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Intimate partner violence and risk of HIV infection in Pakistan

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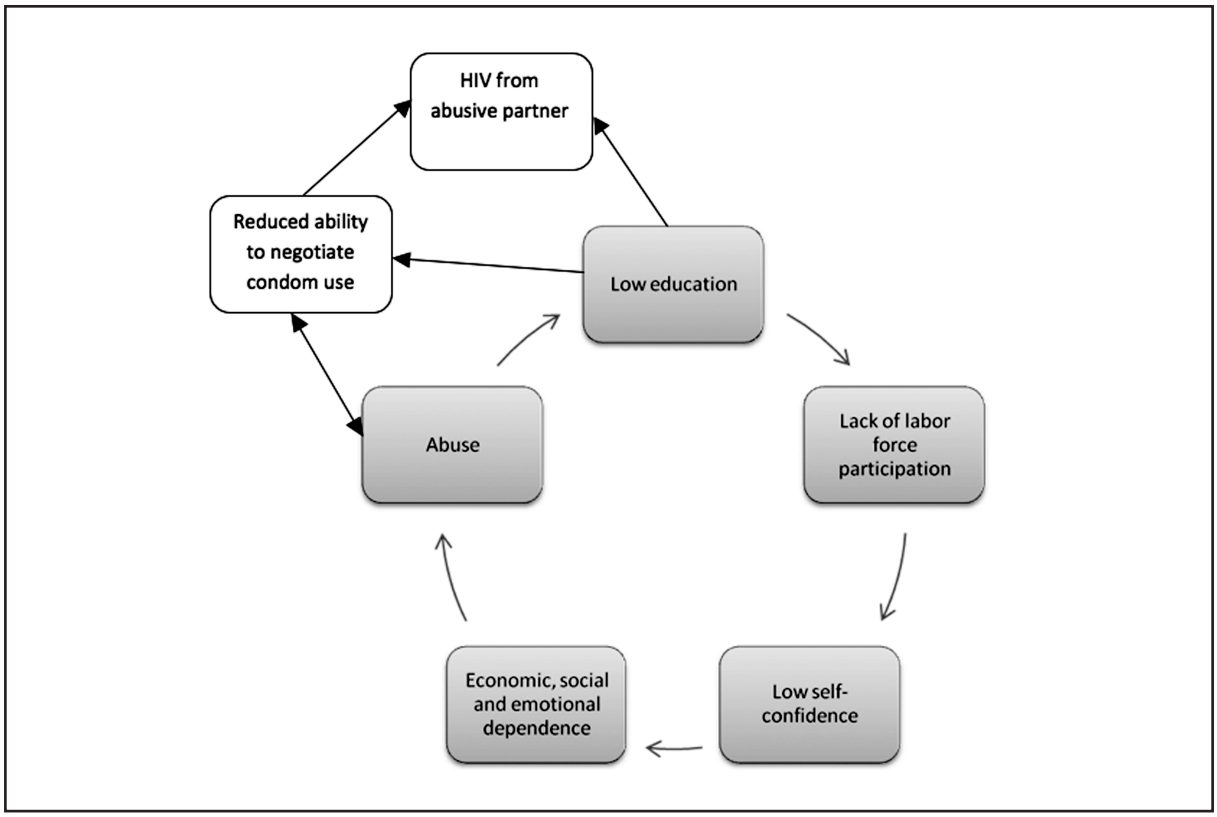
Globally, violence against women is increasing, and is currently recognized as a major public health problem with significant consequences to women's health [1]. The detrimental health effects such as injury, chronic pain, gastrointestinal, and gynecological signs including sexually-transmitted diseases, depression, and post-traumatic stress disorder have been observed in abused women [2]. Violence, like in other Asian countries [3], is a huge problem in Pakistan [4,5]. In particular, domestic violence is common [6,7], and low educational status, low empowerment, poverty, the dowry system, and males' addiction to alcohol were found to be some of the factors associated with domestic violence [4]. In addition, Pakistan has high burden of HIV/AIDS, with an estimated 85,000 people living with HIV [8]. The HIV/AIDS epidemic has begun in Pakistan [9], but it is still "concentrated" in injection drug users (IDUs) and male sex workers (MSWs) including transgender, often known as "Hijras" [8].

