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Abstract

Background: Violence against women is a public health issue worldwide, affecting the physical and mental wellbeing of women, children and families.

Aim: To determine the socio-demographic and economic factors contributing to violence against women in Morocco and offer recommendations for the prevention and reduction of violence.

Methods: Data for this study was obtained from the 2018 National Population and Family Health Survey. We applied the Chi-square test and t-test to study the possible associations between some socio-demographic and economic variables and violence against women. We performed a logistic regression to indicate the simultaneous association of the variables.

Results: Among 9969 ever-married women aged 15–49, 15.0% [CI (95%): 14.3-15.7%] had suffered an act of violence in the last 12 months preceding the survey (17.0% in urban and 11.9% in rural areas). Violence against women depended significantly on age, age at first marriage, marital status, total children ever born, educational level, wealth index, being a household head, employment status, decision-maker regarding employment, number of marriages ever had, smoking, relationship with the husband, husband's age, husband's educational level, husband’s polygamy, area of residence, and region of residence (P

Conclusion: Violence against women has reached endemic proportions in Morocco and this

has serious consequences for population health and the country's economy. There is a need to reinforce and better structure public health programmes to sustainably prevent or reduce violence against women in the country. It is also important to take actions to mitigate the risk factors and provide adequate and quality care for victims.

Keywords: violence, women’s health, ever-married women, demography, Morocco.

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Introduction

Global estimates for 2018 show that 26% (~641 million) of ever-married/partnered women aged ≥ 15 years and 27% (~753 million) of those aged 15–49 years have been subjected to physical and/or sexual violence from a current or former husband or male intimate partner at least once since the age of 15 years (1). Similarly, 10% (~245 million) of ever-married/partnered women aged ≥ 15 years and 13% (~307 million) of those aged 15–49 years have been subjected to physical and/or sexual intimate partner violence at some point within the past 12 months. Violence against women is a flagrant violation of human rights and a worldwide public health issue (2, 3). Physical and mental health and well-being of women, children, and families are adversely affected by violence against women in the short, medium, and long terms (4–6). There are also serious social and economic repercussions for countries and societies (7).

Over 3 decades ago, violence against women was acknowledged on a global scale as a severe and ubiquitous scourge on women’s lives, health, and rights (8). Women’s health and rights organizations have long been calling for elimination of violence against women. These appeals have their roots in many international agreements and consensus texts; most notably, the 1993 United Nations Declaration on the Elimination of Violence Against Women and the 1995 Beijing

Platform for Action. Thus, WHO resolution WHA69.5 encourages all countries to engage on the path to achievement of the Sustainable Development Goals (SDGs), including Target 5.2: “Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation”; Target 16.1: “Significantly reduce all forms of violence and related death rates everywhere”; and Target 16.2: “End abuse, exploitation, trafficking, and all forms of violence against and torture of children”.

Health systems can play a role in preventing and combating all forms of interpersonal violence, particularly against women and children, which remains hidden (9).

The battle against violence against women in Morocco is relatively recent (10); however, several achievements have been made (11). Morocco has acceded to international human rights instruments, including the main international conventions and programmes. Morocco has shown its willingness to reduce social, territorial, and gender inequalities and democratize the system of governance. Individuals’ rights are protected by dedicated independent institutions and civil society organizations, supported by the rule of international law, as set out in the Moroccan Constitution.

The Moroccan Ministry of Health and Social Protection has been involved in all these changes. The ministry has institutionalized the National Health Program for the Care of Women and Children Victims of Violence, which focuses on 4 strategic areas: (1) quality care delivery at multiple levels of the care system; (2) prevention as an important means of reducing new cases; (3) advocacy, communication, promotion of gender equality, and strengthening coordination; and (4) research, knowledge development, and evaluation to strengthen the scientific evidence around violence. The inclusion of issues related to violence against women in the 2018 National Survey of Population and Family Health was an important step towards realizing this final area.

The survey for ever-married women aged 15–49 years contained several questions about violence against women; whether they had experienced physical, sexual, or psychological abuse, including domestic violence, in the last 12 months. The survey showed that 15% of women aged 15–49 years had experienced violence in the 12 months preceding the survey (12). This proportion exceeds the WHO estimate of 10% for Morocco in 2018 (1). Abuse was reported by 17% of urban and 11.9% of rural women. Women in the Casablanca–Settat Region reported the highest prevalence of violence (22.5%), followed by those in Rabat–Salé–Kénitra Region (17.1%). Verbal abuse was the most prevalent (89.8%), followed by psychological (34.5%) and physical (20.2%) abuse. Nonfamily members were claimed to have assaulted women the most (40.8%), followed by spouses (38.4%), and 65.1% of women reported being abused at home, while 27.5% reported being abused on the street (12). There were some

differe–ces according to sociodemographic and economic variables such as age group, educational level, and well-being quintile.

