cause problems/hurt family or other (unspecified reason).

Data Analysis

Database Management

IBM-SPSS-version 22 was used to manage and analyze the study data. The variables that were used in the data analyses, came from the MEF subsample interview questions that are shown in Appendix section and described in the measures section. The ethnic groups used in the analysis were Mestizo/White, Indigenous and Afro-Ecuadorian-Ecuadorian, therefore excluding women who responded as “other” ethnicity in the MEF subsample, due to their small sample size and unknown/uncertainty response to ethnicity (n=10,730).

Statistical Analysis

The descriptive data analyses of all measures consisted frequency and percent for categorical variables in the univariate analysis. The bivariate analyses were used to explore the study questions of interest using cross-tabulation with Pearson's Chi-Square (X^2) or Likelihood

Ratio if low cell count was present, for categorical variables. Statistically significant ($p < 0.05$) and marginally significant ($p < 0.10$) bivariate associations are noted. The respondent and household characteristics identified in the initial analyses as associated with IPV were further investigated using multinomial logistic regression for each IPV measure. The data from the multinomial logistic regression are presented as adjusted prevalence ratio estimates with 95% confidence intervals in the tables. The prevalence ratio estimates for the referent category (Mestizo/White) for the multivariate analysis adjusted for the respondent age, education, outside employment, marital status, income quintile and residence location was adjusted in prevalence ratio estimates. Statistically significant ($p < 0.05$) and marginally significant ($p < 0.10$) multivariate associations are noted.

Chapter 4: Results

Descriptive Statistics

Sociodemographic Characteristics

Results for descriptive statistics of sociodemographic characteristics and measures for IPV are presented in Table 1. All female respondents included in the dataset are of reproductive age 15 to 49 who were Mestizo/White (86.7%), Indigenous (9.7%), or Afro-Ecuadorian (3.6%). Approximately 83.5% of the respondents reported an educational attainment level of secondary school or less. Over two-fifths of respondents were legally married. Approximately half of women respondents equally reported dwelling areas resided in urban (54.3%) or rural (45.7%) Ecuador. The majority (88.8%) reported having no health insurance.

Intimate Partner Violence Measures

Women who observed IPV (psychological, physical, and both types) among their parents before age 15 (35%, 32.2%, 37.2%), and had a history of early life mistreatment (22.1%, 25.1%, 27.7%). Women also reported psychological, physical, and sexual IPV in their lifetime (30.8%, 21.7%, 7.8%) and in the past 12 months (11.8%, 7.5%, 2.7%). IPV-related injuries experienced in the past 12 months included bruises (3.5%), body-aches/headaches (4.3%), injuries in parts of body (1.2%), disabled/paralyzed (0.1%), anxiety/fear (3.8%), fear of re-attack (4.8%). Help seeking for IPV in the past 12 months consisted of her family (2.4%), the perpetrator's family (0.5%), police station (0.2%), federal women's commission (0.3%), women's organization (0.0%), church (0.1%), health establishment (0.0%), other (0.4%). A total of 477 (4.4%) women reported that they did not seek out help for IPV. Respondent reasons were as follows: afraid of retaliation (22.4%), felt embarrassed (23.9%), didn't know where to go for help (10.9%), the respondent thought that she could solve problems alone (26%), thought that the authorities would not do anything to help (1.7%), thought that the perpetrator would not do it again/would change

(2.5%), thought that she didn't need help (7.5%), didn't want to cause problems or hurt the family (2.3%), and other unspecified reason (2.7%).

Bivariate Analysis for Ethnic Differences

For all IPV measures, we are reporting those that significantly differed by ethnicity. A significant difference indicates that at least one ethnic group differs in the rate for that specific IPV measure. There are significant bivariate association between ethnicity and in early life exposure to physical ($p=0.004$) IPV (Table 2) and also psychological ($p=0.005$), physical ($p<0.001$), and both physical/psychological ($p<0.001$) in history of early life mistreatment (Table 3).

For psychological and physical IPV, ethnic differences in lifetime ($p=0.009$; $p<0.001$ respectively) (Table 4) and recent ($p=0.031$; $p<0.001$ respectively) (Table 5) experience. As shown in Table 6, there are significant ethnic differences for any injury from IPV ($p<0.001$), as well as in specific physical injuries including bruises ($p=0.001$), body-aches/headaches ($p<0.001$), injuries in other parts of the body ($p=0.016$) and psychological/emotional injuries including; anxiety/stress ($p=0.024$) and constant fear of being re-attacked ($p<0.001$). As shown in Table 7, there were significant bivariate association in ethnicity and any help seeking for IPV among women who looked for help ($p<0.001$); from either family ($p<0.001$) and/or any organization ($p=0.027$).

Multivariate Analysis for Adjusted Ethnic Differences

The multivariate analysis to assess ethnic differences in IPV measures was adjusted for respondent age, education, outside employment, marital status, income quintile, and residence location. The reference category was the Mestizo/White women. As shown in Table 2, Mestizo/White had significantly less physical early life exposure to IPV compared to Indigenous (Adj PR = 0.84; 95% CI: 0.72-0.98) while, Mestizo/White also had marginal significantly less

psychological early life exposure to IPV compared to Indigenous (Adj PR= 0.87; 95% CI: 0.74-1.02) women. Mestizo/White majority had significantly less psychological (Adj PR= 0.77; 95% CI: 0.65-0.92), physical (Adj PR= 0.72 95% CI: 0.61-0.85), and both physical/psychological (Adj PR= 0.76 95% CI: 0.65-0.90), and history of early life mistreatment compared to Indigenous women (Table 3).

Mestizo/White women had significantly less physical lifetime exposure to IPV compared to Indigenous (Adj PR= 0.82; 95% CI: 0.67-0.99) and Afro-Ecuadorian (Adj PR= 0.65; 95% CI: 0.51-0.83) women (Table 4). Mestizo/White women had marginal significantly less psychological lifetime exposure to IPV compared to Afro-Ecuadorian (Adj PR= 0.82; 95% CI: 0.65-1.02) women. Mestizo/white also had significantly less physical recent IPV experience compared to Afro-Ecuadorian (Adj PR= 0.60; 95% CI: 0.43-0.83) and marginally less compared to Indigenous (Adj PR= 0.77; 95% CI: 0.59-1.01) women (Table 5).

As shown in Table 6, Mestizo/White women experienced significantly less injuries from any IPV in the last past 12 months (Adj PR= 0.63; 95% CI: 0.45-0.90); injuries included body aches/headaches (Adj PR= 0.65; 95% CI: 0.43-0.98), injuries to other parts of the body (Adj PR= 0.49; 95% CI: 0.26-0.94) and constant fear of being re-attacked (Adj PR= 0.59; 95% CI: 0.40-0.87) and marginal significantly less anxiety/stress compared to Afro-Ecuadorian (Adj PR= 0.65; 95% CI: 0.42-1.00). Also, Mestizo/White women experienced significantly less bruises (Adj PR= 0.66; 95% CI: 0.46-0.95) and marginal significantly less body aches/headaches compared to Indigenous (Adj PR= 0.73; 95% CI: 0.52-1.03) (Table 6). Mestizo/White women reported significantly less help-seeking measures for IPV in the past 12 months compared to Afro-Ecuadorian women (Adj PR= 0.51; 95% CI: 0.34-0.77), including respondents who looked of

help from either family (Adj PR= 0.54; 95% CI: 0.35-0.84), and any organization (Adj PR= 0.40; 95% CI: 0.17-0.97) (Table 7).

Chapter 5: Discussion

In this study, we hypothesized self-reported rates of IPV will differ by ethnicity and self-reported rates of IPV will be higher for minority Ecuadorian women (Indigenous and Afro-Ecuadorian) compared to the majority (Mestizo/White). Lastly, self-reported rates of IPV-related injuries and help-seeking for IPV-related injuries will be lower for minority Ecuadorian women (Indigenous and Afro-Ecuadorian) compared to the majority (Mestizo/White).

