

## ORIGINAL ARTICLE

## Intimate partner violence against Japanese and non-Japanese women in Japan: A cross-sectional study in the perinatal setting

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**Aim:** To identify the prevalence of intimate partner violence (IPV) against Japanese women (JW) and non-Japanese women (NJW) in a perinatal setting. Additional purposes were to identify the associated factors of IPV, describe the characteristics of IPV against NJW, and assess the acceptability of the Violence Against Women Screen (VAWS) instrument as a screening tool.

**Methods:** A cross-sectional survey was conducted from September to November 2007 in an urban hospital maternity clinic in Tokyo, Japan. Women who attended the maternity clinic received the VAWS instrument, which was translated into four languages (Japanese with Kanji and Hiragana, English, Chinese, and Tagalog) and was used to identify IPV.

**Results:** A total of 400 women participated in the study: 357 were JW and 43 were NJW. The prevalence rate of IPV among the JW was 31.4% and 21.4% among the NJW. There was no statistical significance between the two groups. A multiple logistic regression with adjusted odds ratio identified two associated factors for IPV: being multipara and previous experience of physical violence from a partner.

**Conclusion:** The prevalence of IPV was not statistically different among JW and NJW. Screening for IPV, early intervention, and support should be expanded in hospitals and maternity clinics in Japan.

**Key words:** cross-sectional study, foreign residents, intimate partner violence, Japan, pregnancy.

**INTRODUCTION**

Intimate partner violence (IPV) is a global public health problem. The World Health Organization described intimate partner violence as physical and sexual violence, emotional abuse, and controlling behaviors by current partners or ex-partners (WHO, 2000a,b). In Japan, a government survey found that one in three (33.2%) Japanese women had been physically, mentally, or sexually abused by their husband or partner (Japan Cabinet Office, 2006). In addition, every year, ~120 women are murdered by their husband (National Police Agency,

2008). Health-care providers have important roles for women who are experiencing IPV through screening and intervention.

Research reports reveal the IPV risk factors as multidimensional. The biological factors associated with pregnancy are: pregnancy within the previous year (Richardson *et al.*, 2002); unintended pregnancy (Goodwin *et al.*, 2000; Nasir & Hyder, 2003); late entry for prenatal care; and smoking during the third trimester (Goodwin *et al.*). In Japan, Kataoka, Yajyuu, Eto and Horiuchi (2005) and Suzuki *et al.* (2006) identified multiparity as an additional risk factor. An interpersonal factor is previous experience of intimate partner violence (Coker, Smith, McKeown & King, 2000). Demographic and social characteristics are risk factors, such as low income (Jacoby, Gorenflo, Black, Wunderlich & Eyler, 1999), low education level (Nasir & Hyder), being single, and being young (Goodwin *et al.*). In the USA, ethnicity was identified as a

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Received 3 February 2009; accepted 17 January 2010.

risk factor (Field & Caetano, 2003; 2004). Race, economic status, and immigrant status are seen as related to IPV (Jasinski, 2004; Menjivar & Salcido, 2002).

Japan is one of the more ethnically homogeneous countries in the world; however, the number of non-Japanese residents is growing and, in 2006, they accounted for 1.6% of the population (Legal Affairs Bureau, Immigration Service, 2007). In the past 5 years, there were >35 000 international marriages; almost 80% of couples consisted of a Japanese husband with a non-Japanese wife (Health and Welfare Statistics Association, 2007a). Half of the newcomers are in their 20s or 30s; thus, many non-Japanese women experience marriage, delivery, and child-rearing in Japan (Lee, 2004). Still, few hospitals or clinics provide translation services or educational material in other languages and advocacy for non-Japanese women is minimal (Fujiwara, 2007).

Adapting to a new culture is replete with challenges and difficulties, such as cultural gaps, social discrimination, low social support, and, economic distress (Fujiwara, 2007). Non-Japanese women who live in Japan might encounter these difficulties due to their ethnicity. These added difficulties might contribute to the existing risk for IPV that is encountered by non-Japanese women. Health-care staff also might fail to recognize the potential of IPV. However, little is known about the prevalence of IPV among the growing population of non-Japanese women in the vulnerable child-bearing age group living in Japan.

The main purpose of this study was to identify the prevalence of IPV during the perinatal period and to compare the prevalence of IPV among Japanese and non-Japanese women by using the Violence Against Women Screen (VAWS) instrument. Additional purposes were to identify the associated factors that are related to IPV, describe the characteristics of IPV against non-Japanese women, and assess the acceptability of the VAWS instrument as a screening tool.