This study was an in-depth analysis of the 2018 National Survey of Population and Family Health to test the significance of observed differences and identify the main sociodemographic and economic determinants of violence against women in Morocco. The issue of violence against women is now more topical than ever, given its epidemic proportions and its consequences on population health and the country's economy. The main objective of this study was to contribute to the prevention and reduction of violence against women in Morocco through increased awareness of the explanatory sociodemographic and economic factors.

Methods

National Population and Family Health Survey

The Moroccan Ministry of Health and Social Protection uses an internationally recognized standard methodology to conduct periodic demographic and health surveys (13). These surveys are justified by the need to carry out periodic assessments of population health and to evaluate the impact of the policies and programmes implemented. They provide up-to-date statistics to the government, civil society, and development partners in Morocco to better estimate the extent of health problems and assess progress. The National Population and Family Health Survey also assesses progress in implementing Morocco's international commitments, particularly in the context of the SDGs. Questions about violence against women were included for the first time in the 2018 survey.

This study was based on data from the 2018 National Population and Family Health Survey. The methodology, results, and more details on the survey can be found in the final report available on the website of the Ministry of Health and Social Protection (www.sante.gov.ma).

Variables and data analysis

We investigated the possible associations between sociodemographic and economic variables and violence against women. For categorical variables, we conducted a $\chi 2$ test to verify the significance of observed differences between groups (14). In the case of continuous variables, we determined the significance of the associations using Student's independent sample t test (15). After performing the $\chi 2$ test, t test, and screening the independent variables that had a significant association with violence against women, we performed logistic regression analysis to indicate the simultaneous association of the variables and calculated the odds ratios (ORs) and 95% confidence intervals (CIs). Continuous variables were: age; total number of children birthed; husband's age; wife–husband age difference; age at first marriage; and duration of marriage. Categorical variables were: marital status; educational level; wealth index; being

household head; employment status; health insurance (yes, no); decision-maker regarding work; number of marriages; smoking (yes, no); relationship with husband; husband's educational level; polygamous husband; husband with a permanent income; area of residence; and region of residence.

The prevalence of violence against women was calculated as the proportion of ever-married women aged 15–49 years who had suffered an act of violence in the last 12 months (16). This proportion was presented according to the selected sociodemographic and economic variables. The 95% CI was calculated using standard error (SE):

with p the estimated prevalence and n the sample size. Thus, 95% CI = p ± 1.96 SE(p)

Questions about the type, place, and perpetrator of violence had multiple answers, which corresponded to as many dichotomous questions (no/yes) as there were methods of response. Therefore, they were coded in several dichotomous variables (0/1). The questions were analysed based on the number of observations in the final report of the survey. Thus, the number of responses for each modality and the percentage of responses were calculated relative to the number of respondents (not responses). The total percentage could be > 100% because several answers were possible. This percentage could be interpreted by noting that each respondent has an average of appendices. In contrast, the questions were analysed according to the number of responses in our study. This method showed different results from the published results, but it allowed us to quantify the weight of each response modality relative to the other modalities because the sum of the percentages was 100%.

Data source

The database of the 2018 National Population and Family Health Survey is not publicly available. However, it can be requested by contacting the Moroccan Department of Studies and Health Information (dpeseis@gmail.com). Dr. Ahmed Abdelmonem (demographic and health surveys expert), who made a significant contribution to the execution of the 2018 and previous surveys in Morocco and other Arab countries, provided the data.

Data analysis

SPSS version 26.0 and Microsoft Excel 2016 were used to analyse the data.

Results

Sociodemographic and economic characteristics of respondents

The 2018 National Population and Family Health Survey was completed by 9969 women aged 15–49 years, with a response rate of 99.5%. Most of the women surveyed (72.0%) were aged 25–44 years, 15.1% were Table 1). For marital status, 93.3% were married, 4.4% divorced, and 2.3% widowed. At the national level, the women were evenly distributed according to wealth index (~20.0% for each quintile). However, poverty was more common in rural than in urban areas.

At the national level, 13.0% of ever-married women aged 15–49 years were employed at the time of the survey. The percentage of employed women differed depending on where they lived, with 17.8% in urban and 5.8% in rural areas. According to educational level, 42.0% of women with a secondary level or higher education were employed, compared with 12.0% of those with a basic level (primary and college) of education, and 9.3% of those with no education. The distribution of employed women according to the household wealth index showed some disparities, with 21.8% of women from the richest families employed compared with 14.5% from the fourth quintile, 13.9% from the third quintile, 9.4% from the second quintile, and 6.5% from the poorest households.