One of the patterns found in our study were higher rates of psychological and physical early life exposure and mistreatment among the Indigenous minority women compared to the majority Mestizo/White women (Tables 2 & 3). Therefore we can conclude early life mistreatment and abuse of IPV among minority women results in higher rates of IPV in adulthood. A study that confirms this association examined childhood experiences with IPV perpetration among men surveyed for the UN Multi-Country Study on Men and Violence in Asia and the Pacific (n=1252) found that witnessing abuse of one's mother was associated with the greatest increase in the odds of perpetrating physical IPV (AOR: 1.82; 95% CI: 1.29-2.58) (Fonseka, Minnis, & Gomez, 2015). They also found that male childhood mistreatment/abuse was strongly associated with perpetration of any IPV in adulthood (AOR: 2.36; 95% CI: 1.69-3.30) (Fonseka, Minnis, & Gomez, 2015). Thus both studies correlate early life exposure and mistreatment to IPV among male and female children, whether as a perpetrator or victim of IPV in adulthood, resulting in higher rates of IPV in the future for minority women.

Another pattern found in our study was that there were higher rates of physical lifetime and recent IPV, among the Indigenous and Afro-Ecuadorian minority women compared to the majority Mestizo/White women (Tables 4 & 5).

A similar study by Gomez & Speizer, (2009), also using the ENDEMAIN 2004, examined the effect of childhood physical and/or psychological abuse with recent and lifetime (psychological, physical and sexual) IPV among two Ecuadorian groups (Indigenous and non-Indigenous) of women (n= 8,961). The adjusted multivariate analysis revealed that both psychological/physical abuse in childhood were significantly associated with recent and lifetime psychological (AOR:1.8; 95% CI:1.5–2.2; p<0.001); (AOR:1.9; 95% CI:1.6–2.2; p<0.001), physical (AOR:1.6; 95% CI:1.3–2.0; p<0.001); (AOR:1.7; 95% CI:1.5–2.0; p<0.001) and sexual (AOR:1.8; 95% CI:1.3–2.6; p<0.001); (AOR:2.2; 95% CI:1.7–2.7; p<0.001) IPV (Gomez & Speizer, 2009). The Gomez & Speizer study was mostly similar to our study in that they used data from the ENDEMAIN 2004 along with similar Ecuadorian groups of women, types of early life abuse and types of IPV. The results of the Gomez & Speizer study show that early life abuse and exposure is an important risk factor because it is associated with an increased risk of recent and lifetime IPV among minority women.

Although both Indigenous and Afro-Ecuadorian minority women are experiencing more lifetime and recent physical IPV compared to the majority Mestizo/White women (Table 4 & 5), Indigenous women are not seeking help as often as Afro-Ecuadorian women, due to less severe injuries (bruises and headaches). Afro-Ecuadorian women are more likely experiencing more violent injuries from IPV, thus help-seeking more often, than the majority Mestizo/White women and their Indigenous minority counterpart (Table 6 & 7).

In a study by Roldos, (2010) which analyzed data from the ENDEMAIN 2004 among Ecuadorian Mestizo and Indigenous groups of women between 15 and 49 years of age, revealed that similar low rates were found in the reported prevalence of recent help seeking for IPV; (5%) for our study vs. (2%) in the Roldos, (2010) study among Ecuadorian women. Thus, in

comparing this study and Roldos study, similar results of low self-reported help-seeking for IPV were found. Also, similar to the results of our multivariate data, help seeking was most frequently found among family and the organization of women and family commissaries ($p>0.005$) (Roldos, 2010).

The Fanslow & Robinson, (2011) study reported injuries from IPV and women's use of healthcare for treatment of IPV injuries using the New Zealand Violence Against Women Study ($n=956$), (age 18–64) were interviewed about their experience of IPV, injuries resulting from violence, and their use of healthcare services. Similar to this study, a low percentage of women (6.6%), reported IPV-related injuries, with both psychological and physical types of injuries being the most common (Fanslow & Robinson, 2011). The most common injuries were very similar to Indigenous minority women IPV-related injuries in this study, Fanslow & Robinson study showed injuries consisted of less severe injuries such as minor abrasions and bruises. Also similar to help-seeking behaviors among minority Indigenous women in this study, results in shown in Fanslow & Robinson, 2011 study revealed women injured who received treatment told a healthcare provider the reason they did not disclose were due to barriers such as embarrassment and fear of further violence (Fanslow & Robinson, 2011).

Strengths

One of the major strengths of the analyses is the large sample size (n=10,814) and the fact that the data came from a nationally representative sample of reproductive-aged Ecuadorian women. The large data set allowed for ethnic diversity and a large enough number of women in each ethnic group (Mestizo/White, Afro-Ecuadorian, and Indigenous) for comparison. Also, since minority ethnic group (Indigenous and Afro-Ecuadorian) women are not integrated into main stream society as are Mestizo and White women, focusing on the vulnerable risk group (minority) instead of the general population allowed us to concentrate more on the affected group by IPV.

Another strength was that in the design and methods of the study there was assistance of international U.S. institutions such as USAID, UNC and CDC. Thus, established institutions with experience in large population studies allowed for representative sample. Highly qualified interviewers, staff, and supervisors were effectively trained through staff workshops in relation to study design, data collection methods, data entry and management. Also data entry was performed concurrent with data collection in order to identify any inconsistencies and, if necessary, material was returned to the field for corrections, increasing data accuracy in the study.

Limitations

Limitations of the study were the possible underestimation of IPV prevalence in the general Ecuadorian population because this study focused only on the households of reproductive aged women (15-49 yrs.). It did not include older or younger women in the study. Also, since the study is not among general population, women were the only respondents to answer interview questions from the MEF subsample of violence against women questionnaire,

thus, men who also may have been exposed to IPV were excluded from the study. Lastly, this was a household study, therefore it did not include homeless women of reproductive age that may have been exposed to IPV outside of a home. Another possible limitation to the underestimation of IPV was the under-reporting of IPV by the women respondents because of fear of male retaliation (over hearing interview), men not allowing women to participate in the study and/or embarrassment of sharing sensitive information with interviewer. Furthermore, the information collected is limited to MEF pre-determined questions that are vague and answer choices are limited to certain types of responses in which respondents can choose from, thus does not necessarily capture the all nuances of a violent situation for respondents. For these reasons, the data in the ENDEMAIN 2004 can be considered as a minimum estimate of the magnitude & complexity of the current problem in Ecuador.

Chapter 6: Conclusion

The data from the study suggests that there is need for supporting healthcare systems and law enforcement to identify IPV victims to reduce underreporting of IPV, increase pressing charges, increase the treatment of IPV-related injuries, and decrease barriers to help-seeking. Possible solutions would be increasing communication with healthcare providers and law enforcement to eliminate barriers of help-seeking victims and response to social services. Also integrating educational preventive programs for youth through workshops on character building, moral and ethical principles, play therapy life skills and recreational activities to build healthy adults and break the cycle of further violence. Future research studies can assess the influence of culture in IPV among men and women. Also, future studies can look at how protective factors such as higher income and education levels play a role in reducing rates of IPV.

Master in Public Health Core Competencies

The main focus of this study was on the social and behavioral sciences core competency, which addressed the behavioral, social and cultural factors such as sociodemographic, help-seeking, injuries, and other related to IPV measures among women as a major public health disparity issue worldwide. The biostatistics competency in the study related to the analysis of data used from the ENDEMAIN 2004. The reporting of sociodemographic characteristics, IPV rates for IPV measures chosen, and lastly to determine ethnic differences when comparing all IPV measures among women was used. The Hispanic and border health concentration competency applies to this study in that the sample population was Hispanic women. High rates of IPV found in this population of Hispanic women may indicate high rates of IPV among Hispanic women in regions with similar culture and sociodemographic factors such as low education and income, regardless of their country of origin.