Female victims of intimate partner violence (IPV) have been found to be associated with increasing risk of sexually transmitted infections (STIs) and HIV infection [10,11].These studies have shown that intimate partner violence yielded 3.9 and 1.6 times higher odds of resulting in HIV among women in India [10] and South Africa [11] respectively. This is likely due to increased sexual risk behaviors and STI prevalence among abusive men [12], who subsequently transmit these infections to female partners. Thus, IPV is considered a risk marker for sexual transmission of HIV infection to female partners. Extramarital and multiple sex partners, no or inconsistent condom use, and forced unprotected sex among abusive men appears to be directly related to higher transmission of HIV to their wives [10]. It has been demonstrated that sexual risk behavior is high among abusive men [13,14] and that they have higher level of control over sex and sexual protection [15,16]. In addition, socio-cultural pressure, and fear of leaving the husband and children, result in females bearing the violence of their husbands/main partners, making them more vulnerable to contract HIV. Gender inequality is common in Pakistan, more so in rural areas. This is one of the major risk factors of IPV, and subsequently contracting HIV from abusive husbands. As a part of societal norms, especially in rural areas, where the majority of the population resides, women are suppose to stay home and care for their husbands and children, thus women have fewer opportunities for education as compared to males, even before marriage. As a result when they grow up, women's participation in the labor force is less and they become economically, socially and emotionally dependent on their husbands (Figure 1). The lack of empowerment and independence of women reduces their ability or willingness to negotiate condom use thus making them likely to contract HIV from their abusive husbands.

There is a risk that the concentrated HIV epidemic in Pakistan could spread to the general population. Several factors contribute to the spread of HIV, for instance, the high volume of unprotected sexual acts and poor infection control strategies in the country [17]. One of the factors that is often overlooked is the role of IPV and risk of sexual transmission of HIV to the wives/main partner of IDUs, clients of sex workers, truck or bus drivers, and migrant workers. They can act as "bridging groups" [18]

Figure 1. Conceptual framework of risk of contracting HIV from abusive partner.



that could spread this epidemic to the general population. IPV is prevalent among IDUs, it has been estimated in one of the study in 2007, more than 40% of male IDUs reported perpetrating physical and/or sexual violence against their main female partners in the past year [19]. The findings in this study revealed that low education, homelessness, psychological distress, and unprotected sex with main and nonmain HIV-negative female partners were associated with IPV perpetration against main female partners. Male IDUs often avoid disclosing their drug use to their wives. The majority of their wives do not know of their drug-using activities until they are married, making them generally helpless to protect themselves. Similarly, one quarter of married truck drivers were found to engage in commercial or non-commercial extramarital sex, and rarely used condoms during sexual acts [9], and were also found to be abusive to their wives/main partners [20]. A large majority of Pakistanis work abroad [9], especially poor manual workers [21], and many of them remain away from their homes and families for years [21]. Prolonged absence from their homes increases the likelihood of these individuals in engaging in sexual activities, especially with sex workers. In one study over half (55%) of single men reported that they were sexually experienced and 36% of married men reported premarital sex., with a very few individuals stating that they wore a condom during sex [21] thus increasing the likelihood of transmitting HIV infection to their wives/main partners.

There are several potential areas where we can intervene to break the vicious cycle of IPV and HIV. We can intervene by promoting civil rights for women, focusing on prosecution of men who inflict violence, empowering women to oppose violence, and identifying the causal pathways leading to IPV along with social, political, economic, and environmental factors that influence IPV. Another approach is to engage local communities in the process of problem-solving, building on local knowledge and generating local response. The community participation approach has shown promising results, as illustrated in the evaluation of the UNAIDS/UNITAR AIDS Competence Program. This program is based on building local knowledge and community ownership to achieve effective HIV prevention [22,23]. Clinicians can also play a vital role in reducing IPV and the risk of HIV transmission by incorporating screening for IPV among women who go to physicians' clinics [24], especially STI clinics, and by educating women about how to reduce the risk of HIV transmission. Developing clinical programs for men in which

IPV is identified as a potential risk factor for HIV transmission to their female partners can also be helpful. These programs may benefit both men and women in the modification of gender norms supporting both IPV and sexual risk.

Given the high prevalence of IPV, including sexual violence in Pakistan [4], it is likely that wives/main partners of abusive men, especially IDUs, clients of sex workers, truck drivers, and migrant workers, can spread this epidemic to the general population. Exposure to IPV can potentially be a risk marker for having sex with a high-risk partner, a direct risk factor to facilitate HIV infection based on unprotected forced sex, or both [10]. Reducing gender inequality by empowering women through education, social support, economic development schemes, and employment creation is necessary to reduce IPV and its risk for HIV among women in Pakistan.