Type, place, and perpetrator of violence against women

The type of violence experienced by ever-married women aged 15–49 years in the 12 months before the survey was verbal (60.0%), psychological (23.0%), physical (14.0%), sexual (3.0%), and other types (1.0%). Women were subjected to violence at home (61%), on the street (26%), at work (6%), at the market or an educational institution (1% each), and other locations (5%). In most cases, the perpetrator of violence was someone outside the family (38.0%), followed by the husband (35.0%), a family member (23.0%), and in 4.0% of cases, violence was perpetrated by another person.

Sociodemographic and economic determinants of violence against women

The average age of women included in the study was 34.8 (0.16) years (P Table 2). The average age of husbands was 42.6 (0.20) years (P 0.05). The average age at the first marriage was 21.2 (0.10) years (P 0.05). The average duration of marriage was 13.3 (0.17) years (P > 0.05).

Violence during the 12 months preceding the survey was experienced by 15.0% (95% CI: 14.3–15.7%) of ever-married women aged 15–49 years. This violence mainly affected divorced (30.1%) and married women (14.3%) (Table 3). The prevalence of violence against women increased significantly with age (P = 0.003), from 6.2% at 15–19 years to 16.3% at ≥ 40 years.

Violence increased significantly with women's educational level (P

The variables significantly associated with violence against women were subjected to logistic regression analysis (Table 4). The following variables simultaneously and significantly influenced the probability of violence against women: educational level, employment status, decision-maker regarding work, number of marriages, husband's educational level, polygamous husband, area of residence, and region of residence (P

Discussion

We investigated the possible associations between sociodemographic and economic factors and the prevalence of violence against ever-married women aged 15–49 years in Morocco. The 2018 National Population and Family Health Survey final report revealed that the overall prevalence of violence against ever-married women of reproductive age in the past 12 months preceding the survey was 15.0% (12). This prevalence exceeded the WHO global prevalence estimate (13.0%) and Moroccan estimate for the same year (10.0%). In contrast, it was below the WHO Eastern Mediterranean and African Regions prevalence estimates, where 17.0% and 20.0% of ever-married/partnered women aged 15–49 years were subjected to physical and/or sexual violence from a current or former husband or male partner in the past 12 months (1).

Our results showed that violence was mainly among women aged ≥ 20 years (> 14.0%). This is similar to WHO estimates that showed that 10.0–16.0% of women aged 20–44 years had experienced violence in the past 12 months (1). Our analysis showed that violence against women in Morocco increased significantly with age. This was also reported by Ennaji in 2011 (17) and Boughima et al. in 2018 (18). In contrast, Peters and colleagues discovered that rates of domestic violence decreased as women's age decreased, and younger reproductive-age women have roughly 10 times the risk of domestic abuse than older women have (19). The link between age and violence against women has been demonstrated in several countries, including Morocco (17, 18), India (20), Turkey (21), Sweden (22), and the United States of America (23). We found that the prevalence of violence increased significantly with women's level of education. The 12.8% reported by women with no education increased to > 17.0% among women with a middle or secondary school level of education, and > 20.0% among women with higher education. Similarly, the prevalence of violence was higher among women in richer than poorer households. Some of these findings seem paradoxical because it has been demonstrated worldwide that prevalence of violence is significantly associated with lower well-being conditions (24). They may reflect a different tolerance of violence against women, taking into account their level of education, standard of living, age, and place of residence, and not simply a reflection of violence experienced. Many women were of the opinion that a husband has the right to hit his wife if he considered that she had behaved improperly (24). Kebede et al. also showed that women in lower socioeconomic categories may not necessarily face higher rates of violence (25).

We found that verbal violence predominated (60.0%) among ever-married women aged 15–49 years who experienced violence in the 12 months preceding the survey, followed by psychological (23.0%), physical (14.0%), and sexual (3.0%) violence. According to the 2018 WHO global combined estimates, 31.0% of women aged 15–49 years and 30.0% of women aged ≥ 15 years experienced physical and/or sexual violence from current or former husbands or male intimate partners, and/or men who were neither husbands nor intimate partners (1). We found that most cases (61.0%) of violence against women took place at home, which confirmed the findings of many other studies (5, 26–29). Street violence is not a trivial phenomenon in Morocco and accounted for 26.0% of attacks against women. The perpetrators of violence were mostly husbands (35.0%) and family members (23.0%). Even though violence against women is mainly inflicted by husbands and intimate partners, it also occurs in a family or community context, as well as economic, social or political violence. We can even find self-inflicted violence as a consequence of psychological violence suffered by women.