## METHODS

### Definitions

#### *Japanese women*

Women were identified as Japanese (JW) if their place of birth was Japan and their nationality was Japanese. Women whose nationality was Japanese but who were born in a foreign country because of a family member's work status also were identified as JW.

#### *Non-Japanese women*

Women were identified as non-Japanese (NJW) if they were living outside their country of birth and their nationality was not Japanese. Also identified as NJW were those whose country of birth was Japan and whose family had lived in Japan for several generations but their nationality was not Japanese. Women born to non-Japanese citizens who became Japanese (have Japanese nationality) also were identified as NJW.

Implicit in the distinction between JW and NJW is the frame of reference of a highly ethnicity-homogeneous country, where "fitting in", a strong group identity, and harmony are the prevailing values, as opposed to Western values of individuality, independence, and diversity.

### Design

This was an exploratory study, given the limited representativeness of the women attending an outpatient maternity clinic of an urban hospital during a 3 month period.

### Setting and sample

National registers for foreign residents (the legal term in Japan) are protected; thus, a random population-based survey was difficult (Japanese Center for DV information and prevention (2005)). Given the restricted access to an official sample frame, we selected a perinatal clinic as a logical site to access NJW and JW. This study was conducted from September to November 2007 at an urban hospital maternity clinic in Tokyo, where ~600 deliveries are carried out each year.

Women attending the maternity clinic were regarded as possible participants for the study. To be eligible, the women had to be  $\geq 10$  weeks pregnant, have no serious mental disorder, and understand one of the languages that was used in the questionnaire (Japanese with Kanji and Hiragana, English, Chinese, and Tagalog). The purposive sample also could include women who were post-partum and did not have a chance to join the research during their pregnancy or who were a "walk-in" delivery. Research assistants identified potentially eligible women from their medical records, after which the eligible women were approached individually by the researcher and asked about their willingness to participate in the research. If a woman was accompanied by her husband/partner, children, or family member, she was invited to a private area to discuss the study in order to ensure privacy and safety. Women had the choice of completing the questionnaire at the clinic in a private

area or mailing it back to the researcher. After completing the questionnaire, the women dropped it in a collection box or returned it by mail.

### Measurement

The questionnaire covered three topics: demographic information about the woman and her husband/partner, the IPV screening instrument, and the woman's response to completing the survey, including if she wished for a consultation. A pilot test was conducted with 10 registered nurses who were asked to consider the contents of the questionnaire, which established face validity and the amount of time required to respond.

### Demographics

The women were asked to provide standard demographic information: place of birth, nationality, length of stay in Japan, and their reason for coming to Japan; parity, gestational date/date of delivery, previous physical abuse by an intimate partner, living arrangements, and the availability of a person with whom they could consult; and their partner's age, nationality, and employment status. The demographic part of the questionnaire was based on the works of Kataoka (2005) and Brownridge and Halli (2002).

### Violence Against Women Screen

The VAWS, a self-administered, seven-item questionnaire, included questions that referred to the women's experience during the preceding 12 months. The VAWS was developed in Japan (Kataoka, 2005). After comprehensive comparison with other screening tools, its psychometric properties and acceptability recommended its use as an IPV screening instrument (Kataoka). The seven-item, three-point questionnaire has a score range of 7–21. A score >9 indicates IPV.

For this study, the VAWS was translated into Chinese, English, and Tagalog by bilingual native speakers of these languages. Japanese Hiragana was placed next to the Kanji of the original version to add clarification. The languages were selected by the researcher, based on the population of NJW that was served by the clinic.

The Cronbach's  $\alpha$  for the 400 participants of this study was 0.73, indicating fairly good reliability. The principal component analysis and factor analysis confirmed the one-dimensional nature of the scale. To establish the one-dimensional nature of VAWS, both a principal component analysis and factor analysis were used. In the principal component analysis, two principal components were extracted. However, the second principal component had a low value (1.057). Also, the first

principal contribution ratio was 40.15% and the second principal contribution ratio was 15.09%, together confirming the one-dimensional structure of the scale. For the factor analysis, the principal factor method with promax rotation was used and a two-factor structure was found. However, the second factor's Eigenvalue was low (1.057), indicating an adequate correlation (0.54). Also, the first principal contribution ratio was 32.43% and the second principal contribution ratio was 7.92%.

### Response to completing the questionnaire and desire for consultation

The women were asked two questions: "How does it make you feel being questioned about your relationship with your partner?" and "Would you like to consult with a nurse or midwife if you have a problem with your partner?"