References

- Abramsky, T., Watts, C.H., Garcia-Moreno, C., Devries, K., Kiss, L., Ellsberg, M., Jansen, H.A., & Heise, L. (2011). What factors are associated with recent intimate partner violence?: Findings from the WHO multi-country study on women's health and domestic violence. *BMC Public Health*, 1-17. doi: 10.1186/1471-2458-11-109
- Ackerson, L.K., & Subramanian, S.V. (2008). Domestic violence and chronic malnutrition among women and children in India. *American Journal of Epidemiology*, 167(10), 1188–1196.
- Alsaker, K., Moen, B.E., & Kristoffersen, K. (2008). Health-related quality of life among abused women one year after leaving a violent partner. *Social Indicators Research*, 86(3), 497-509.
- Anselmi, M., Avanzini, F., Moreira, J.M., Montalvo, G., Armani, D., Prandi, R., Marquez, M., Caicedo, C., Colombo, F., & Tognoni, G. (2003). Treatment and control of arterial hypertension in a rural community in ecuador. *Lancet*, 361(9364), 1186-1187.
- Bibi, S., Ashfaq, S., Shaikh, F., & Qureshi, P.M.A. (2014). Prevalence instigating factors and help seeking behavior of physical domestic violence among married women of HyderabadSindh. *Pak J Med Sci*, 30(1), 122-125. doi: 10.12669/pjms.301.4533
- Bonomi, A.E., Tompson, R.S., Anderson, M., Reid, R.J., Carrell, D., Dimer, J.A., Rivara, F.P. (2006). Intimate partner violence and women's physical, mental, and social functioning. *American Journal of Preventive Medicine*, 30(6), 458–466. doi:10.1016/j.amepre.2006.01.015
- Bonomi, A.E., Anderson, M.L., Cannon, E.A., Slesnick, N., Rodriguez, M.A. (2009). Intimate partner violence in Latina and non-Latina women. *American Journal of Preventative Medicine*. 36(1), 43-48. doi:10.1016/j.amepre.2008.09.027.
- Bott, S., Guedes, A., Goodwin, M., & Mendoza, J.A. (2012). Violence against women in Latin America and the Caribbean: A comparative analysis of population-based data from 12 countries. Washington, DC: Pan American Health Organization.
- Brady, S.S., Tschann, J.M., Ellen, J.M., Flores, E. (2009). Infidelity, trust, and condom use among Latino youth in dating relationships. *Sexually Transmitted Diseases*, 36(4), 227-231. doi:10.1097/OLQ.0b013e3181901cba.
- Breiding, M.J., Black, M.C., & Ryan, G.W. (2008). Chronic disease and health risk behaviors associated with intimate partner violence—18 U.S. states/territories. *Ann Epidemiology*, 18, 538–544.
- Caetano, R., Field, C.A., Ramisetty-Mikler, S., McGrath, C. (2005). The 5-year course of intimate partner violence among white, black, and hispanic couples in the united states. *Journal of Interpersonal Violence*, 20, 1039–1057. doi:10.1177/0886260505277783

Carbone-López, K., Kruttschnitt, C., & Macmillan, R. (2006). Patterns of intimate partner violence and their associations with physical health, psychological distress, and substance use. *Public Health Reports*, 121(4), 382–392.

Chen, P. H., Rovi, S., Vega, M., Jacobs, A., & Johnson, M. S. (2009). Relation of domestic violence to health status among hispanic women. *Journal of Health Care for the Poor and Underserved*, 20(2), 569–582. doi: 10.1353/hpu.0.0145.

Centro Ecuatoriano para la Promoción y Acción de la Mujer (CEPAM). (2009). El Camino transitado: Sistematización del proyecto “Fortalecimiento institucional y atención emergente de delito sexuales desde instancia de administración de justicia convencionales”. Quito, Ecuador: Centro Ecuatoriano para la Promocion y Accion de la Mujer

Chibber, K.S., & Krishnan, S. (2011). Confronting intimate partner violence: A global health care priority. *Mt Sinai Journal of Med.*,78(3), 449–457. doi:10.1002/msj.20259.

Collins, R.L., Ellickson, P.L., Orlando, M., & Klein, D. J. (2005). Isolating the nexus of substance use, violence and sexual risk for HIV infection among young adults in the United States. *AIDS & Behavior*, 9, 73-87.

Cummings, A.M., Gonzalez-Guarda, R.M., & Sandoval, M.F. (2013). Intimate partner violence among hispanics: A review of the literature. *Journal Family Violence*, 28(2), 153-171. doi:10.1007/s10896-012-9478-5.

De la Torre, C. (2001). Everyday forms of racism in contemporary ecuador: The experiences of middle-class Indians. *Ethnic and Racial Studies*, 22(1), 92-112. doi: 10.1080/014198799329602.

Devries, K. M., Mak, J. Y. T., García-Moreno, C., Petzold, M., Child, J. C., Falder, G., Lim, S., Bacchus, L. J., Engell, R. E., Rosenfeld, L., Pallitto, C., Vos, T., Abrahams, N. & Watts, C. H. (2013). Global health: The global prevalence of intimate partner violence against women. *Science*, 340(6140), 1527-1528. doi: 10.1126/science.1240937

DiClemente, R.J., Wingood, G.M., Crosby, R.A., Sionean, C., Cobb, B.K., Harrington, K., Davies, S.L., Hook, E.W. III, Oh, M.K. (2002). Sexual risk behaviors associated with having older sex partners: A study of black adolescent females. *Sexually Transmitted Diseases*, 29(1), 20–24.

Dillon, G., Hussain, R., Loxton, D., & Rahman, S. (2013). Mental and physical health and intimate partner violence against women: A review of the literature. *International Journal of Family Medicine*, 1-15. doi :10.1155/2013/313909.

Dude, A.M. (2011). Spousal intimate partner violence is associated with HIV and other STIs among married Rwandan women. *AIDS and Behavior*, 15(1), 142-152.

- Edwards, V.J., Black, M.C., Dhingra, S., McKnight-Eily, L., & Perry, G.S. (2009). Physical and sexual intimate partner violence and reported serious psychological distress in the 2007 BRFSS. *International Journal of Public Health*, 54(1), 37-42.
- El-Bassel, N., Gilbert, L., Wu, E., Go, H., Hill, J. (2005). Relationship between drug abuse and intimate partner violence: A longitudinal study among women receiving methadone. *American Journal of Public Health*, 95(4), 465-470. doi: 10.2105/AJPH.2003.023200
- Ellsberg, M., Jansen, H.A., Heise, L., Watts, C.H., & Garcia- Moreno, C. (2008). Intimate partner violence and women's physical and mental health in the WHO multi-country study on women's health and domestic violence: An observational study. *The Lancet*, 371(9619), 1165-1172.
- Fanslow, J. L., & Robinson, E. M. (2011). Physical injuries resulting from intimate partner violence and disclosure to healthcare providers: results from a new zealand population-based study. *Injury Prevention: Journal of The International Society For Child And Adolescent Injury Prevention*, 17(1), 37-42. doi:10.1136/ip.2009.026104
- Fedovskiy, K., Higgins, S., & Paranjape, A. (2008). Intimate partner violence: How does it impact major depressive disorder and post traumatic stress disorder among immigrant latin@s? *Journal of Immigrant and Minority Health*, 10(1), 45-51. doi: 10.1007/s10903-007-9049-7
- Fonseka, R.W., Minnis, A.M., Gomez, A.M. (2015). Impact of adverse childhood experiences on intimate partner violence perpetration among sri lankan men. *Plos one*, 10(8): e0136321. doi:10.1371/journal.pone.0136321.
- Fortin, I., Guay, S., Lavoie, V., Boisvert, J.-M., & Beaudry, M. (2012). Intimate partner violence and psychological distress among young couples: Analysis of the moderating effect of social support. *Journal of Family Violence*, 27(1), 63-73.
- Franco, E.L., Rohan, T.E., & Villa, L.L. (1999). Epidemiologic evidence and human papillomavirus infection as a necessary cause of cervical cancer. *Journal of the National Cancer Institute*, 91(6), 506-511.
- Garrison, R.J., Gold, R.S., Wilson, P.W.F., & Kannel, W.B. (1993). Educational attainment and coronary heart disease: The Framingham offspring study. *Prev. Med.*, 22, 54-64.
- Go, A.S., Mozaffarian, D., Roger, V.L., Benjamin, E.J., Berry, J.D., et al. (2013). Heart disease and stroke statistics-2013 update: A report from the american heart association. *Circulation*, 127(1) doi:10.1161/CIR.0b013e31828124ad.
- Goicolea, I., Öhman, A., Salazar Torres, M., Morrás, I., & Edin, K. (2012). Condemning violence without rejecting sexism?: Exploring how young men understand intimate partner violence in Ecuador. *Global Health Action*, doi:10.3402/gha.v5i0.18049

