INFLUENCE OF PREGNANCY WOMEN'S POWER FACTORS AND DOMESTIC VIOLENCE ON THE RISK OF INFECTION WITH HIV/AIDS

PINTIPPA SANGWAN

A THESIS SUBMITTED IN PARTIAL FULFILLMENT
OF THE REQUIREMENTS FOR
THE DEGREE OF MASTER OF ARTS
(MEDICAL AND HEALTH SOCIAL SCIENCES)
FACULTY OF GRADUATE STUDIES
MAHIDOL UNIVERSITY
2008

Thesis

Entitled

INFLUENCE OF PREGNANCY WOMEN'S POWER FACTORS AND DOMESTIC VIOLENCE ON THE RISK OF INFECTION WITH HIV/AIDS

Pintippa Sangwan
.....
Miss Pintippa Sangwan
Candidate

.....
Assoc. Prof. Siriwan Grisurapong,
Ph.D. (Population and
Development(Health))
Major-Advisor

Veena Sirisook.
.....
Asst. Prof. Veena Sirisook,
Ph.D. (Health and Psychology)
Co-Advisor

S. Tanchainan
.....
Assoc.Prof. Sucheela Tanchainan,
M.A. (Development Studies)
Co-Advisor

B. Mahaisavariya
.....
Prof. Banchong Mahaisavariya, M.D.
Dean
Faculty of Graduate Studies

S. Tanchainan
.....
Assoc.Prof. Sucheela Tanchainan,
M.A. (Development Studies)
Chair
Master of Arts Programme in
Medical and Health Social Sciences
Faculty of Social Sciences and Humanities

Thesis

Entitled

INFLUENCE OF PREGNANCY WOMEN'S POWER FACTORS AND DOMESTIC VIOLENCE ON THE RISK OF INFECTION WITH HIV/AIDS

was submitted to the Faculty of Graduate Studies, Mahidol University

for the degree of Master of Arts (Medical and Health Social Sciences)

On

May 29, 2008

Pintippa Sangwan

Miss Pintippa Sangwan
Candidate

Asst. Prof. Vanawipha Pasandhanatorn
Ph.D. (Social Administration)
Chair

Asst. Prof.Suchada Ratchukul,
Ed.D (Developmental Education)
Member

Assoc. Prof. Siriwan Grisurapong,
Ph.D. (Population and
Development (Health))
Member

Assoc.Prof. Sucheela Tanchainan,
M.A. (Development Studies)
Member

Asst. Prof. Veena Sirisook,
Ph.D. (Health and Psychology)
Member

Prof. Banchong Mahaisavariya, M.D.
Dean
Faculty of Graduate Studies
Mahidol University

Assoc.Prof. Wariya Chinwanno, Ph.D.
Dean
Faculty of Social Sciences and Humanities
Mahidol University

ACKNOWLEDGEMENTS

I wish to express my sincere gratitude and appreciation to my major advisor, Associate Professor Dr. Siriwan Grisurapong, for her excellent supervision, great assistance, valuable guidance, understanding and constant encouragement throughout this study.

I am sincerely grateful to Assistant Professor Dr. Vanawipha Pasandhanatorn, chairwoman of the thesis defense committee, Associate Professor Dr. Mullika Mattiko the proposal external examiner, my co-advisor, Assistant Professor Dr. Veena Sirisook, Associate Professor Dr. Sucheela Tanchainan, for their kind assistance, valuable advice and comments.

I am also very grateful to Assistant Professor Dr. Suchada Ratchukul, the thesis external examiner, for the time she provided to me giving me valuable suggestions and comments during my thesis defense.

My gratitude also goes to the lecturers and staff of the Department of Social Sciences, for their teaching, suggestions and assistance during my study at the Faculty of Social Sciences and Humanities.

My sincere appreciation also is extended to the director of the Rajvithi Hospital, for his permission to collect the data, the head, and staff of the antenatal care clinic for their kind cooperation during data collection.

I would like to thank all of my friends for their warm friendship, helpful guidance, and valuable encouragement.

In addition, I also like to thank all pregnant women who participated in this study for their willingness to answer the questionnaire and their valuable cooperation.

Finally, I am deeply grateful to my parents, for their love and sincere encouragement as well as their great moral support throughout my study, which helped me to achieve my goal as desired.

Pintippa Sangwal

INFLUENCE OF PREGNANCY WOMEN'S POWER FACTORS AND DOMESTIC VIOLENCE ON THE RISK OF INFECTION WITH HIV/AIDS

PINTIPPA SANGWAN 4737509 SHMS/M

M.A. (MEDICAL AND HEALTH SOCIAL SCIENCES)

THESIS ADVISORS : SIRIWAN GRISURAPONG, Ph.D.,
VEENA SIRISOOK, Ph.D., SUCHEELA TANCHAINAN., M.A.

ABSTRACT

This study investigated whether the risk of pregnant women being infected with HIV/AIDS is dependent on the ability (power) of pregnant women to control sexual relationships or not, decide about family matters or not, and if they are or are not exposed to their partner's dominance and domestic violence. Domestic violence can be classified as being physical, psychological/emotional or involving sexual abuse. The investigation also included information about the demographic background of the study participants and husbands/partners; their socio-economic status; the type of violence in the family and risk behaviors of pregnant women and husbands/partners that may possibly result in HIV/AIDS infection; such as alcohol consumption, drug and substance abuse, sexual relationships with other persons besides the spouse, inability to negotiate use of a condom or the refusal to use one.

A questionnaire was developed as a research tool. A purposive sampling method selected a group of 360 pregnant women visiting the antenatal care clinic of the Rajvithi Hospital in Bangkok, who were asked to participate in the investigation. The study was conducted from January 2007 to February 2007. Data were analyzed by using descriptive statistical tests as well as using the Chi-square test.

The results of the investigation revealed that most of the study participants neither had a bad nor an extraordinarily good sexual relationship, could somehow control the sexual relationship, were more or less involved in decision-making and sometimes were exposed to domestic dominance. However they often experienced physical, psychological/emotional and sexual abuse. The variables associated with the ability (power) to control sexual relationship were education, occupation, income of the participants, education of the husbands/partners, experience of violence in the family, sexual contacts with another man, refusal of the husband/partner to use a condom, alcohol consumption of the husband/partner, sexual contacts with a prostitute or another women. The variables related to the ability (power) of decision-making in the family were linked to the occupation of pregnant women, violence in the family, and the sexual relationship of the husband/partner with other women. Variables such as education, occupation, income, alcohol consumption, and marital status of participants; education and income of husbands/partners as well as the refusal of husbands/partners to use condoms had an influence on domestic violence.

The results of this study hint towards a connection of the ability (power) of pregnant women to control sexual relationships and be involved in decision-making and women exposed or not to husband's/partner's dominance, with the risk of infection with HIV/AIDS. Hence HIV/AIDS is recognized as a grave public health problem, in order to prevent the further spread of HIV/AIDS, the health personnel concerned should work on a policy preventing both domestic violence and the spread of HIV/AIDS. The inability to control sexual matters, the distorted gender role and inequality for women may expose women to an increased risk for HIV infection. An appropriate policy should aim to succeed in a positive development, which will give more power and confidence to women. Such a development will significantly change the relations between women and men at all levels of the society.