### Ethical considerations

This study was approved by the ethics board of St Luke's College of Nursing, Tokyo, Japan and the director of the study hospital. Informed consent and withdrawal without penalty were assured. Precautions were taken to protect privacy, the questionnaire was anonymous, and the data were presented so that no individual could be identified. In addition, we made resource cards that presented information about IPV consultation centers and resource phone numbers and put them in the outpatient restroom. The chief nurse-midwife was responsible for consultation and the study participants were given information about how to contact her.

### Statistical analysis

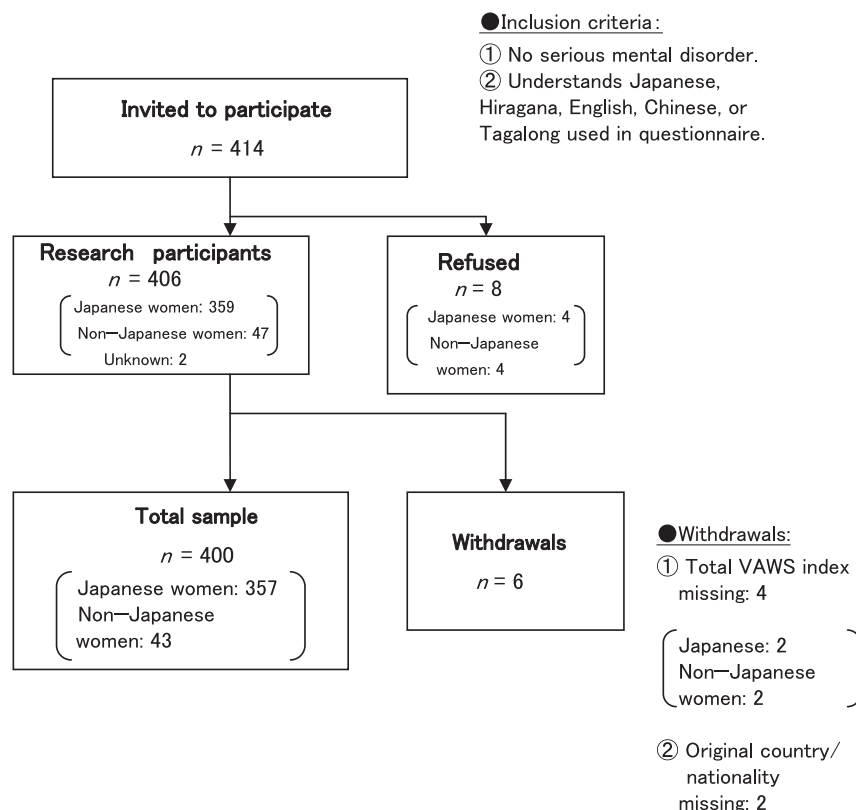
All the analyses were carried out by using SPSS for Windows 15.0 J (SPSS, Tokyo, Japan). We calculated basic statistics for the demographics and response to the survey instrument for each group. Next, we calculated the IPV prevalence rate for the entire sample and each group. To test the significance of the differences, we used the  $\chi^2$ -test, odds ratio (OR), and 95% confidential interval (95% CI) for the categorical data and the *t*-test for the continuous data. A multiple logistic regression analysis was used to adjust for confounding factors. We considered  $P < 0.05$  to be statistically significant.

## RESULTS

### Retention rates and sample

#### All women

A total of 414 eligible women were asked to participate in the study. Eight women refused the invitation.



**Figure 1** Flow of the participants through the study and data collection. VAWS, Violence Against Women Screen.

Responses were returned from 406 women; however, six were not usable because of incomplete responses to the VAWS or because they did not indicate their nationality or country of origin. Thus, the analysis refers to 400 women (43 NJW and 357 JW), 96.6% of those approached (Fig. 1).

Almost all of the women were in their 20s or 30s and most were primiparas. Almost all were married and, with the exception of one in the JW group, were living with their family. Two-thirds of the women had education beyond high school; more than half were not working. Almost all the women reported that they had someone, other than their husband/partner, “to talk problems over with”. Of the JW, 10.1% reported that they had experienced physical violence from their intimate partner (Table 1). Their responses represent 9.0% of the total sample.