- Gómez, A., & Speizer, I. (2009). Intersections between childhood abuse and adult intimate partner violence among ecuadorian women. *Maternal & Child Health Journal*, 13(4), 559-566. doi:10.1007/s10995-008-0387-4.
- Helfrich, C. A., Fujiura, G. T., & Rutkowski-Kmitta, V. (2008), Mental health disorders and functioning of women in domestic violence shelters. *Journal of Interpersonal Violence*, 23(4), 437–453. doi: 10.1177/0886260507312942.
- Himelfarb Hurwitz, E.J., Gupta, J., Liu, R., Silverman, J.G. & Raj., A. (2006). Intimate partner violence associated with poor health outcomes in U.S. South Asian women. *Journal of Immigrant and Minority Health*, 8(3), 251–261.
- Houry, D., Kemball, R., Rhodes, K.V. & Kaslow, N.J. (2006). Intimate partner violence and mental health symptoms in African American female ED patients. *American Journal of Emergency Medicine*, 24(4), 444–450. doi: 10.1016/j.ajem.2005.12.026.
- Ishida, K., Stupp, P., Melian, M., Serbanescu, F. & Goodwin, M. (2010). Exploring the associations between intimate partner violence and women’s mental health: evidence from a population-based study in Paraguay. *Social Science and Medicine*, 71(9), 1653-1661.
- Jewkes, R.K., Dunkle, K., Nduna, M., & Shai, N. (2010). Intimate partner violence, relationship power inequity, and incidence of HIV infection in young women in South Africa: A cohort study. *The Lancet*, 376(9734), 41–48.
- Johnson, P.J., & Hellerstedt, W.L. (2002). Current or past physical or sexual abuse as a risk marker for sexually transmitted disease in pregnant women. *Perspectives on Sexual and Reproductive Health*, 34(2), 62-67.
- Josephs, L.L., & Abel, E.M. (2009). Investigating the relationship between intimate partner violence and HIV risk-propensity in black/African-American women. *Journal of Family Violence*, 24(4), 221- 229.
- Kouyoumdjian, F.G., Calzavara, L.M., Bondy, S.J., O’Campo, P., Serwadda, D. (2013) Intimate partner violence is associated with incident hiv infection in women in uganda. *Aids*, 27: 1331–1338.
- Loxton, D., Schofield, M., Hussain, R., & Mishra, G. (2006). History of domestic violence and physical health in midlife. *Violence Against Women*, 12(8), 715–731.
- Ludermir, A.B., Schraiber, L.B., D’Oliveira, A.F.P.L., França-Junior, I., & Jansen, H.A. (2008). Violence against women by their intimate partner and common mental disorders. *Social Science and Medicine*, 66(4), 1008–1018.
- Magdol, L., Moffitt, T.E., Caspi, A., Newman, D.L., Fagan, J., & Silva, P.A. (1997). Gender differences in partner violence in a birth cohort of 21 year olds: Bridging the gap between clinical and epidemiological approaches. *J. Consult. Clin. Psychology*, 65, 68-78.

- Martinez-Torteya, C., Bogat, G.A., von Eye, A., Levendosky, A.A., & Davidson, W.S. (2009). Women's appraisals of intimate partner violence stressfulness and their relationship depressive and posttraumatic stress disorder symptoms. *Violence and Victims*, 24(6), 707-722. doi: 10.1891/0886-6708.24.6.707.
- Mason, S.M., Wright, R.J., Hibert, E.N., Spiegelman, D., Forman, J.P., et al. (2012). Intimate partner violence and incidence of hypertension in women. *Ann Epidemiol*, 22, 562-567.
- Mayo, Y., & Resnick, R. (1996). The impact of machismo on Hispanic women. *Affilia*, 11, 257-277.
- National Center for Injury Prevention and Control. (2003). Costs of intimate partner violence against women in the united states. *Centers for Disease Control and Prevention (CDC)*, 1-55.
- Naved, R.T. & Akhtar, N. (2008). Spousal violence against women and suicidal ideation in Bangladesh. *Women's Health Issues*, 18(6), 442-452.
- Organization of American States (OAS). Constitucion de la Republica del Ecuador, 2008. http://www.oas.org/juridico/PDFs/mesicic4_ecu_const.pdf.
- O'Campo, P., Kub, J., Woods, A., Garza, M., Jones, A.S., Gielen, A.C., Dienemann, J., Campbell, J. (2006). Depression, PTSD, and comorbidity related to intimate partner violence in civilian and military women. *Brief Treatment and Crisis Intervention*, 6(2), 99-110.
- Owen, N., & Bauman, A. (1992). The descriptive epidemiology of a sedentary lifestyle in adult Australians. *Int. J. Epidemiology*, 21, 305-310.
- Parish, W.L., Wang, T., Laumann, E.O., Pan, S., & Luo, Y. (2004). Intimate partner violence in China: National prevalence, risk factors and associated health problems. *International Family Planning Perspectives*, 30(4), 174-181.
- Pico-Alfonso, M.A., Garcia-Linares, I.M., Celda-Navarro, N., Blasco-Ros, C., Echeburúa, E., & Martinez, M. (2006). The impact of physical, psychological, and sexual intimate male partner violence on women's mental health: Depressive symptoms, posttraumatic stress disorder, state anxiety, and suicide. *Journal of Women's Health*, 15(5), 599-611.
- Ponce, J. (2006). Más allá de los promedios, afrodescendientes en américa latina: Los afroecuatorianos. *World Bank Report*, 1-62. http://siteresources.worldbank.org/INTLACAFROLATINSINSPA/Resources/ECUADOR_final.pdf.
- Prattala, R., Karisto, A., & Berg, M.A. (1994). Consistency and variation in unhealthy behavior among Finish men. *Soc. Sci. Med.*, 39, 115-121.
- Quigley, B.M., & Leonard, K.E. (1996). Desistance of husband aggression in the early years of marriage. *Violence Vict.* 11, 355-370.