KEY WORDS : PREGNANCY WOMEN / POWER FACTORS / DOMESTIC VIOLENCE / RISK TO HIV/AIDS INFECTION

158 pp.

ความสัมพันธ์ระหว่างปัจจัยด้านอำนาจ ความรุนแรงในครอบครัวและพฤติกรรมเสี่ยงต่อการติดเชื้อ HIV/AIDS ของหญิงตั้งครรภ์ในโรงพยาบาลราชวิถี (INFLUENCE OF PREGNANCY WOMEN'S POWER FACTORS AND DOMESTIC VIOLENCE ON THE RISK OF INFECTION WITH HIV/AIDS)

พินทิพย์พา สังวาลย์ 4737509 SHMS/M

ศศ.ม. (สังคมศาสตร์การแพทย์และสาธารณสุข)

คณะกรรมการควบคุมวิทยานิพนธ์ : ศิริวรรณ ไกรสุรพงศ์, Ph.D., วีณา ศิริสุข, Ph.D., สุชีลา ตันชัยนันท์, M.A.

บทคัดย่อ

การวิจัยครั้งนี้มีวัตถุประสงค์เพื่อวัดระดับของปัจจัยด้านอำนาจของหญิงตั้งครรภ์ (อำนาจในความสัมพันธ์ทางเพศ, การควบคุมความสัมพันธ์, การครอบงำการตัดสินใจ และอำนาจการตัดสินใจภายในครอบครัว) เพื่อวัดขนาดความรุนแรงในครอบครัวที่เกิดกับหญิงตั้งครรภ์ ในด้านร่างกาย จิตใจ และเพศ รวมทั้งเพื่อศึกษาความสัมพันธ์ระหว่างปัจจัยทางด้านเศรษฐกิจ สังคม ประชากรของหญิงตั้งครรภ์และสามี/คู่รัก (อายุ, การศึกษา, อาชีพ, รายได้และสถานภาพสมรส) กับปัจจัยด้านอำนาจและความรุนแรงในครอบครัว, ความสัมพันธ์ระหว่างปัจจัยด้านอำนาจของหญิงตั้งครรภ์กับความรุนแรงในครอบครัว และพฤติกรรมเสี่ยงต่อการติดเชื้อ HIV/AIDS ของหญิงตั้งครรภ์และสามี/คู่รัก (การดื่มเครื่องดื่มแอลกอฮอล์, การใช้ยาและเสพติด, การมีเพศสัมพันธ์กับบุคคลอื่น, การขอร้อง/ต่อรองให้สามี/คู่รักใช้ถุงยางอนามัย และสามี/คู่รักปฏิเสธการใช้ถุงยางอนามัย) และศึกษาความสัมพันธ์ระหว่างความรุนแรงในครอบครัวกับพฤติกรรมเสี่ยงต่อการติดเชื้อ HIV/AIDS ของหญิงตั้งครรภ์ กลุ่มตัวอย่างเป็นหญิงตั้งครรภ์ที่มารับการฝากครรภ์ที่แผนกฝากครรภ์ โรงพยาบาลรามาธิบดี จำนวน 360 ราย ทำการเก็บข้อมูลโดยใช้แบบสัมภาษณ์ สถิติที่ใช้ในการวิเคราะห์ข้อมูลคือ ร้อยละ ค่าเฉลี่ย ส่วนเบี่ยงเบนมาตรฐาน และการทดสอบไคว์แสคว์

ผลการศึกษา พบว่า หญิงตั้งครรภ์ส่วนใหญ่มีอำนาจในความสัมพันธ์ทางเพศ, การควบคุมความสัมพันธ์, การครอบงำการตัดสินใจ และอำนาจการตัดสินใจในครอบครัวอยู่ในระดับปานกลาง ส่วนการได้รับความรุนแรงในครอบครัว พบว่า หญิงตั้งครรภ์ที่ได้รับความรุนแรงทั้งทางจิตใจ ร่างกาย และเพศมีสัดส่วนมากที่สุด ส่วนตัวแปรที่มีความสัมพันธ์กับอำนาจในความสัมพันธ์ทางเพศ ได้แก่ การศึกษา อาชีพ และรายได้ของหญิงตั้งครรภ์, การศึกษาของสามี/คู่รัก, ความรุนแรงในครอบครัว, การมีเพศสัมพันธ์กับชายอื่นในขณะอยู่กินกับสามี/คู่รักและการถูกสามี/คู่รักปฏิเสธการใช้ถุงยาง, การดื่มเครื่องดื่มแอลกอฮอล์ของสามี/คู่รัก, การมีเพศสัมพันธ์กับหญิงขายบริการและการมีเพศสัมพันธ์กับหญิงอื่นของสามี/คู่รัก ส่วนตัวแปรที่มีความสัมพันธ์กับอำนาจการตัดสินใจในครอบครัว ได้แก่ อาชีพของหญิงตั้งครรภ์, ความรุนแรงในครอบครัว, การมีเพศสัมพันธ์กับหญิงอื่นของสามี/คู่รัก และตัวแปรที่มีความสัมพันธ์กับความรุนแรงในครอบครัวได้แก่ การศึกษา อาชีพ รายได้และสถานภาพสมรสของหญิงตั้งครรภ์, การศึกษา และรายได้ของสามี/คู่รัก, การดื่มเครื่องดื่มแอลกอฮอล์ของหญิงตั้งครรภ์ และสามี/คู่รักปฏิเสธการใช้ถุงยางอนามัย

การศึกษาครั้งนี้แสดงให้เห็นว่า ปัจจัยด้านอำนาจ ความรุนแรงในครอบครัว และพฤติกรรมเสี่ยงต่อการติดเชื้อ HIV/AIDS ของหญิงตั้งครรภ์ ต่างก็มีความสัมพันธ์ซึ่งกันและกัน การวางแผนนโยบายในการแก้ปัญหาการแพร่ระบาดของโรคเอดส์จึงต้องพิจารณาอย่างรอบด้านทั้งการส่งเสริมด้านพลังอำนาจของผู้หญิง (Empowerment) และการแก้ไขปัญหาความรุนแรงในครอบครัวที่ต้องทำควบคู่กันไป

158 หน้า

CONTENTS

CONTENTS (CONT.)

CONTENTS (CONT.)

LIST OF TABLES

CHAPTER I
INTRODUCTION

Background and importance of the problem

Gender, as a term which refers to a construct based on social conceptions. Individuals follow their gender roles regardless of which biological sex they are as a child. In the process of socialization the behavior of the child is determined following the 'proper' gender attributes.