#### *Non-Japanese women*

Of the 43 NJW that participated in this study, six had been living in Japan for  $\geq 10$  years; however, the majority ( $n = 22$ ) had been living in Japan for  $< 5$  years. Most were from China ( $n = 18$ ), the Philippines ( $n = 11$ ), India

( $n = 3$ ), and other countries ( $n = 11$ ). Among the frequent reasons for coming to Japan were: study ( $n = 15$ ); marriage ( $n = 10$ ); and husband’s job transfer ( $n = 7$ ). Three women had Japanese nationality. More than half of the husbands/partners were Japanese ( $n = 24$ ). The remaining were identified as: Chinese ( $n = 6$ ), Filipino ( $n = 4$ ), Indian ( $n = 3$ ), Korean ( $n = 3$ ), and other nationalities ( $n = 3$ ) (Table 2).

#### **Experience of intimate partner violence: All women**

##### *Prevalence of intimate partner violence*

The total scores for the VAWS ranged from 7 to 18 (possible range: 7–21) (mean = 8.20, median = 7.00, SD = 1.67). Of the total sample, almost half ( $n = 197$ , 49.3%) gave negative responses to all the items, whereas 203 (50.7%) answered one or more items negatively. The prevalence of IPV, defined as a score of  $\geq 9$  on the VAWS, was 30.1% ( $n = 121$ ).

##### *Associated factors for intimate partner violence*

The significance with OR and 95% CI for current experience of IPV from one’s husband/partner was:

**Table 1** Demographic characteristics (*n* = 400)

Characteristic	Japanese women ( <i>n</i> = 357) N (%)	Non-Japanese women ( <i>n</i> = 43) N (%)	<i>P</i> -value <sup>†</sup>
Age (years)			–
≤19	4 (1.1)	1 (2.4)	
20–29	135 (37.8)	21 (48.8)	
30–39	211 (59.1)	21 (48.8)	
≥40	6 (1.7)	0 (0)	
Missing	1 (0.3)	–	
Gestational week			0.38
≤15	20 (5.6)	5 (11.6)	
16–27	168 (47.0)	18 (41.9)	
≥28	150 (42.0)	16 (37.2)	
Post-partum	17 (4.8)	3 (7.0)	
Missing	2 (0.6)	1 (2.3)	
Parity			0.09
Primipara	183 (51.3)	29 (67.5)	
Multipara	173 (48.5)	13 (30.2)	
Missing	1 (0.3)	1 (2.3)	
Spacing of pregnancies (weeks) (multipara only: <i>n</i> = 186)			0.62
≤18	17 (9.8)	1 (7.7)	
19–24	23 (13.3)	3 (23.1)	
≥25	131 (75.7)	9 (69.2)	
Missing	2 (1.2)	–	
Educational background			0.00
Junior high	24 (6.7)	3 (7.0)	
High school	84 (23.5)	13 (30.2)	
Vocational school/college	140 (39.2)	8 (18.6)	
University	106 (29.7)	12 (27.9)	
Graduate school	2 (0.6)	7 (16.3)	
Missing	1 (0.3)	–	
Marital status			0.64
Married	332 (93.0)	41 (95.3)	
Single	23 (6.4)	2 (4.7)	
Missing	2 (0.6)	–	
Working status			0.06
Full-time work	92 (25.8)	5 (11.6)	
Part-time work	49 (13.7)	10 (23.3)	
Not working	214 (59.9)	28 (65.1)	
Missing	2 (0.6)	–	
Living arrangement			–
Living with family	355 (99.4)	43 (100)	
Living alone	1 (0.3)	0 (0)	
Missing	1 (0.3)	–	
Person to consult with			0.02
Yes	347 (97.2)	39 (90.7)	
No	9 (2.5)	4 (9.3)	
Missing	1 (0.3)	–	
Experience of physical violence by past male partner			–
Yes	36 (10.1)	0 (0)	
No	320 (89.6)	43 (100)	
Missing	1 (0.3)	–	

<sup>†</sup> $\chi^2$ -test or Fisher's exact test was used to compare the two groups.