- Rahier, J.M. (1998). Blackness, the racial/spatial order, migrations, and miss Ecuador 1995-96. *Amer Anthropologist*, 100(2), 421-430.
- Raj, A., Silverman, J.G., & Amaro, H. (2004). Abused women report greater male partner risk and gender based risk for HIV: Findings from a community-based study with hispanic women. *AIDS Care*, 16(4), 519-529.
- Roldos, M.I. (2010). Ethnic differences in intimate partner violence between mestizo and indigenous women in Ecuador. *Injury Prevention*, 16A48.
- Roldos, M.I., & Corso P. (2013). The economic burden of intimate partner violence in Ecuador: Setting the agenda for future research and violence prevention policies. *Western Journal of Emergency Medicine*, 14(4), 347-353. doi: 10.5811/westjem.2013.2.15697
- Romero-Sandoval, N., Flores, O., Sánchez-Pérez, H.J., Sánchez-Pérez, I., Martín-Mateo, M. (2007). Pulmonary tuberculosis in an indigenous community in the mountains of Ecuador. *Int J Tuberc Lung Dis*, 11, 550-555.
- Ryan, S., Franzetta, K., Manlove, J. S. & Schelar, E. (2008). Older sexual partners during adolescence: Links to reproductive health outcomes in young adulthood. *Perspectives on Sexual and Reproductive Health*, 40, 17-26. doi: 10.1363/4001708.
- Sharps, P.W., Koziol-McLain, J., Campbell, J., McFarlane, J., Sachs, C., & Xu, X. (2001). Health care providers' missed opportunities for preventing femicide. *Prev Med*, 33(5), 373-380.
- Sorenson, S., Upchurch, D., & Shen, H. (1996). Violence and injury in marital arguments: Risk patterns and gender differences. *Am. J. Public Health*, 86, 35-40.
- Stephenson, R., Koenig, M.A., & Ahmed, S. (2006). Domestic violence and symptoms of gynecologic morbidity among women in North India. *International Family Planning Perspectives*, 32(4), 201-208.
- Straus, M.A. (1990). Social stress and marital violence in a national sample of American families. In: Straus, M. A., and Gelles, R. J. (eds.), *Physical Violence in American Families*, Transaction Publishers, New Brunswick, NJ.
- Teitelman, A.M., Tennille, J., Bohinski, J.M., Jemmott, L.S., & Jemmott, J.B. (2011). Unwanted unprotected sex: Condom coercion by male partners and self-silencing of condom negotiation among adolescent girls. *Advances in Nursing Science*, 34(3), 243-259.
- Thompson, R.S., Bonomi, A.E., Anderson, M., Reid, R.J., Dimer, J.A., Carrell, D., & Rivara, F.P. (2006). Intimate partner violence: prevalence, types, and chronicity across adult women's lifetime. *Am J Prev Med*, 30, 447-457.
- Tubman, J.G., Montgomery, M.J., Gil, A.G., & Wagner, E.F. (2004). Abuse experiences in a community sample of young adults: Relations with psychiatric disorders, sexual risk behaviors,

and sexually transmitted diseases. *American Journal of Community Psychology*, 34, 147-162.

United Nations Development Programme (UNDP). (2010). Human development report: The real wealth of nations: Pathways to human development, 20th Anniversary Edition. http://hdr.undp.org/en/media/HDR_2010_EN_Complete_reprint.pdf.

Valdivierzo, C. (2004). Questionnaire to governments on implementation of the beijing platform for action. Quito, Ecuador: National Council of Women (CONAMU)

Vives-Cases, C., Ruiz-Cantero, M.T., Escribà-Agüir, V., & Miralles, J.J. (2011). The effect of intimate partner violence and other forms of violence against women on health. *Journal of Public Health*, 33(1), 15–21.

Vives-Cases, C., Torrubiano-Domínguez, J., Gil-González, D., La Parra, D., Agudelo-Suárez, A.A., Davó, M.C., Pérez-Belda, M.C, Martínez-Román, M.A. (2013). Social and immigration factors in intimate partner violence among Ecuadorians, Moroccans and Romanians living in Spain, *European Journal Of Public Health*, 24(4), 605-612.

Volpe, E.M., Hardie, T.L., Cerulli, C., Sommers, M.S., & Morrison-Beedy, D. (2013). Age got to do with it?: Partner age difference, power, intimate partner violence, and sexual risk in urban adolescents. *J Interpers Violence*, 28(10), 2068–2087. doi: 10.1177/0886260512471082

Vos, T., Astbury, J., Piers, L. S., Magnus, A., Heenan, M., Stanley, L., Walker, L., & Webster, K. (2006). Measuring the impact of intimate partner violence on the health of women in Victoria, Australia. *Bulletin of the World Health Organization*, 84(9), 739–744.

Weigel M.M., & Castro, N.P. (2000). The food acquisition, dietary practices, and nutritional status of minority women of African descent living in tropical South America. *Ecology Food and Nutr*, 19,135-167.

Weigel, M.M., & Caiza, M.E. (2013). Ethnic/racial disparities in the fetal growth outcomes of Ecuadorian newborns. *J Immigrant Minority Health*, 15(1), 198-206. doi: 10.1007/s10903-011-9571-5.

Wuest, J., Merritt-Gray, M., Ford-Gilboe, M., Lent, B., Varcoe, C., & Campbell, J.C. (2008). Chronic pain in women survivors of intimate partner violence. *Journal of Pain*, 9(11), 1049-1057.

Wuest, J., Merritt-Gray, M., Lent, B., Varcoe, C., Connors, A.J., & Ford-Gilboe, M. (2007). Patterns of medication use among women survivors of intimate partner violence. *Canadian Journal of Public Health*, 98(6), 460–464.

Wong, S.P.Y., Wang, C., Meng, M., & Phillips, M.R. (2011). Understanding self-harm in victims of intimate partner violence: A qualitative analysis of calls made by victims to a crisis hotline in China. *Violence Against Women*, 17(4), 532–544.

World Health Organization (WHO). (2013). Intimate partner violence and alcohol factsheet *World Health Organization*, 1-10.

Yoshihama, M., Bybee, D., Dabby, C., & Blazeovski, J. (2011). Life course experience of intimate partner violence and help seeking among Filipina, Indian and Pakistani women: Implications for justice system responses. *U.S. Department of Justice*, 1-123.

Yoshihama, M., Horrocks, J., & Kamano, S. (2009). The role of emotional abuse in intimate partner violence and health among women in Yokohama, Japan. *American Journal of Public Health*, 99(4), 647–653.

TABLES

Table 1. Descriptive statistics of sociodemographic characteristics and measures for IPV among Ecuadorian women (n=10,730)

SOCIODEMOGRAPHIC CHARACTERISTICS	Frequency (%)
Ethnicity	
Mestizo/White	9303 (86.7%)
Indigenous	1043 (9.7%)
Afro-Ecuadorian	384 (3.6%)
Education *	
None	10 (0.1%)
Primary (ages 6-11)	4282 (41.4%)
Secondary (ages 12-17)	4343 (42%)
Tertiary ages (18 & above – bachelor)	1632 (15.8%)
Postgraduate (graduate level)	33 (0.3%)
Literacy Center (ages 15 to adults)	43 (0.4%)
Age Group	
15-24 years	3545 (33%)
25-34 years	3570 (33.3%)
35-49 years	3615 (33.7%)
Marital Status	
Common Law Marriage	2495 (23.3%)
Legally Married	4621 (43.1%)
Widowed	148 (1.4%)
Divorced/Separated	886 (8.3%)

Single, never married	2580 (24%)
Income Quintile	
1 (lowest quintile) (20% poorest)	2575 (24%)
2	2307 (21.5%)
3 (intermediate quintile)	2097 (19.5%)
4	2013 (18.8%)
5 (highest quintile) (20% richest)	1738 (16.2%)
Residence Locales	
Urban	5828 (54.3%)
Rural	4902 (45.7%)
Any Health Insurance	
Public	842 (7.8%)
Private	272 (2.5%)
Combination of Public & Private	44 (0.4%)
None	9531 (88.8%)
Don't Know	41 (0.4%)
INTIMATE PARTNER VIOLENCE MEASURES	
Early Life (<15yrs.) Observed Exposure to IPV	
Psychological	3756 (35%)
Physical	3470 (32.3%)
Physical/Psychological	3995 (37.2%)
History of Early Life (<15yrs.) Mistreatment	
Psychological	2371 (22.1%)