Men physically differ from women; and this is considered a biological issue. The gender role however relates to a given society, their culture and tradition and is imposed on men and women and influences the relationship between men and women (Pimpawan Boonmongkol, Nartruedee Dengduang ande Niporn Sanhajiriya, 2003). The issue of the gender role draws public interest because the difference in power, rights and responsibility depends on it and is the reason for the difference of women and men within the society. (WHO, 2002 cited by Turmen, 2003:411).

Due to gender inequity women may have less opportunity for gaining a higher education in comparison to men and may also disadvantaged in the economic status. In fact men and women don't differ in their ability to achieve a high education level and a good economic status. However, there are some differences in skills that are due to inequities in opportunity and experience for women and girls compared to men and boys. Most women in the labor force are working in the service sector or have other jobs with lower salary than men. Often the economic status of women's depends on the income of men, who is the leader of the family (UNAIDS, WHO & UNFEM). Nowadays Thai women achieve higher educational level; have better job opportunities and a higher income than before. Nevertheless in general the women's economic status depends on the husband's income. Due to the gender role women are subordinated to men and gender stereotypes usually decide what is expected of men and women within a given social structure. Women are expected to be weak, polite and respond to the men's needs, while men are expected to be tough, unfeeling, insensitive, and combative (Pimpawan Boonmongkol, Nartruedee Denduang ande

Niporn Sunhajariya, 2003). In Thai culture, the presence of the superiority of a patriarch or other men are clearly noticed since men are supposed to be the leader of the family, the owner or ruler of the home, and women just follow and do what men ask them to do (Thananowan, 2004: 10). It is according to the Thai proverb “husband is the front legs and his wife is the back legs of the elephant”.

The imbalance of power between men and women is the result of social structures and historical practices in regard to financial- and educational issues, as well as the exercise of authority and decision making. According to Pulerwitz the gender and power inequity let have men better access to social or interpersonal power than women. Inequities also can be observed in a multi cultural setting in which men has superiority power over women which also is true in case of sexual activities. Women are at a distinct disadvantage when considering both power and equity (Pulerwitz et al., 2000).

The gender-based power in the sexual relationship of men and women in Thailand cannot be determined, because of a lack of appropriate and valid methods. Power in sexual relationships can hardly be measured even this issue is critically discussed and usually is defined by a qualitative approach (Blanc, 2001, Suwajee translated, 2004). Attempts had been made to create a Sexual Relationship Power Scale (SRPS) which is used to evaluate sexual relationships among HIV/AIDS patients and their partners (Pulerwitz et al; 2000). In this study the researcher applied the Sexual Relationship Power Scale (SRPS) in order to measure the power in sexual relationships of study participants. The power of women not only is an important aspect within sexual relationships but also relates to household decision making. Many studies used the exercise of power as an indicator to describe a marital relationship (Autchara Sakoontaniyom, 1998; Blood & Wolfe, 1960; Mason & Smith, 2000; Kim & Emery, 2003; Sa, 2004; McCloskey, Williams & Larsen, 2005; Sopikul, 2005). Decision making by husband and wife in terms of family activities is based on the role and authority of both within the family (Prapaphan Ouonob, 1995:45).

Due to the superiority of men they exercise their power and physically or psychologically dominate their wives. Violence is the most extreme form of gender inequality and it is the direct result of gender norms that make male to be aggressive against women to be a socially acceptable way to control an intimate partner. It occurs

in all cultures and with people of all races, ethnicities, religions, and social classes can be the perpetrators of domestic violence (Helpguide, Wikipedia, http://en.wikipedia.org/wiki/Domestic-violence#Risk-assessment). The power imbalance in sexual relationships may lead to physical and sexual abuse, and may have an effect on sexual and reproduction health of women (Blanc, 2001; Suwajee translated, 2004).

The relationship of domestic violence and HIV/AIDS infection has been the subject of many investigations as can be judged from a literature review of this issue. Violence against women not only interfere with their physical- and psychological well being but also has an affects on their reproductive and sexual health thereby making them vulnerable to HIV/AIDS infection (K. Blanc, 2001; Dunkle, 2003; Lichtenstein, 2004; Jewkes et al., 2004; Turmen, 2003; Fact Sheet: Gender and HIV/AIDS, UN Special Session on HIV/AIDS, 25-27 June 2001; Innocenti Digest 6-Domestic Violence cited in Watcharin et al., 2003: 64). Numerous studies in America and sub-saharan Africa investigated the issue of domestic violence and HIV/AIDS infection as well. Gender inequality in sexual relationships is increasingly being cited as an important determinant of the higher rate of HIV infection among women in sub-Saharan Africa. As mentioned from Rwanda, Tanzania and South Africa gender-based violence increases women's risk for HIV infection. It was shown that HIV-positive women were 3 times more likely to have experienced violence in an intimate relationship in comparison with those who were HIV negative (WHO, 2002). The rate of domestic violence is high in Uganda. In many Ugandan communities beating the wife is tolerated and is considered a normal part of marriage in case it does not result in serious injury. (Human Right Watch report, 2003 quoted in Just Die Quietly: Domestic Violence and Women's Vulnerability to HIV in Uganda, August 2003).

Domestic violence and HIV/AIDS infections are the main factors affecting women's health. Women are placed at risk for HIV infection because of unequal balance of power in sexual relations which make them less able to avoid unsafe sexual behaviors. Forced sex such as in connection with rape can contribute to injuries and lacerations of the vagina tissue and this increases the opportunity for HIV transmission. Sexual violence which many women experienced in childhood is linked to risky behavior towards HIV infection such as having multiple partners, earn their living as sex worker, take drugs and drink alcohol in excess (Maman et al., 2000).

The inequality that characterizes the social and economic spheres of society, in which women have less access to productive resources than men, is often mirrored in sexual interactions, creating an unequal balance of power in sexual relations. Women who have less power in their sexual relationship were at elevated risk of having HIV because they were unable to discuss the use of condoms.

Women might be exposed to violence at any time in their lives including while being pregnant. Actually women should be especially cared and protected by their husbands during pregnancy which does not mean that to be pregnant should be regarded as an illness (Wannee Diewisares et al., 2001: 77). But contrary to this some pregnant women are abused during this time and this might be due to the fact that pregnant women usually not only change their physical appearance, being less attractive, but they also might be in a bad and vulnerable mood and are easily stressed (Jintana Watcharasin, 1990: 1; Wannee Diewisares et al., 2001: 102; Fact sheet of the Programe on women, Health and Development, 2000 cited by www.planetwrite. org/file.fcgi/2368_violence pregnancy.PDF). During pregnancy women are often unwilling to have sex with their husbands. But because they have less power in their sexual relationship they have to give in and allow sexual intercourse (Wannee Diewisares et al., 2001: 91). From a national survey conducted in the USA it is known that the proportion of pregnant women exposed to violence with 35.6 % is higher than of non pregnant women (Gelles R., 1988: 841-843 quoted in Donya Thanaudom, 1996: 3). The study of domestic violence in relation to pregnancy in rural West Virginia reveled that 19% of women were abused during pregnancy (Online Journal of Rural Nursing and Health Care). A study of domestic violence and pregnancy in Sweden showed that 14.5% of Swedish women had been the object of violence after they became pregnant (Hedin & Janson, 2000 cited by Thananowan, 2004: 16).