**Table 2** Characteristics of non-Japanese women ( $n = 43$ )

Characteristic	N (%)
National origin	
China	18 (41.9)
the Philippines	11 (25.6)
India	3 (7.0)
Korea	2 (4.7)
Thailand	2 (4.7)
Japan	2 (4.7)
Romania	1 (2.3)
Peru	1 (2.3)
Taiwan	1 (2.3)
Brazil	1 (2.3)
Myanmar	1 (2.3)
Length of stay (years)	
≤1	3 (7.0)
1–4	19 (44.1)
5–9	12 (27.9)
≥10	6 (14.0)
Missing	3 (7.0)
Reason for coming to Japan	
Study	15 (34.9)
Marriage	10 (23.3)
Husband's transfer	7 (16.3)
Work	5 (11.6)
Old-comer	2 (4.7)
Family's transfer	1 (2.3)
Internship	1 (2.3)
Work/family's transfer	1 (2.3)
Missing	1 (2.3)
Place of birth	
China	17 (39.5)
the Philippines	9 (20.9)
Korea	4 (9.3)
India	3 (7.0)
Japan	3 (7.0)
Thailand	2 (4.7)
Romania	1 (2.3)
Peru	1 (2.3)
Taiwan	1 (2.3)
Brazil	1 (2.3)
Myanmar	1 (2.3)
Partner's age (years)	
≤19	0 (0)
20–29	12 (27.9)
30–39	24 (55.8)
40–49	6 (14.0)
≥40	1 (2.3)
Partner's national origin	
Japan	24 (55.8)
China	6 (14.0)
the Philippines	4 (9.3)
Korea	3 (7.0)
India	3 (7.0)
Peru	1 (2.3)
Taiwan	1 (2.3)
Myanmar	1 (2.3)

Old-comer, staying in Japan at their grandfather/mother's age because of the war or other reasons.

<20 years old (OR = 2.71, 95% CI = 1.71–4.32), multipara (OR = 1.73, 95% CI = 1.27–2.36), not a college graduate (OR = 1.39, 95% CI = 1.03–1.88), single (OR = 1.79, 95% CI = 1.19–2.70), and a partner whose work was not full-time (OR = 1.81, 95% CI = 1.19–2.77). The multiple logistic regression with adjusted OR showed the associated factors as: multipara (OR = 2.39, 95% CI = 1.49–3.82) and physical violence from a male partner at some time in one's life (OR = 2.51, 95% CI = 1.18–5.32) (Table 3).

### Comparison of the prevalence of intimate partner violence among Japanese women and non-Japanese women

Of the JW, 31.4% (111 of 357 women) scored >9 on the VAWS. The rate for the NJW was 21.4% (9 of 43 women). This difference was not statistically significant ( $P = 0.19$ ). The VAWS total scores ranged from 7 to 18 among the JW (mean = 8.24, median = 7.5, SD = 1.72) and from 7 to 11 among the NJW (mean = 7.93, median = 8.0, SD = 1.20). There was no statistically significant difference between the groups for their average total scores ( $t [63.08] = 1.50, P = 0.14$ ). However, statistical significance was found for two items by JW: “frightened by what he does or says” ( $t [73.76] = 4.24, P \leq 0.00$ ) and “partner ever kicked or hit you” ( $t [356.00] = 3.52, P = 0.00$ ) (Fig. 2).

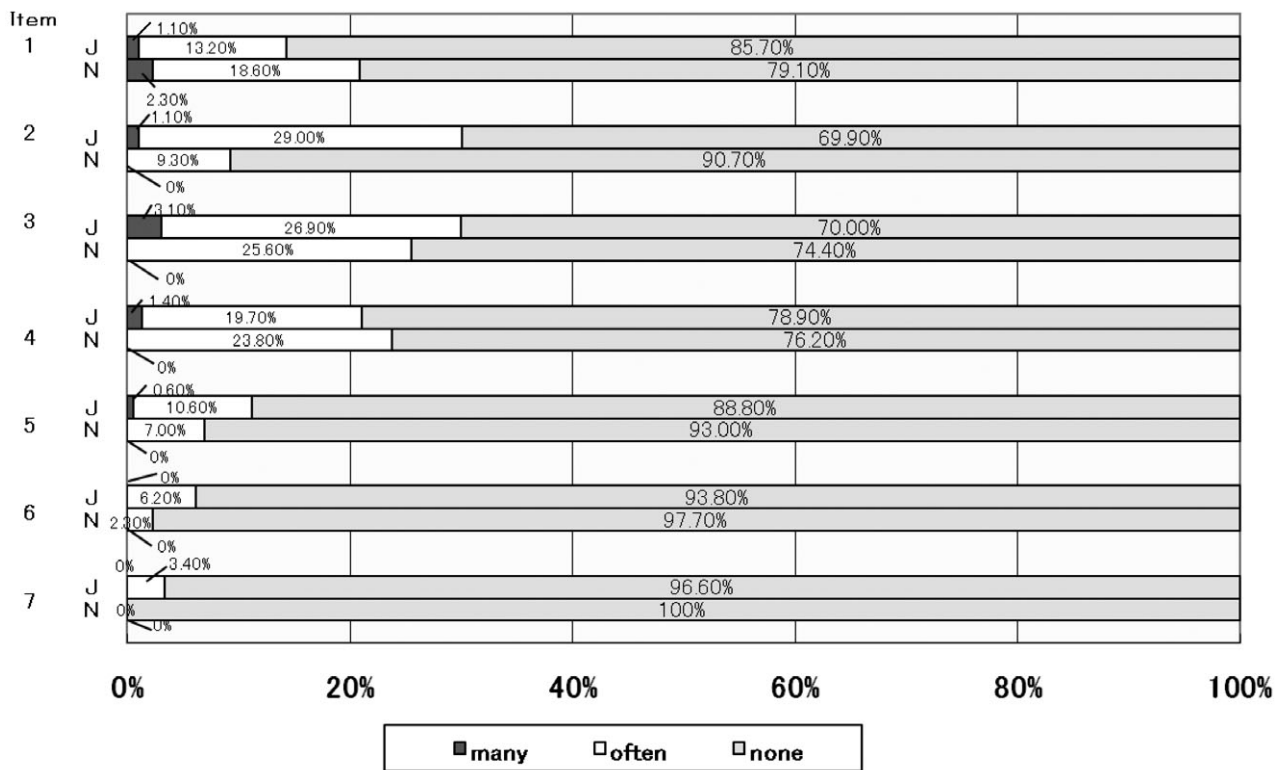
### Description of non-Japanese women in relation to the Violence Against Women Screen score