Physical	2688 (25.1%)
Physical/Psychological	2967 (27.7%)
Lifetime Exposure to IPV	
Psychological	3303 (30.8%)
Physical	2333 (21.7%)
Sexual	836 (7.8%)
Recent IPV Experience (past 12 months)	
Psychological	1271 (11.8%)
Physical	807 (7.5%)
Sexual	287 (2.7%)
IPV-related Injuries (past 12 months)	
Bruises	375 (3.5%)
Body-aches/Headaches	461 (4.3%)
Injuries in parts of body	129 (1.2%)
Disabled/Paralyzed	6 (0.1%)
Anxiety/Fear	407 (3.8%)
Fear of Re-attack	514 (4.8%)
Help-Seeking for IPV (past 12 months)	
Her Family	259 (2.4%)
His (perpetrator) Family	52 (0.5%)
Police Station	22 (0.2%)
Federal Women's Commission	34 (0.3%)
Women's Organization	2 (0.0%)
Church	6 (0.1%)

Health Establishment	1 (0.0%)
Other	44 (0.4%)
Looked for Help from Either Family	342 (3.2%)
Looked for Help from Any Organization	61 (0.6%)
Primary Reason for No Help-Seeking for IPV (past 12 months) *	
No One	477 (4.4%)
Afraid of retaliation	107 (22.4%)
Felt embarrassed	114 (23.9%)
Didn't know where to go for help	52 (10.9%)
Thought could solve problem alone	124 (26%)
Thought authorities wouldn't help	8 (1.7%)
Thought that he wouldn't do it again/would change	12 (2.5%)
Thought she didn't need help	36 (7.5%)
Didn't want to cause problems/hurt family	11 (2.3%)
Other (unspecified reason)	13 (2.7%)

* Missing Values for Education (n=387), and Primary Reason for not seeking help was only asked of those who did not seek help (n=10,253)

Table 2. Ethnic Differences in Early Life Observed Exposure to IPV (n=10,730)

				Bivariate	Multivariate			
					Indigenous		Afro-Ecuadorian	
Early Life (<15yrs.) Observed Exposure to IPV	Mestizo/White (n=9303)	Indigenous (n=1043)	Afro- Ecuadorian (n=384)	p-value	Adj. PR (95% C.I.) ^{a,b}	p-value	Adj. PR (95% C.I.) ^{a,b}	p-value
Psychological	3232 (34.7%)	383 (36.7%)	141 (36.7%)	0.345	0.87 (0.74-1.02) †	0.081	0.91 (0.73-1.13)	0.393
Physical	2956 (31.8%)	382 (36.6%)	132 (34.4%)	0.004 **	0.84 (0.72-0.98) ‡	0.031	0.91 (0.73-1.13)	0.397
Physical/Psychological	3446 (37%)	402 (38.5%)	147 (38.3%)	0.579	0.90 (0.77-1.05)	0.194	0.93 (0.75-1.16)	0.520

a. adjusted prevalence ratio (Adj. PR) and 95% confidence interval (95% C.I.) adjusted for respondent age, education, outside employment, marital status, income quintile & residence location.

b. referent category for multivariate analysis are the Mestizo/White.

** Statistically significant (p-value<0.05) and * marginally significant (p-value<0.10) bivariate associations are noted.

‡ Statistically significant (p-value<0.05) and † marginally significant (p-value<0.10) multivariate associations adjusted for respondent age, education, outside employment, marital status, income quintile & residence location are noted.

Table 3. Ethnic Differences in Early Life Mistreatment (n=10,730)

				Bivariate	Multivariate			
					Indigenous		Afro-Ecuadorian	
History of Early Life (<15yrs.) Mistreatment	Mestizo/White (n=9303)	Indigenous (n=1043)	Afro-Ecuadorian (n=384)	p-value	Adj. PR (95% C.I.) ^{a,b}	p-value	Adj. PR (95% C.I.) ^{a,b}	p-value
Psychological	2008 (21.6%)	267 (25.6%)	96 (25%)	0.005 **	0.77 (0.65-0.92) ‡	0.004	0.88 (0.69-1.13)	0.319
Physical	2257 (24.3%)	333 (31.9%)	98 (25.5%)	<0.001 **	0.72 (0.61-0.85) ‡	<0.001	1.02 (0.80-1.30)	0.862
Physical/Psychological	2518 (27.1%)	343 (32.9%)	106 (27.6%)	<0.001 **	0.76 (0.65-0.90) ‡	0.001	1.04 (0.82-1.32)	0.760

a. adjusted prevalence ratio (Adj. PR) and 95% confidence interval (95% C.I.) adjusted for respondent age, education, outside employment, marital status, income quintile & residence location.

b. referent category for multivariate analysis are the Mestizo/White.

** Statistically significant (p-value<0.05) and * marginally significant (p-value<0.10) bivariate associations are noted.

‡ Statistically significant (p-value<0.05) and † marginally significant (p-value<0.10) multivariate associations adjusted for respondent age, education, outside employment, marital status, income quintile & residence location are noted.

Table 4. Ethnic Differences in Lifetime Experience of IPV (n=10,730)

				Bivariate	Multivariate			
					Indigenous		Afro-Ecuadorian	
Lifetime Experience of IPV	Mestizo/White (n=9303)	Indigenous (n=1043)	Afro-Ecuadorian (n=384)	p-value	Adj. PR (95% C.I.) ^{a,b}	p-value	Adj. PR (95% C.I.) ^{a,b}	p-value
Psychological	2860 (30.7%)	300 (28.8%)	143 (37.2%)	0.009 **	0.98 (0.82-1.17)	0.812	0.82 (0.65-1.02) †	0.079
Physical	1969 (21.2%)	243 (23.3%)	121 (31.5%)	<0.001 **	0.82 (0.67-0.99) ‡	0.042	0.65 (0.51-0.83) ‡	0.001
Sexual	725 (7.8%)	78 (7.5%)	33 (8.6%)	0.784	0.84 (0.63-1.12)	0.236	1.13 (0.77-1.67)	0.535

a. adjusted prevalence ratio (Adj. PR) and 95% confidence interval (95% C.I.) adjusted for respondent age, education, outside employment, marital status, income quintile & residence location.

b. referent category for multivariate analysis are the Mestizo/White.

** Statistically significant (p-value<0.05) and * marginally significant (p-value<0.10) bivariate associations are noted.

‡ Statistically significant (p-value<0.05) and † marginally significant (p-value<0.10) multivariate associations adjusted for respondent age, education, outside employment, marital status, income quintile & residence location are noted.

Table 5. Ethnic Differences in Recent IPV (n=10,730)

				Bivariate	Multivariate			
					Indigenous		Afro-Ecuadorian	
Recent IPV Experience (past 12 months)	Mestizo/White (n=9303)	Indigenous (n=1043)	Afro-Ecuadorian (n=384)	p-value	Adj. PR (95% C.I.) ^{a,b}	p-value	Adj. PR (95% C.I.) ^{a,b}	p-value
Psychological	1075 (11.6%)	137 (13.1%)	59 (15.4%)	0.031 **	0.86 (0.68-1.09)	0.217	0.80 (0.60-1.08)	0.149
Physical	660 (7.1%)	97 (9.3%)	50 (13.0%)	<0.001 **	0.77 (0.59-1.01) †	0.061	0.60 (0.43-0.83) ‡	0.002
Sexual	241 (2.6%)	33 (3.2%)	13 (3.4%)	0.376	0.76 (0.50-1.18)	0.220	0.98 (0.54-1.79)	0.956

a. adjusted prevalence ratio (Adj. PR) and 95% confidence interval (95% C.I.) adjusted for respondent age, education, outside employment, marital status, income quintile & residence location.

b. referent category for multivariate analysis are the Mestizo/White.

** Statistically significant (p-value<0.05) and * marginally significant (p-value<0.10) bivariate associations are noted.

‡ Statistically significant (p-value<0.05) and † marginally significant (p-value<0.10) multivariate associations adjusted for respondent age, education, outside employment, marital status, income quintile & residence location are noted.