Domestic violence affects the physical health of pregnant women and makes them vulnerable to HIV/AIDS infections, other sexually transmitted diseases (STDs), cervical- and kidney infections as well as abdominal trauma (Journal of the American Medical Association, 1992: 267). Domestic violence also is connected to the psychological status of pregnant women in that they are suffering from depression and anxiety (Campbell et al., 1992). Domestic violence during pregnancy had been

repeatedly linked to a poor birth outcome including the delivery of a preterm child or low birth weight infant. Low birth weight of a newborn can also be the result of maternal infection caused by forced sex during pregnancy or the exacerbation of chronic maternal health problems (Curry et al., 1998). Abused pregnant women are at increased risk of miscarriage, infection, pre-term labour, placental abruption and low-birth-weight babies (Journal of the American Medical Association, 1992: 267).

Abuse during pregnancy affects not only women's health but also the health of the fetus. That violence during pregnancy is also a problem in Thailand could be shown by a number of investigators such as Donya Thanaudom (1996), who investigated violence in connection with pregnancy in a group of women who visited the Health Centre 1 of the Ministry of Public Health and Wannee Diewisares et al., (2001), who examined pregnant women in the eastern region of Thailand. While the study of Donya Thanaudom, (1996) focused only on physical and emotional abuse, Thananowan, (2004: 12) also included the issue of sexual abuse in her study and Kritaya Archawanitkul, (1999: 528) hinted towards the fact that it is likely that sexual abuse occurs after physical abuse.

Inequities in the power of the gender are believed to play a key role in the HIV epidemic in that women have less influence on their sexual relationships. Gender norms influence women and girls' vulnerability to HIV. In many places, these norms allow men to have more sexual partners than women. HIV/AIDS is now one of the major public health problems in Thailand. Thai researchers up to now did not really focus on the issue of domestic violence related to HIV/AIDS infection. Not only commercial sex workers are at risk to acquire HIV/AIDS infections but also house wives who are physically or sexually abused.

Information about how domestic violence and HIV/AIDS is related to women's health should be made clear to women and people who interested in this issue and especially should be an issue for women visiting health centers or antenatal care clinics in hospitals. Today, there are a number of organizations aiming to protect the right of women and campaigning against violence towards women and children.

But they are short of information about the role of power inequity in sexual relationships and about the link between domestic violence and HIV/AIDS infection. In order to fill this gap the researcher intended to investigate this matter.

Because of the importance of the problem and the fact that only few investigations had been conducted so far the researcher decided to look into the issue and took the chance to survey pregnant women who came to the antenatal care clinic of the Rajvithi Hospital, Bangkok.

Research questions

1. How does the power of pregnant women influence sexual relationship, the control over sexual relationship, dominance in a partner relationship as well decision making in a household?
2. How can physical, psychological and sexual violence being measured that pregnant women are exposed too?
3. Which factors are related to the power of pregnant women and influence sexual relationship, control over sexual relationship, dominance in a partner relationship and household decision making and do these factors influence pregnant women's risky behavior putting them in danger to acquire a HIV/AIDS infection?
4. How does domestic violence and risky behavior results in HIV/AIDS infection of pregnant women?

Main objective

To study the relationship of the demographic pattern, socio-economic status and factors of power related to sexual relationships, control over sexual relationships, dominance in a partner relationship and decision making in household affairs and how is all of this related to the risky behavior of pregnant women putting them in danger to acquire HIV/AIDS?

Research objective

1. To measure the power of pregnant women to control sexual relationship, dominance in a partner relationship and household decision making.

2. To measure the level of physical, emotional and sexual abuse pregnant women are exposed to.

3. To study the relationship of the demographic pattern, socio-economic status and factors of power related to domestic violence pregnant women might experience.

4. To study the relationship of the demographic pattern, socio-economic status and factors of power related to domestic violence pregnant women are experiencing and their husband/partners' risky behavior which might transmit HIV/AIDS infection to them?

5. To study the relationship of domestic violence and the risky behavior of pregnant women's to be infected with HIV/AIDS.

Research framework

The study was conducted from January to February 2007. Pregnant women who visited the antenatal care clinic of Rajvithi Hospital volunteered to participate in the study. The investigator is aware of the fact that the pregnant women investigated here are not representative for all pregnant women in Thailand. Therefore the information obtained from this study relates only to the experiences pregnant women who participated in this investigation had and this experience is not necessarily the same as other pregnant women in Thailand might have had.

Operation Definition

1. Factors of power are thought to be related to 4 issues.

1.1 Power over sexual relationship means the ability of men and women to freely decide about their actions and how one might dominate over the other and controls the behavior of the other (Pulerwitz, et al., 2000). The Sexual Relationship Power Scale (SRPS) of Pulerwitz was applied in this study in order to measure the power over sexual relationships of pregnant women such as control over sexual relationships, dominance and household decision making.

1.2 Household decision making refers to who has the final say in family issues such as buying car, a house, having a child, moving from one place to the other,

invest money, decide how to cope with illnesses of family members and how to deal with matters concerning the education and upbringing of children.

2. Domestic violence means the attempts of husbands or partners to physically, psychologically or sexually dominate pregnant women during their life time and 12 months before they were asked for this study. Domestic violence was classified into emotional abuse, physical abuse and sexual abuse.

1) Emotional abuse is any kind of abuse that is emotional rather than physical in nature:

- Being insulted or made to feel bad about oneself;
- Being humiliated or disparaged in front of others;
- Being intimidated or scared on purpose for example by a partner yelling at them and smashing things;
- Being threatened to be harmed (directly or indirectly in such a way that there is the threat to hurt someone the respondent cared about).

2) Physical abuse means involving contact intended to cause pain, injury, or other physical suffering or harm. The basic forms include:

- Slapping or throwing something at the victim that could hurt her
- Pushing or shoving
- Hitting with fist or something else that could hurt
- Kicking, dragging, or beating
- Choking or burning victim on purpose
- Threatening to use weapon such as knife, gun to hurt victim

3) Sexual abuse was defined by the following three issues:

- Being physically forced to have sexual intercourse against the wives will.
- Agree to have sexual intercourse because the wife was afraid the husband/partner will assault her or he won't love her any longer; or she was afraid that he will have another female sexual partner.
- Being forced to do some sexual practice she found degrading or humiliating.

3. Risky behavior of pregnant women with the chance to acquire HIV/AIDS infection involves:

1) Alcohol consumption, including all drinks that contain alcohol such as beer, wine and liquor. The frequency of alcohol consumption was divided into regularly: ≥ 4 times per week; often 3 - 4 times per week; sometimes: ≤ 1-2 times per week.

2) Substance use such as sleeping pill, amphetamine which effect the women physically and emotionally and when stopping to use the substance she will be irritated, or are of bad mood.