As the numbers for analysis were small, the data are presented descriptively, without statistical testing. As might be expected because of their majority in the sample, the women from the Philippines showed a higher rate of positive scores on the VAWS (45.5% in contrast to 12.9% for all other NJW combined). Yet, even through the major reason for the NJW to come to Japan was to study, none of the Filipino women came for study. Of the three women who had Japanese nationality, one had a positive IPV score. Similar to the results for the total sample, multiparas seemed more likely to have positive scores. The two single women in the sample both scored IPV-positive. Four women who had no one, other than their partner to consult with, screened IPV-negative and all five of the women who worked full-time also screened IPV-negative. The living arrangements seemed to be important as three of the four women living apart from their partner had positive scores for IPV, as did three of the four women living with their partner's family. We could see no trend of

**Table 3** Associated factors with adjusted odds ratios (*n* = 400)

Characteristic	N	P-value	Adjusting OR (95% CI)
Age (teenager)	395	0.26	4.04 (0.35–46.64)
Parity (multipara)	394	0.00	2.39 (1.49–3.82)*
Educational background (less than college graduate)	395	0.47	1.20 (0.73–1.95)
Marital status (single)	394	0.16	1.99 (0.77–5.14)
Experience of physical violence by male partner (yes)	395	0.02	2.51 (1.18–5.32)*
Partner’s working status (other than full-time job)	395	0.13	2.13 (0.80–5.65)

\**P* < 0.05. CI, confidence interval; OR, odds ratio.



**Figure 2** Frequencies of Violence Against Women Screen. Japanese women (J): *n* = 357; non-Japanese women (N): *n* = 43. Items: 1, Difficult to settle arguments between you and your partner by talking; 2, Afraid of what he said; 3, Yelled; 4, Hit the wall or threw objects; 5, Forced you to have sex; 6, Pulled your arm, pushed, slapped you; 7, Hit or kicked.

IPV-positive scores and age, migrant background, or length of stay in Japan. In terms of the characteristics of the husbands/partners, the women whose partners were in their 20s and not working full-time seemed more likely to have positive scores on the VAWS.

As a result of reports in the literature, we looked carefully at the nationality of the partners. The women who had a Japanese partner were more likely to have positive scores (26.1%) on the VAWS compared

to those women with non-Japanese husbands/partners (15.8%).

**Women’s responses regarding consultation with nurses or midwives about intimate partner violence**

Most women (97.3%) indicated that they did not feel discomfort in being asked to respond to questions about their relationship with their partner; the others (4.3%)

indicated little discomfort. With respect to wanting consultation support from a nurse or midwife if they had any problems with their husband/partner, 21.3% said they would want such consultation, 20.8% did not want consultation support, and 60.8% answered “difficult to say”.

## DISCUSSION

### Comparison of the relevance of intimate partner violence between Japanese women and non-Japanese women

The clinical and research question addressed the possibility of differences between non-Japanese pregnant women living in Japan, compared to native-born pregnant women of Japanese nationality, with respect to their current exposure to IPV. In this study, the percentage of NJW with current experience of IPV was 21.4%, in contrast to 31.4% among JW. This difference was not statistically significant.