Table 6. Ethnic Differences in Recent IPV-related Injuries (n=10,730)

				Bivariate	Multivariate			
					Indigenous		Afro-Ecuadorian	
IPV-related Injuries (past 12 months)	Mestizo/White (n=9303)	Indigenous (n=1043)	Afro-Ecuadorian (n=384)	p-value	Adj. PR (95% C.I.) ^{a,b}	p-value	Adj. PR (95% C.I.) ^{a,b}	p-value
Any injury from IPV	585 (6.3%)	81 (7.8%)	43 (11.2%)	<0.001 **	0.80 (0.60-1.07)	0.127	0.63 (0.45-0.90) ‡	0.010
Bruises	301 (3.2%)	54 (5.2%)	20 (5.2%)	0.001 **	0.66 (0.46-0.95) ‡	0.025	0.70 (0.43-1.12)	0.136
Body aches & Headaches	373 (4.0%)	59 (5.7%)	29 (7.6%)	<0.001 **	0.73 (0.52-1.03) †	0.071	0.65 (0.43-0.98) ‡	0.040
Injuries in other parts of body	102 (1.1%)	16 (1.5%)	11 (2.9%)	0.016 **	0.62 (0.32-1.18)	0.146	0.49 (0.26-0.94) ‡	0.033
Disabled or paralyzed	4 (0.0%)	1 (0.1%)	1 (0.3%)	0.358	0.68 (0.06-8.27)	0.765	0.29 (0.03-2.72)	0.279
Anxiety & stress that won't be able to perform her duties	339 (3.6%)	44 (4.2%)	24 (6.3%)	0.024 **	0.76 (0.52-1.11)	0.158	0.65 (0.42-1.00) †	0.052
Constant fear of being re-attacked	417 (4.5%)	63 (6.0%)	34 (8.9%)	<0.001 **	0.77 (0.56-1.07)	0.121	0.59 (0.40-0.87) ‡	0.008

a. adjusted prevalence ratio (Adj. PR) and 95% confidence interval (95% C.I.) adjusted for respondent age, education, outside employment, marital status, income quintile & residence location.

b. referent category for multivariate analysis are the Mestizo/White.

** Statistically significant (p-value<0.05) and * marginally significant (p-value<0.10) bivariate associations are noted.

‡ Statistically significant (p-value<0.05) and † marginally significant (p-value<0.10) multivariate associations adjusted for respondent age, education, outside employment, marital status, income quintile & residence location are noted.

Table 7. Ethnic Differences in Recent Help Seeking for IPV (n=10,730)

				Bivariate	Multivariate			
					Indigenous		Afro-Ecuadorian	
Help-Seeking for IPV (past 12 months)	Mestizo/White (n=9303)	Indigenous (n=1043)	Afro-Ecuadorian (n=384)	p-value	Adj. PR (95% C.I.) ^{a,b}	p-value	Adj. PR (95% C.I.) ^{a,b}	p-value
Looked for Help	329 (3.5%)	35 (3.4%)	31 (8.1%)	<0.001 **	0.92 (0.60-1.41)	0.708	0.51 (0.34-0.77) ‡	0.001
Looked for help from either family	286 (3.1%)	30 (2.9%)	26 (6.8%)	<0.001 **	0.99 (0.63-1.56)	0.962	0.54 (0.35-0.84) ‡	0.006
Looked for help from any organization	49 (0.5%)	5 (0.5%)	7 (1.8%)	0.027 **	0.70 (0.24-2.05)	0.513	0.40 (0.17-0.97) ‡	0.043

a. adjusted prevalence ratio (Adj. PR) and 95% confidence interval (95% C.I.) adjusted for respondent age, education, outside employment, marital status, income quintile & residence location.

b. referent category for multivariate analysis are the Mestizo/White.

** Statistically significant (p-value<0.05) and * marginally significant (p-value<0.10) bivariate associations are noted.

‡ Statistically significant (p-value<0.05) and † marginally significant (p-value<0.10) multivariate associations adjusted for respondent age, education, outside employment, marital status, income quintile & residence location are noted.

FIGURES

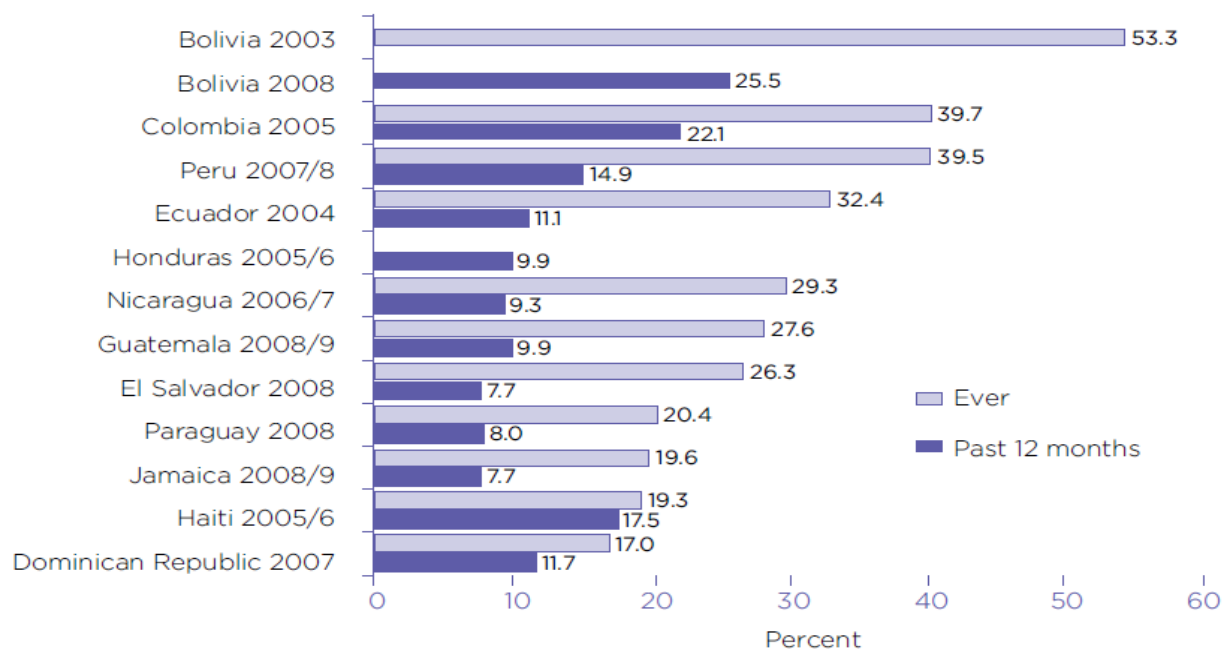


Figure 1. Prevalence of Physical or Sexual Partner Violence, Ever and in the Past 12 Months, among women aged 15-49 in the Latin America & Caribbean Region

(Source: Bott et al., 2012)

Appendix: ENDEMAIN 2004 (selected questions)

200. Por favor dígame, ¿En qué mes y año nació usted?

201. Entonces, ¿Qué edad cumplió en su último cumpleaños? AÑOS CUMPLIDOS

202. ¿Cómo se considera usted:

1. INDÍGENA
2. MESTIZA
3. NEGRA
4. BLANCA
5. OTRO, Cuál?

204. ¿Qué idioma (lengua) hablan habitualmente los miembros de su hogar o la mayoría de ellos?

- QUICHUA
- ESPAÑOL
- LENGUA EXTRANJERA
- OTRO IDIOMA NATIVO, Cuál?

205. ¿Usted puede entender el español? SI / NO

206. ¿Usted puede hablar el español? SI / NO

209. ¿Dónde nació usted?

- AQUÍ
- EN OTRO LUGAR DEL PAÍS
- Cantón:
- Provincia:
- OTRO PAÍS:
- País: _____

219. ¿Cuál fue el grado, curso o año más alto que usted aprobó y en qué nivel de estudios?