3) Risky sexual behavior:

(1) Multiple sex partners before marriage

(2) Partnerships outside the marriage

4) Condom use

(1) Before the marriage, the pregnant women never asked the male partner to use a condom while having sex; inconsistently use, and consistently use of condom while having sexual intercourse.

(2) Negotiation of condom use to prevent sexually transmitted disease and HIV/AIDS infection.

(3) Refusal of the husband to use a condom, and successive reaction of the husband or partner in being angry, or swearing, attempting to hurt or harm the women.

4. Risky behavior of the husband or partner with the danger to acquire HIV/AIDS infection. This issue was subdivided into three items:

1) Alcohol consumption means all drinks that contain alcohol such as beer, wine and liquor. The frequency of alcohol consumption was divided into regularly: ≥ 4 times per week; often: 3 - 4 times per week; sometimes: ≤ 1-2 times per week.

2) Substance use such as smoking cigarette, taking sleeping pill, or amphetamine which might effects men physically or emotionally and when stopping using it he will be irritated and might often be of bad temper.

3) Extramarital sex occurs when a married person engages in sexual activity with someone other than his spouse such as commercial sex worker or casual sex partner.

CHAPTER II
LITERATURE REVIEWED AND PREVIOUS RESEARCHES

The aim of this study was to explore the power of pregnant women to avoid- and when lacking the power how they are exposed to domestic violence. Women who visited the antenatal care clinic of the Rajvithi Hospital, Bangkok were the subjects for this investigation. The following topics had been reviewed and served as guidelines for this study:

2.1 Concept of gender

2.2 Concept of gender-based power

2.2.1 Power to control sexual relationships and the possibility to use the Sexual Relationship Power Scale (SRPS) to measure the power to control sexual relationships

2.2.2 Household decision-making

2.3 Domestic violence

2.4 Measurement of domestic violence

2.5 Consequence of domestic violence

2.6 Consequence of domestic violence in relation to HIV/AIDS infection of pregnant women

2.7 The connections between domestic violence and HIV/AIDS

2.8 Power and domestic violence

2.9 Factors of power and domestic violence

2.9.1 Demographic background and socio-economic status of pregnant women and their husbands or partners

2.9.2 Risk of acquiring HIV/AIDS infection of pregnant women and their husbands and partners

2.10 Preceding research

2.1 Concept of gender

Gender refers to the differences between men and women as far as their socially constructed roles, behavior, activities and attributes are concerned and what a particular society considers appropriate for men and women. The distinct roles and behavior may give rise to gender inequalities, i.e. differences between men and women that systematically favor one group. In turn, such inequalities can lead to inequities between men and women in the economic and political status and spirituality. The word "gender" started to be widely used during the end of 1960 in connection with feminism in the United States of America and the United Kingdom. At that time quite a number of books related to the gender issue. Gender and particularly the role of woman are widely recognized as vitally important to international development issues. To focus on gender-equality and ensuring participation of women in development issues requires an understanding of the different roles and expectations of the genders within the communities (Suchada Thaweesit, 2004" 3-4).

Many languages have a system of grammatical gender, a type of a noun class system — nouns may be classified as masculine or feminine for example in Spanish and French. The feminists used the word gender to express behavior without any assumptions regarding biology (Suchada Thaweesit, 2004 : 4-6)..

The word gender was translated into the Thai language by Thai academics who studied women issues; they defined it as "the role of men and women", "the sexual role" or "relationship between men and women". But Kanjana Kaewthep (2004) used the word "Phaes-pava" which defines the sexual status. The word "gender" and "sex" in English is used by feminist in order to emphasize that the meaning between these two words is distinctively different. A distinction was made because "sex" is determined by biological facts while "gender" might need social intervention (Suchada Thaweesit (2004). "Sex" is defined as a person's biological category, while the word "gender" refers to cultural determined different roles given to men and women based on the culture of a given society and involves duties and responsibilities and influence. Gender relates to those affectations that are attributed to men and those affectations that are attributed to women (WHO, 2002 cited by Turmen, 2003:1).

Sex- and gender role. The sex role is defined by the biological status determined by sex organs, menstruation, and seminal ejaculation. The gender role is defined by responsibilities and expectations, and include a set of perceived behavioral norms associated particularly with males or females, in a given social group or system. Gender roles can influence all kinds of behavior, such as choice of clothing, choice of work and personal relationships. For example in western society girls like to play jumping rope, like clothing, and pinky ornaments. Boys prefer climbing the tree, soiled with mud, untidy hands or dirty body, like to work as a police man or soldier, and like wearing blue cloth (Supatra Suphap, 1980: 52). The value of social institutions has an influence on all kinds of behavior of male and female (Marie Richmond-Abbott, 1992: 4). The family or educational institution plays a major role in male and female behavior (Napaporn Hawanon, 1999).

The society assigns the roles to the two genders such as which gender has more power than the other, more rights and responsibilities (Turmen, 2003:411). The women are the subordinated gender with less power, and gender inequity is linked to imbalance in sexual power and domestic violence.

2.2 Concept of gender-based power

Men and women do differ in their ability to influence others and that differences correspond to gender differences in power. Gender differences in power have real consequences for women. Stratification on the basis of sex/gender channel males and females into very different and often unequal life situations (Abbott, 1992: 5). The society socializes men and women to play different gender roles; women are subordinated in power which can obviously be concluded from the phrase of “men are regarded as front leg of elephants, women as the back leg of elephants” (Sunya Sunyawiwat, 2001: 76). Social power and cultural norms determine the characteristics of men and women since childhood such as men are supposed to be independent, strong, and they like to compete with each other., All this brings men into the position to be successful in their careers in that they might hold a high position or are the leader in the society as well as in their family. It is rather difficult for women to change their role and not to be subordinated. Society expects women to be dependent on men and follow them.

The system of gender inequality corresponds to the type of society it belongs to and its stratification system. Men and women are unequal in how they can exercise their power in that unmarried women are under the supervision of fathers and brothers, and married women are dependent on their husbands. Men, besides being powerful in political matters, in governing, and in the economic world, they also have power over their families. Due to gender stratification and social values men are favored from the society above women (Waraporn Duangjan, 1987 quoted in Donya Thanaudom, 1996: 23).

Gender is a social construct and each individual follows its gender characteristics, as every child is socialized to behave in a certain way and develop the proper gender attributes. Women's influence and power usually is low in sexual relationships and this is due to the gender based power imbalance. Certainly one function of women's sexual relationships has historically been connected with their restricted economic and social resources which placed them into a structural disadvantage (K. Blanc, 2001 translated by Suwajee Janthanom Good, 2004: 201-202).