The World Bank has shown that violence against women is estimated to be a more common cause of death and disability worldwide than cancer among women of childbearing age, and causes more health problems than traffic accidents and malaria combined (30). Similarly, our study showed that violence against women in Morocco was a serious public health issue. Several other studies worldwide have provided evidence of a correlation between exposure to violence and effects on the physical, mental, sexual and reproductive health of women, as well as their children's health (2, 31–34). Several consequences can occur, such as: teenage and unwanted pregnancies, miscarriages, and stillbirths; sexually transmitted infections; intrauterine haemorrhage; nutritional deficiencies; abdominal pain and gastrointestinal disorders; neurological disorders; chronic pain; disabilities; anxiety and post-traumatic stress; hypertension; cancer; and cardiovascular diseases. There are reports of a close link between exposure to violence and physiological mechanisms, explaining certain harmful effects on health through complex neural, neuroendocrine, and immune responses of the body when it is exposed to stressful situations (5, 35).

One limitation of our study was that several potentially important variables were ignored, such as: the state of the relationship between the aggressor and victim; history of mental illness in both partners; history of substance use disorders; and history of criminality. Those variables were not present in the 2018 National Population and Family Health Survey, so we could not add them to our analysis. The strength of this study was that it was an in-depth analysis of the 2018 survey with a representative sample of 9969 women from 15 022 households. This large nationwide sample means that the results can be generalized to all Moroccan women.

Despite the efforts already made to combat violence against women in Morocco, more needs to

be done. The issue is more topical now than ever, given its epidemic proportions and its health and economic consequences. Based on the results of our study we call upon decision-makers in Morocco to: create and enact legislation that supports gender equality; invest in and empower independent organizations that advocate women's rights; review discriminatory norms and attitudes towards women and girls, especially concerning the legitimacy of violence against women; strengthen related data collection, communication, and use; maintain and enhance local and national prevention programmes and strategies based on solid evidence; and strengthen the comprehensive, easily available, and high-quality survivor-centred services for victims of violence.

Conclusion

Our study shows that violence against women depends significantly on sociodemographic and economic factors related to women as well as the perpetrators of violence, such as: age; age at first marriage; marital status; number of children birthed; educational level; wealth index, being household head; employment status; decision-maker regarding work; number of marriages; smoking; relationship with husband; age at first marriage; husband's age; husband's educational level; husband's polygamy; area of residence; and region of residence. Our study demonstrates that violence is a socioeconomic phenomenon that affects the fringes of society in Morocco, particularly the most vulnerable populations. The 2018 National Population and Family Health Survey shows that violence against women in Morocco is a public health problem that is reaching worrying proportions, with 15.0% of ever-married women aged 15–49 years affected, and a predominance in the large conurbations. Therefore, preventive programmes should be directed towards the large urban centres. It is worth stressing the particularly high frequency of domestic violence against young, rural, and uneducated women. This violence has a psychological impact in particular, is perpetrated mainly by husbands or family members, does not necessarily leave physical traces, and could explain, along with the profile of the abused woman, the reluctance to seek help.

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Prévalence, déterminants socio-démographiques et économiques des

violences à l’égard des femmes mariées ou l’ayant déjà été au Maroc

Résumé

Contexte : La violence à l'égard des femmes constitue un problème de santé publique dans le monde entier, qui a des conséquences sur le bien-être physique et mental des femmes, des enfants et des familles.

Objectif : Déterminer les facteurs socio-démographiques et économiques contribuant à la violence envers les femmes au Maroc et formuler des recommandations afin de prévenir et de réduire ces violences.

Méthodes : Les données utilisées pour cette étude ont été obtenues à partir de l'enquête nationale sur la santé de la population et de la famille menée en 2018. Nous avons appliqué le test du chi-carré et le test T pour étudier les associations possibles entre certaines variables socio-démographiques et économiques et la violence à l'égard des femmes. Nous avons procédé à une régression logistique pour déterminer l'association simultanée des variables.

Résultats : Sur 9969 femmes âgées de 15 à 49 ans mariées ou l'ayant été, 15,0 % [IC à 95 % : 14,3-15,7 %] avaient subi un acte de violence au cours des 12 mois précédant l'enquête (17,0 % en milieu urbain et 11,9 % en milieu rural). La violence à l'égard des femmes dépendait considérablement des éléments suivants : l'âge ; l'âge au moment du premier mariage ; le statut matrimonial ; le nombre total d'enfants nés ; le niveau d'éducation ; l'indice de richesse ; le fait d'être chef de famille et décideur en matière d'emploi ; le statut professionnel ; le nombre de mariages ; la consommation de tabac ; la relation avec le mari ; l'âge, le niveau d'éducation, la polygamie de ce dernier ; ainsi que la résidence en milieu urbain/rural et la région de résidence (valeur p