- NIVEL GRADO
- NINGUNO..... 0 0
- C. ALFABETIZACIÓN
- PRIMARIO
- SECUNDARIO
- SUPERIOR
- POSTGRADO

220. ¿Trabaja usted actualmente en algo por lo cual reciba dinero u otra forma de pago?

- SI, DINERO
- SI, OTRA FORMA DE PAGO

- NO

805. ¿Su primera relación sexual ocurrió porque usted y su pareja decidieron juntos, usted le convenció, le convenció su pareja o le obligó su pareja?

- DECIDIERON JUNTOS
- USTED LE CONVENCIO
- LE CONVENCIO SU PAREJA
- LE OBLIGO SU PAREJA
- SIMPLEMENTE PASO
- NS / NR

807. ¿Cuál era su relación con esa persona en ese momento?

- ESPOSO / COMPAÑERO
- NOVIO
- AMIGO
- FAMILIAR
- DESCONOCIDO
- OTRO, Cuál?
- NS / NR

900. ¿Es usted actualmente unida, casada, viuda, separada, divorciada o soltera?

- UNIDA
- CASADA
- VIUDA
- SEPARADA
- DIVORCIADA
- SOLTERA

1007. Pensando en su niñez, antes que cumpliera 15 años, ¿Alguna vez usted vio o escuchó a su padre o madre, padrastro o madrastra, maltratarse físicamente o psicológicamente?

- Maltratarse Físicamente
- Maltratarse Psicológicamente

1008. Antes que usted cumpliera los 15 años, ¿Fue usted alguna vez golpeada o maltratada físicamente o psicológicamente por alguna persona?

- Maltratarse Físicamente
- Maltratarse Psicológicamente

1009. ¿Quién le golpeó o maltrató físicamente o psicológicamente:

- Padre?
- Madre?
- Hermano?
- Hermana?
- Padrastro / Madrastra?

- F. Novio /Enamorado?
- G. Otro, Quién?

1010. Actualmente esta casada o unida, separada, divorciada, viuda, nunca casada o unida?

1011. ¿Alguna vez ha tenido usted pareja, novio o enamorado?

1012. Durante los últimos 12 meses, ha tenido usted un compañero, pareja, novio o enamorado?

1013. Por favor dígame si en toda su vida alguna pareja o ex-pareja le hizo alguna vez lo siguiente:

- ¿Le hizo algo para humillarla?
- ¿Le gritó, insultó o llamó por apodos ofensivos?
- ¿La amenazó con dañarse o dañar a alguien que sea importante para usted?
- ¿La empujó, sacudió o le lanzó algún objeto?
- ¿La bofeteó o le torció el brazo?
- ¿La golpeó con puñete u otra cosa que podría herirla?
- ¿Le dio patadas, le ahorcó, o le dio una golpiza?
- ¿La amenazó con un cuchillo, arma, u otro objeto que podría herirla?
- ¿La obligó a tener relaciones sexuales aunque usted no quiso?

1014. Usted me dijo que alguna pareja o (ex) parejaEsto le ha ocurrido durante los últimos 12 meses?

1015. En el momento que esto ocurrió en la última vez, cuál fue su relación con la persona que lo hizo?

1017. ¿En qué situaciones particulares esta[s] persona[s] le ha(n) agredido:

- Cuando el esta / Borracho / Drogado?
- Cuando el esta celoso?
- Cuando usted quiere salir?
- Cuando usted quiere algo de el?
- Cuando el tiene problemas familiares, hijos, suegros, etc?
- Cuando a la familia le falta dinero?
- Cuando el o tiene trabajo o tiene problemas en el trabajo?
- Otro, Cuál?

1018. Cuando esta(s) persona(s) le ha(n) agredido durante los últimos 12 meses, ¿a quién o a quienes ha acudido?

- A Nadie
- Su Familia
- Familia de el
- Estacion de Policia
- Comisaria de la mujer
- Organizacion de mujeres

- Iglesia
- Establecimiento de salud
- Otro, Cuál?

1019. ¿Cual fue la razón mas importante por la que no acudió a nadie?

- Tiena miedo de represalia
- Tiena verguenza
- No hay donde acudir
- Cree que puede solucionar sola
- Cree que las autoridades no la van a ayudar
- Cree que no va a volver a ocurrir y el va a cambiar
- Cree que no era necesario
- Otro, Cuál?

1020. En los últimos 12 meses, como consecuencia de esta agresión, usted ha quedado con:

- Moretones?
- Dolores de cabeza o de cuerpo?
- Heridas en algunas partes del cuerpo?
- Ha quedado invalida permanentemente?
- Ansiedad o Angustia tal que no podia cumplir con sus deberes?
- Miedo que la persona la vuelva a agredir?

1021. Alguna vez en su vida, ¿Alguien la obligó o la ha obligado a tener relaciones sexuales con penetración (violación) cuando usted no lo quiso?

1022. ¿Qué edad tenía usted cuando le pasó eso por primera vez?

1023. Quién la obligó a tener relaciones sexuales que usted no quiso en la primera vez?

- Esposo / Companero
- Ex-esposo / Ex- Companero
- Padre
- Padraastro
- Hermano
- Tio
- Primo
- Maestro
- Novio / Ex-Novio
- Patron / Hijo del Patron
- Vecino / Amigo / Conocido
- Desconocido
- Otro, Quién?

1024. Más de una vez en su vida alguien la obligó a tener relaciones sexuales con penetración (violación) cuando usted no lo quiso?

1025. Qué edad tenía usted cuando eso le pasó por última vez?

1026. ¿Cuándo eso le pasó (la última vez), ¿pidió ayuda a alguien?

1027. A quién pidió ayuda?

- Policía
- Comisaria de la mujer
- Familiar
- Amigo / Amiga
- Vecino / Vecina
- Iglesia
- Organizaciones de mujeres
- Otro, Cuál?

1028. ¿Cual fue la razón más importante por la que no pidió ayuda?

- Tiena miedo de represalia
- Tiena verguenza
- No hay donde acudir
- Cree que puede solucionar sola
- Cree que las autoridades no la van a ayudar
- Otro, Cuál?

1029. ¿Y alguien la obligó o la ha obligado a hacer algo como lo siguiente: a desvestirse, tocarle o dejarse tocar las partes íntimas, besar, abrazar o a hacer cualquier otro acto sexual, sin llegar a la penetración?

1030. ¿Qué edad tenía usted cuando le pasó eso por primera vez?

1031. Quién la obligó o la ha obligado?

- Esposo / Companero
- Ex-esposo / Ex- Companero
- Padre
- Padraastro
- Hermano
- Tio
- Primo
- Maestro
- Novio / Ex-Novio
- Patron / Hijo del Patron
- Vecino / Amigo / Conocido
- Desconocido
- Otro, Quién?

Curriculum Vita

Marlene Lara was born in Chicago, Illinois. The first daughter of Francisco and Francisca Lara, she graduated with honors from Franklin High School in El Paso, Texas in the 2007. She then immediately went on to pursue a bachelor's degree in Kinesiology with a minor in Education from the University of Texas at El Paso, while working in the music industry as music representative and volunteering for the local El Paso community as a health advocate. As soon as she graduated in May of 2011 with Cum Laude honors, she began her master's in Public Health degree at the same university. During her journey through graduate school, she participated in the Fiesta de Las Flores Pageant in 2011 and held several jobs. First, she served as a graduate research assistant coordinating a grant funded tutoring program at her university and later taught health courses at Dona Ana Community College and Arrowhead Early College in Las Cruces, NM, as well as in Gadsden Early College in Anthony, New Mexico. Toward the end of her graduate journey, she returned to work for the University of Texas at El Paso and became a teaching assistant, until she graduated.

Permanent address: 905 Agua Caliente #A
El Paso, TX, 79912

This thesis was typed by Marlene Lara