2.2.1 Power to control sexual relationships and the possibility to use the Sexual Relationship Power Scale (SRPS) to measure the power to control sexual relationships

The imbalance in the power of sexual relationships of married- or partner couples is well recognized but the magnitude of power could hardly being measured up to now. In Thailand only a few qualitative researches related to power in sexual relationship were conducted such as the study of Rewadee Lertsintanapat (1998). She studied the belief, sexual behavior, power in sexual relationships and the negotiation of safe sex in a group of house wives. No quantitative study had been conducted up to now about gender and power related to the sexual relationships and domestic violence and its cause for HIV/AIDS infection. The HIV situation is a challenging problem that should rise academic interest and stimulate innovative solutions. The skills, resources, and broader vision of academic researchers are essential to solve these problems in an effective way that lead to new and more widely

applicable insight into the matter. The HIV/AIDS epidemic is a health problem that many countries are faced with and that might be among others based on the imbalance of power in sexual relationships.

Many investigators tried to develop techniques to measure the power in sexual relationships. In the opinion of Blanc (2001), the Sexual Relationship Power Scale-(SRPS) designed and developed by Pulerwitz et al., (2000) is a reliable and validated, tool. It has been divided into two subscales with a different context and is ease to use.

In this study the investigator applied the Sexual Relationship Power Scale-(SRPS) of Pulerwitz, who developed the scale based on the theory of gender and power, considering the interchange between genders and psychosocial factors. It is an appropriate technique to measure the power in sexual relationships, domestic violence and causes of HIV/AIDS infection. In Thailand no one applied such a technique to measure the sexual power yet and to determine women's health related risks in their behavior which might put them into danger to acquire HIV/AIDS. The result obtained from using the SRPS in this study might be useful for further quantitative studies in this field.

Measuring the power in sexual relationships in connection with HIV/AIDS by Pulerwitz resulted in a theoretically based and validated measure of power dynamics in sexual relationships. In connection with prevention of HIV and other sexually transmitted diseases (STD) as well as reproductive health, the ability of women to negotiate for safe sexual practices rose great interest. Sexually transmitted diseases (STDs), including infection with the human immunodeficiency virus (HIV), are an ever-growing problem for women nationwide. A report published by the Centers for Disease Control and Prevention (CDC, 1998b) about the HIV/AIDS epidemic in the United States 1997-98, noted that the epidemic continues to affect women disproportionately. Women, especially members of racial and ethnic minorities are the fastest growing affected group with HIV infection, with approximately half of these infections transmitted via heterosexual contacts. A number of researchers suggested that women have difficulties in negotiating safe sex because of gender-based imbalances in the power of sexual relationships. Power is a ubiquitous term, and can

express influence on many levels such as within the society, in organizations on interpersonal and individual relations. The most common theories applied to HIV risk reduction do not consider interpersonal power.

Present evidence links the risk of HIV infection among women in the United States to inequalities in gender, social class, race and ethnicity. It was concluded that these inequalities, which are manifest at the national level, in neighborhoods, within households, and on an individual level, can explain the high rate of HIV infection among certain groups of women, especially poor and colored women.

Pulerwitz draws attention on both structural- and psychosocial theories for the understanding of power in relationships. The theory involving gender and power is a structural one focusing primarily on gender-based power imbalances. Three overlapping but distinct concepts are proposed to explain the roles and behaviors of men and women: (a) economic inequality--referred to as the sexual division of labor, (b) male partner control within relationships--referred to as the sexual division of power, and (c) social norms related to gender roles—and what Freud termed as cathexis. The theory of gender and power postulates that gender-based inequalities are pervasive societal characteristics which result in men's disproportionate higher power in society and their control over decision-making in a number of areas, including the sexual arena.

The social exchange theory, a psychosocial theory, is built around an interpersonal definition of power within relationships (Emerson 1981) and defines power as the amount of resistance on the part of one individual that can be potentially overcome by another. Power has no meaning for only one individual actor, but needs the confrontation with at least one other actor. Power within relationships is expressed through decision-making dominance, the ability to engage in behaviors against a partner's wishes, or the ability to control a partner's actions. According to the theory, power is based upon a number of factors, including the dependence of one partner on the other, the amount of valued resources (e.g., economic and emotional) one partner possesses compared to the other, and whether potential alternatives to the current

relationship are perceived to exist. Greater power is held by the member of the couple, who maintains control over decision-making in the relationship, has control over both their own and their partner's actions, is less dependent on the relationship, possesses more resources, and is perceived to have alternatives to the current relationship.

The questionnaire use in this study was modified from the SRPS of Pulerwitz by the researcher.

The development and the evaluation of SRPS

The study of Pulerwitz was not only conducted to develop the Sexual Relationship Power Scale but also to assess its psychometric properties. The Sexual Relationship Power Scale (SRPS) as suggested by Pulerwitz, Gortmaker, and DeJong was used here to measure power in sexual relationships as well as to investigate the role of power in relationships in sexual decision making and risk to get infected with HIV. The SRPS contains two subscales that address two conceptual dimensions of the power in relationships: control over partners in relationships and dominance in decision-making dominance. The scale were developed both in Spanish and in English. Among others, the scale includes questions about control over decision-making, commitment to the relationship, condom negotiation ability, and freedom of action within the relationship.

The SRPS was administered to 388 women at a community health clinic in the United States of America. All respondents had a primary male partner, the majorities were Latina and African-American, and their mean age was 27 years. Factor analyses were conducted to determine the subscales. The SRPS possesses a good internal reliability. As hypothesized, the SRPS was inversely associated with physical violence and directly associated with education and consistent condom use.

The 23-item SRPS possesses good internal reliability and predictive and construct validity. Factor analysis supported two subscales: Relationship control and decision-making dominance. The two subscales are sufficiently reliable to use independently or in conjunction with one another.

In this study, the researcher applied the SRPS of Pulerwitz because of its reliability in assessing the power in sexual relationships. Power in sexual relationships according to Pulerwitz et al. (2000) is not linked to an individual factor only but refers to one partner engaging in behavior against the other partner's wishes, having greater control over decision making in the relationship, and having greater control over a partner's behavior. SRPS contains 23 items with two subscale, one subscale with 15 items about control over relationships, and 8 items about dominance in decision-making for the other partner.

2.2.2 Household decision-making

Many studies tried to measure the power in household decision-making of men and women, using the questionnaire related to the power in the family, about who is able to influence the other one to get its way, and who is able to block others from getting their way (Blanc, 2001 translated by Suwajee Janthanom Good, 2004: 206). The questionnaire was suitable to assess the power in decision making of husband and wife and who has the final decision in deciding about family activities and issues which involves other family members. The ability to make the decision in the family was regarded by sociologists as the authority of family institutions (Prapaphan Ouonob, 1995; Autchara Sakoontaniyom, 1998). Several studies which investigated how women's health is dependent on the power structure within the family also assessed the power in household decision making.

Blood and Wolfe (1960) examined family and marital decision making in 900 Detroit families. They interviewed wives only, and asked them who make the final decision about buying a car, house, what kind of job the husband should have, whether the wife should go to work or quit work, whether the family should buy a life insurance or not, where to go on vacation, which family doctor to see, and how much money to spend for food in one week. In 72 % of the families husbands and wives made the decision equally, in 25 % of families the decision was only with the husbands and in 3 % only the wives made the decisions.