Conflict of interest

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References

1) Garcia-Moreno C, Jansen HA, Ellsberg M, Heise L, Watts CH. Prevalence of intimate partner violence: findings from the WHO multi-country study on women's health and domestic violence. Lancet 2006;368(9543):1260-9.

2) Campbell, JC. Health consequences of intimate partner violence. Lancet 2002;359(9314):1331-6.

3) Kashif M, Murtaza K, Kirkman M. Violence against women during pregnancy in some Asian countries: a review of the literature. Ital J Public Health 2010;7(2):6-11.

4) Nasrullah M, Xiang H. The epidemic of injuries in Pakistan--a neglected problem. J Pak Med Assoc 2008;58(8):420-1.

5) Nasrullah M, Haqqi S, Cummings KJ. The epidemiological patterns of honour killing of women in Pakistan. Eur J Public Health 2009;19(2):193-7.

6) Nasrullah M, Muazzam S. Newspaper reports: a source of surveillance for burns among women in Pakistan. J Public Health (Oxf) 2010;32(2):245-9.

7) Jalal S. Policy suggestions to deal with intimate partner violence in Pakistan. Ital J Public Health 2010;7(2):69-71.

8) World Health Organization. AIDS and Sexually Transmitted Diseases: Country profiles, Pakistan, Regional Office for the Eastern Mediterranean. 2009. Available from: http://www.emro.who.int/asd/hivsituation_countryprofiles.htm. [Accessed on November 18, 2010].

9) Khan AA, Khan A. The HIV epidemic in Pakistan. J Pak Med Assoc 2010;60(4):300-7.

10) Silverman JG, Decker MR, Saggurti N, Balaiah D, Raj A. Intimate partner violence and HIV infection among married Indian women. JAMA 2008;300(6):703-10.

11) Dunkle KL, Jewkes RK, Brown HC, Gray GE, McIntryre JA, Harlow SD. Gender-based violence, relationship power, and risk of HIV infection in women attending antenatal clinics in South Africa. Lancet 2004;363(9419):1415-21.

12) Silverman JG, Decker MR, Kapur NA, Gupta J, Raj A. Violence against wives, sexual risk and sexually transmitted infection among Bangladeshi men. Sex Transm Infect 2007;83(3):211-5.

13) Raj A, Santana MC, La Marche A, Amaro H, Cranston K, Silverman JG. Perpetration of intimate partner violence associated with sexual risk behaviors among young adult men. Am J Public Health 2006;96(10):1873-8.

14) Martin SL, Kilgallen B, Tsui AO, Maitra K, Singh KK, Kupper LL. Sexual behaviors and reproductive health outcomes: associations with wife abuse in India. JAMA 1999;282(20):1967-72.

15) Raj A, Reed E, Miller E, Decker MR, Rothman EF, Silverman JG. Contexts of condom use and non-condom use among young adolescent male perpetrators of dating violence. AIDS Care 2007;19(8):970-3.

16) Jewkes R, Dunkle K, Koss MP, Levin JB, Nduna M, Jama N, et al. Rape perpetration by young, rural South African men: Prevalence, patterns and risk factors. Soc Sci Med 2006;63(11):2949-61.

17) Burki T. New government in Pakistan faces old challenges. Lancet Infect Dis 2008;8(4):217-8.

18) Aral SO. Behavioral aspects of sexually transmitted diseases: core groups and bridge populations. Sex Transm Dis 2000;27(6):327-8.

19) Frye V, Latka MH, Wu Y, Valverde EE, Knowlton AR, Knight KR, et al. Intimate partner violence perpetration against main female partners among HIV-positive male injection drug users. J Acquir Immune Defic Syndr 2007;46 Suppl 2:S101-9.

20) Balci YG, Ayranci U. Physical violence against women: evaluation of women assaulted by spouses. J Clin Forensic Med 2005;12(5):258-63.

21) Faisel A, Cleland J. Migrant men: a priority for HIV control in Pakistan? Sex Transm Infect 2006;82(4):307-10.

22) UNAIDS. Evaluation of the UNAIDS/UNITAR AIDS Competence Programme. Geneva: Joint United Nations Programme on HIV/AIDS, 2005.

23) Gupta GR, Parkhurst JO, Ogden JA, Aggleton P, Mahal A. Structural approaches to HIV prevention. Lancet 2008;372(9640):764-75.

24) Ahmad F, Mahmood S. What do we know about interactive computer-assisted screening for intimate partner violence and control in clinical settings? A systematic review. Ital J Public Health 2010;7(2):48-58.