Several comparisons of the data from this study to those elsewhere are presented. In the USA, Raj and Silverman (2003) found high IPV-positive rates (40.8%) among South-Asian immigrant women. This compares to 6–16% among all women in the USA (Amaro, Fried, Cabral & Zuckerman, 1990; Goodwin *et al.*, 2000; McFarlane, Parker & Soeken, 1996; Yost, Bloom, McIntire & Leveno, 2005). Cohen & Maclean (2003) reported Canadian native women are at higher risk for IPV compared to immigrants in Canada. In another study from Canada, Brownridge and Halli (2002) categorized immigrants in terms of their country of origin and compared three groups, with the following findings about their experience of IPV for the previous 5 years: immigrants from developing countries were at highest risk (5.5%), next were women born in Canada (3.7%), and at lowest risk were immigrants from developed countries (2.4%). Comparing the results of studies of IPV among immigrants in Canada and USA with those of NJW in Japan indicated different results. It is important to consider the national background in IPV research about people from overseas because the historical background and characteristics of immigrants are different.

### Characteristics of non-Japanese women who screened positively for intimate partner violence

In this first study of the prevalence of IPV during pregnancy among NJW in Japan, 21.4% of the NJW screened positive for IPV. Almost all of the NJW

(93.0%) were from Asia. The sample of NJW is small ( $n = 43$ ), so generalizations should be approached cautiously. We carefully looked at our results and found two noteworthy characteristics: the women who were from the Philippines scored highly for IPV and the NJW married to Japanese men had higher IPV scores.

The women from the Philippines showed a higher rate of positive scores on the VAWS (45.5%) compared to women of other nationalities (12.9%). This rate is higher than the rate identified by the United Nations (2007), which reported that at least one out of ten women in the Philippines had experienced some form of IPV, even when pregnant. Australian researchers estimated that IPV against Filipino women was linked to a patriarchal family model that is rooted in Filipino cultural and religious beliefs (Hunt & Gatbonton, 2000). Also, we assume that Filipino women's reason for coming to Japan might be related to IPV. None of the Filipino women came to Japan for study, even though the major reason for the NJW to come to Japan was study. Of the Filipino women, five came for marriage and three came for work. In the Philippines, they export many immigrants to all over the world and women often work as domestic workers or nurses (UNFPA, 2006). However, in Japan, many Filipino women were working as commercial sex workers (Kasama, 2000). We assume that their migrant background, not just their current circumstances, might be related to their current experience of IPV.

The rate of IPV from Japanese men to NJW was found to be higher than that of IPV from non-Japanese men to NJW, which is similar to another qualitative report (Lee, 2004). International marriage is increasing in Japan and almost 80% of couples are a Japanese husband with a non-Japanese wife (Health and Welfare Statistics Association, 2007b). Ijyuu Roudousha to Renkei suru Zennkoku Network (2007) suggested that this is consistent with the demand of Japanese men for marriage based on patriarchy and the desire of NJW, especially Asian women, to live in Japan. Sometimes, marriage provides the opportunity for human trafficking, as well as granting the request of women for child bearing and successors to take the role of caregivers for grandparents.

The life situations of NJW can be difficult. From the perspective of a Japanese non-governmental agency working with foreign residents, Ijyuu Roudousha to Renkei suru Zennkoku Network (2007) suggested that coerced assimilation in Japan and the neglect of their native culture by their Japanese husband/partner and family are stressful for migrant women, especially



women who are not literate in Japanese. Those women have difficulty accessing minimum information in order to live their life and are socially isolated. In many cases, their abode was decided by their husband and sometimes this was far from the women's cultural community. Thus, a lack of cross-cultural understanding might be associated with the risks for IPV among NJW. A case report by Hayashida & Kataoka (2008), which reflected our findings, was about a woman from South Asia who came to Japan for employment. She married a Japanese man who then abused her.

### Prevalence of intimate partner violence and the associated factors

The prevalence estimate for IPV in this study of 31.4%, using the VAWS, is higher than that of Kataoka (2003) (23.4%), who used the same instrument. Although both studies were conducted in Tokyo, this difference could be because of the variance of the study setting and background of the participants. The participants in this study were younger, there were more multiparas, and they had lower education and less full-time employment than those of Kataoka (2003). These factors might contribute to the higher prevalence of IPV as the women would have fewer resources to exit the marriage.