Kim and Emery (2003), surveyed South Korean married men of 20 years and older to measure their conjugal power based on question from Blood and Wolfe's 1960 research. They asked about who had the final decision in five essential

areas: buying a car, having a child, buying a house, what job either partner should take, and whether a partner should go to work or quit work. The response categories were measured separately using a Likert-type scale with five response categories- wife only, mostly wife, husband and wife equally, mostly husband, and husband only. Using these items, the marital power model classified couples into four types; male dominant, female dominant, divided power and equalitarian. Abusing women increased if men had the dominance in decision-making.

The determinants of women's autonomy and power and their relationship to women's reproductive intentions and behavior were conducted in five Asian countries, namely India, Thailand, Pakistan, Malaysia and the Philippines, with different gender norms. Women were asked not only about their education and their work status but also about their married lives, including their decision-making authority particularly within the family such as who had the decision-making to buy television, refrigerator; their personal freedom of movement, control over economic resources, wife-husband power relations and other attitudes (Mason & Smith, 2000: 299-311 cited by Suwajee Janthanom Good, 2004: 206). From the point of view of the researcher, the marital power related to decision-making can lead to the family violence. The researcher therefore decided to use the term 'authority' in family decision-making to measure the relationship of domestic violence and power in household decision making.

In Thailand no quantitative research related to power in sexual relationships including household decision-making authority, economical power as well as the social power of married couples had been conducted yet. There was only the study of Rewadee Lertsintanapat (1998) investigating power in gender relation and ability of negotiating safe sexual activities of house wives, but this investigation was a qualitative study. There were some studies from non-Thai researchers investigating the power of gender related to decision making, family planning or use of condom. But none of them had a reliable measurement tool to assess the relationship of power and domestic violence. Therefore, for this study the researcher decided to apply the Measuring Relationship Power Scale: SRPS designed and developed by Pulerwity et al., (2000) as a research tool. It seems to be the only reliable and validated scale to measure household decision making authority and domestic violence.

2.3 Domestic violence

Domestic violence is also known as domestic abuse or spousal abuse. Domestic violence is gender-based violence which includes physical, emotional and sexual abuse. In the context of this study the researcher focused on intimate partner violence or male intimate partner violence or wife abuse. For most of the domestic violence the wife is usually the victim. The men having power in sexual relationships play a major role in domestic violence and it is their strategy to gain or maintain power and control over women**.** Little is currently known about the actual number of men who are in a domestic relationship in which they are abused or treated violently by their wives. Men's abuse of women is worse than women's abuse of men (Jitruedee Veerawess, 2000).

2.3.1 The definition of domestic violence

The definition of domestic violence was developed by many academics according to the forms of violence they wanted to emphasize on. In the following a number of ideas and conceptions are described about domestic violence:

For the social worker, domestic violence means a social structure that determines the behavior of people in the society such as for patriarchal society, male with superiority power over women which occur in Asian societies. Some societies are matriarchal societies in that the fathers are subordinated and some are equalitarian societies in that mother and father have equal power.

In the point of view of feminists, domestic violence is about gender and power. The cultural norms put more importance and appreciation on males than females (Jutharat Aueamneuy, 2001).

Domestic violence is the phenomenon of a pattern of abusive behavior in any relationship that is used by one partner to gain or maintain power and control over another who are or have been in an intimate partnership. Domestic violence is likely to result in physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty. (Wacharin Patjakewinyoosakul et al., (2003: 1).

Domestic violence was defined by the United Nations as violence against women within the family, as physical and sexual violence such as battering,

punching, sexual harassment, rape, and included psychological and emotional violence such as threat, humiliation, or other verbal or nonverbal conduct. Psychological violence includes insult, preventing victims from seeing friends and relatives. Psychological violence may also involve economic and/or social control, such as controlling victim's money and other economic resources (United Nation, 1993 cited in Friend of Women Foundation, 2003: 21).

The domestic violence as defined by Innocenti Digest (cited by Wacharin Patjakewinyoosakul et al., (2003: 27) means that women are abused by their intimate partner either physically including sexual abuse or emotionally.

Domestic violence by the UK Home Office is violence between persons who live together, and who have had a past or present intimate or sexual relationship. This includes physical, sexual, emotional and financial abuse.

In this study the term of 'domestic violence' is used and not 'violence against women', because domestic violence often refers to violence between spouses, or spousal abuse but can also include cohabitants and non-married intimate partners. Domestic violence is mostly perpetrated by men and women are victims (Jutharat Aueamneuy, 2001).

Family structure including men and women who play the role as husband and wife and have responsibilities within the family, being married and registered or non married couples, who are cohabiting (Kamolporn Paetchief, 1999: 16).

2.3.2 Forms of domestic violence

Domestic violence was categorized into sexual abuse and non-sexual abuse by the UK Home Office (1999).

Non-sexual abuse is the intentional use of physical minor force with the potential for causing injury, harm such as pushing; slapping, physical major force such as kicking, battering, choking and throwing objects on the victim.

Sexual abuse refers to rape; use of physical force to compel a person to engage in a sexual act against their will, whether or not the act is completed.

Domestic violence relates to family violence such as spousal abuse particularly husband's abuse of the wife which include physical, sexual, and

psychological violence (WHO, 2002; Garcia-Moreno and Watts, 2000; Heise et al., 1999).

1. Physical violence refers to slapping, punching, kicking, use of weapon, and murder.

2. Sexual violence such as rape, coercion, and physical force or threatening the wife to engage in a sexual activity against her will. Many people think that women who were raped mainly by the strangers; but actually the majority of raped women are the victims of their spouses or partners or other members of the family whom the women know well.

3. Psychological violence includes insult, preventing victim from seeing friends and relatives. Psychological violence may also involve economic and/or social control, such as controlling victim's money and other economic resources.

Domestic violence can take many forms, including physical abuse, sexual abuse, emotional, economic, or and/or psychological abuse. Patterns of behavior characterized by the misuse of power and control by one person over another who are or have been in an intimate relationship. Domestic violence effects women's health in both short and long term as well as their economical and social status (Laddawan, 1999: 27).

2.3.3 Cause of domestic violence

According to Grossman, et al., (1989 cited by Preecha UoobYokin, 1995: 102), domestic violence can happen in all kinds of families involving the following conditions and factors:

1. A strategy to gain or maintain power and control over family members. The domestic violence has a positive relationship with power.
2. A family with strict regulations
3. The tight relationship of family members
4. Family members are too independent and not being bound by family ties
5. Fixed ideas about gender and power
6. Family members with bad behavior

7. Relationship of the family members with people outside the family

Nitjawan Weerawatnodom (1997: 18) notified causes of domestic violence including:

1. The gender inequity - in a patriarchal society, men are superior in power and women are subordinated. This can result in men attempting to physically or psychologically dominate women.

2. Gender stratification and power such as employer and employee or foreman and worker, house owner and tenant, creditor and debtor, and teacher and student.