Some studies have reported the prevalence of IPV during pregnancy in Japan as 5.0% (Kataoka *et al.*, 2005), 2.3–3.6% (Yada *et al.*, 2005 and Yada *et al.*, 2005), 1.1% (Katayama *et al.*, 2006), and 1.0% (Suzuki *et al.*, 2006). The lowest estimate was reported by women who attended a private clinic and responded to a self-administered questionnaire that was provided to them by a person who was not a health-care provider. Gazmararian's (1996) review indicated that the prevalence of violence during pregnancy ranged from 0.9% to 20.1% worldwide. The measures of violence, sampled populations, and study methods varied considerably across the studies, and these factors might affect prevalence estimates. We should develop more accurately standard measures of IPV during pregnancy in order to examine prevention and intervention strategies for IPV survivors in the future.

Two associated factors for IPV were identified in this study. Multiparas were 2.4-fold more likely to experience IPV than primiparas. Those who reported previous physical violence were 2.5-fold more likely to experience IPV than women who never experienced physical violence from a male partner. Other studies also have reported those two associated factors (Kataoka, Yaju, Eto, Matsumoto & Horiuchi, 2004; Suzuki *et al.*,

2006). Thus, these factors might be important to take into consideration in providing services or designing studies.

### Acceptability of intimate partner violence screening in Japan

For many women, pregnancy is often the first point of entry into the health-care system and perhaps the first contact with a helping profession (Jasinski, 2004). There is, however, a question about whether or not screening should be undertaken as part of routine care for women, especially those women of child-bearing age, where IPV can have damaging effects on the health of both the woman and her child. In the USA, IPV screening is routinely practised in prenatal clinics because of a professional association's recommendation (ACOG, 2002). However, the routine practise has come into question because of a lack of outcome evidence of effective treatment and intervention (CTFPHC, 2001; Ramsay, Richardson, Carter, Davidson & Feder, 2002). Five organizations from North America and Europe that had screening guidelines concluded that it was "difficult to say" if IPV screening was effective or not (Kataoka, 2007). In Japan, women-centered care working group of St. Luke's college of Nursing (2004) pioneering in its assertion that "IPV screening is usually recommended (Kataoka, 2005)." But, because the evidence to support screening guidelines is mainly from the USA, further study to build evidence that is relevant to Japan is needed (Kataoka).

In Japan, however, not many medical persons are concerned about IPV. According to Tomoda *et al.* (2000), to intervene into private relations are "taboo" and "tactless or rude" in Japanese culture. This might be one reason that there is little active support for IPV screening in clinical settings. Another possibility is that health-care providers simply trivialize IPV (Nemoto, Rodriguez & Valhmu, 2006). However, in this study, most women (97%) did not report feeling discomfort when questioned about their relationship with their partner. This would be an unexpected finding, based on the results of Tomoda *et al.*, and yet is consistent with Kataoka's (2003) earlier findings, using the same instrument and similar procedures. As asking about one's relationship with one's partner is private and sensitive, the careful wording of questions is necessary.

In addition to responding to questionnaires, one in five (21.3%) women in this study was willing to have consultation with nurse-midwives for IPV support. Thus, hospitals should be more concerned about IPV support for all women who might wish for information

or need help. As a minimum service, hospitals should put IPV resource cards in multiple languages in the outpatient restroom. Also, given that there are increasing proportions of foreigners in Japan, multicultural pamphlets and the use of medical translators are needed in the future.

### Limitations of the study

This is the first report of the prevalence of IPV among NJW in Japan. There are limitations of the study. The data were collected in only one maternity unit in an urban area of Tokyo; the sample was not population-based. Further studies are needed in different areas of the country and also in different settings to establish the generalizability of the findings. Moreover, due to a small sample size of NJW, the associated factors of IPV among them could not be described. The four languages that were used for the questionnaire did allow almost all women to participate in the survey. However, some needed assistance. Researchers must continue to design valid and reliable multicultural and multilingual questionnaires to investigate IPV against NJW in Japan.

### CONCLUSION

This study, with its sample of 357 JW and 43 NJW, found no statistically significant difference in the prevalence of IPV: 31.4% among JW and 21.4% among NJW. The prevalence of IPV among all the responders was 30.1%. From the data analysis of the total sample, two associated factors for IPV were identified: being a multipara and previous experience of physical violence by a male partner. As the women reported that they were willing to respond to questions about their relationship with their partner, it might be inferred that the VAWS is acceptable and the women are willing to seek consultation. Therefore, we cautiously claim that IPV is a topic that can be discussed with pregnant women. Intimate partner violence support services should be expanded in hospitals and maternity clinics in Japan.

### ACKNOWLEDGMENT

This study was supported by a grant from the Ministry of Education, Science, Culture and Sports, Japan (no. 17390595).

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