3. Belief and misuse of power, using violence to solve problems or family conflicts.

Men use violence against their partners to maintain dominance within their relationships. The use of violence on the part of husbands reflects their greater relative power, authority, and status in the society. This fact gives many men the impression that they have a right to abuse their wives (Holaling & Strauss, 1980 cited in Protecting right of Women Centre, Friends of Women Foundation 2003: 33).

The report of the Committee on Women, Youth and Elderly Affairs, stated that domestic violence exists in families and the society, and is due to social structures and beliefs. The patriarchal cultural background is the basic main factor related to domestic violence. The Thai society is not very conscious about human rights and does not focus on the rights of women. There is an imbalance of power between the two genders and males claim to be superior. Domestic violence is considered to be a personal issue, and a problem between wife and husband. This situation is causing domestic violence to increase (Protecting right of women Center, Friends of Women Foundation, 2003: 26-27).

The social environment may lead to domestic violence including four social factors (WHO Fact Sheet, June 2000, cited by Kritaya Archavanitkul, et al., 2001:4).

1. The structure of the society is a patriarchal one that emphasizes men’s power.

2. The immediate social context, poses a risk factor that may lead to violence and exists where there is a high rate of unemployment, high criminal rate, gambling, drug addiction, exposing sexual issues in the media, women’s role unaccepted in the

society, and isolation of women. Domestic violence can be prevented by supporting a harmonic living in the society, helping each other, foster to establish women groups, and support the right of women in land possession and resources.

3. The immediate family context, and gender norms influences the power of women in relationships and decision making authority. Men have the privilege to occupy property and to make the decision related to money management in the family. Women feel powerless in relationships when they can not make decisions and are economically dependent. This can lead to conflicts and distorted communication between husband and wife.

4. Domestic violence occurs across the world, in various cultures, originating from the position of power of men over women. Although both men and women can be abused, most victims are women. The factors associated with domestic violence including heavy alcohol consumption, having experienced violence during childhood, occupy weapons, stress at the working place and being unemployed.

2.4 Measurement of domestic violence

A multi-country study on women's health and domestic violence against women was implemented by WHO, in collaboration with the London School of Hygiene and Tropical Medicine (LSHTM), PATH, USA, research institutions and women's organization in other participating countries, that are Bangladesh, Brazil, Ethiopia, Japan, Peru, Namibia, Samoa, Serbia, Montenegro, Thailand and the United Republic of Tanzania. A questionnaire was designed and developed about "women's health and life events". The Foundation of Women and Kritay Archavanitkul from the Institute for Population and Social Research of the Mahidol University were the representative of Thailand and they used this questionnaires to investigate the "Intimate violence and women's health in Thailand".

The content of the questionnaire was divided into 3 parts, psychological or emotional violence (question no. 1-4), physical violence (question no. 5-10), and sexual violence (question no. 11-13). The women were asked to determine in their life time and current **(**within 12 months of the interview) experience with physical, psychological and emotional as well as sexual violence from their intimate partner.

Psychological/emotional violence

The specific acts of emotional abuse by a partner included the following:

1) Being insulted or made to feel bad about oneself

2) Being humiliated or belittled in front of others

3) Being intimidated or scared on purpose for example by a partner yelling and smashing things

4) Being threatened with harm directly or indirectly in the form of a threat to hurt someone the respondent cared about.

Physical violence

As physical violence was concerned women were asked whether her husband/partner had ever

5) Slapped her, or thrown something at her that could hurt her

6) Pushed or shoved her

7) Hit her with a fist or something else that could hurt

8) Kicked, dragged or beaten her up

9) Choked or burnt her on purpose

10) Threatened her with, or actually used a gun, knife or other weapon against her

Sexual violence

Sexual violence was defined by the following three behaviors**:**

11) Being physically forced to have sexual intercourse against her will

12) Having sexual intercourse because she was afraid of what her husband/partner might do otherwise.

13) Being forced to do something sexual she found degrading or humiliating

2.5 Consequence of domestic violence

It is known from a number of studies that domestic violence such as spousal abuse affects the wife directly by damaging her health physically or mentally and that domestic violence has an adverse psychological effect and also indirectly might affect her social standing and economic well-being.

2.5.1 Effects of domestic violence on women in general

1. Physical and health

Physical violence could vary from minor injuries to serious injuries of women that might lead to death such as contusion resulting in swelling, broken bones, and often nose, molars, and arms are affected. In case internal organ are hurt the victim must be sent to the hospital for treatment (Busarin Klongphayabal, 1999). Some victims became disabled caused by the physical violence such as being blind, loss of ability to hear, and limping because of a broken leg (Wacharin Panjakewinyoosakul et al., 2003: 61). Domestic violence not only is a physical assault but it is also harmful to sexual- and reproductive health (WHO, Fact sheet No. 239, June 2000)

2. Mental health and psychological effects

It is not only the wounds the victim gets from physical violence such as hitting, pushing, shoving, use of weapons which is causing external wounds but the victim's mental or psychological condition is also affected (Kamolporn, 1999). Sexual violence also has an influence on the psychological status of the victim; and a spouse has a more opportunities to commit sexual violence than a stranger (Kritaya Archavanitkul, 1999: 528).

Women who are being abused by a partner are at risk for developing certain mental health problems such as depression, anxiety and somatic complain and these symptoms are more often in women being abused than in women who are not abused (P. Jaffe et al., 1986 cited by Miranda, 1994: 5). According to the World Health Organization, anxiety and depression are illnesses of the psychosomatic system including eating disorder, and sexual dysfunction (WHO Fact sheet No. 239 June 2000).

3. Social effect

Domestic violence with its physical and psychological effects also is a family problem that can turn into a social problem. It was observed that the children from a violent home are affected physically and psychologically. Children are at risk when trying to help the mother from being hurt by the father (Jitruedee Veerawess, 2000, Miranda 1994: 6). Pornpen Petsuksiri (1991) indicated that children, whose fathers' batter the mothers, are also often abused by their fathers. Most violence occur

at home, 50 to 70 % of men who often abuse their wives also abuse their children often (John M. Grohol, Psy.D., 2001). The emotional impact of domestic violence on children is pervasive and long-lasting. They fear and develop stress symptoms. Children affected by violence they witnessed, suffer the same as if they were physically or sexually hurt themselves (Laddawan Sukhum, 1999: 44).Domestic or family violence has a direct and indirect impact on children in form of a physical and psychological trauma. If a child's parent act aggressively toward each other or their children, then the child is later likely to act aggressive toward his or her spouse and children as well, this might develop into violence and committing crime. The girls from violent families are more at risk of being lured into prostitution than girls from non violent families (Nijawan Veerawantnodom, 1997; 19).

2.5.2 Domestic violence and pregnancy women

Domestic violence during pregnancy is an attack that puts not just one, but two lives at risk (Siripet Siriwatana, 1995, Dolnapa Hongthong, 1999). Domestic violence is gradually being acknowledged as one of the most severely threats to women's health. Violence is cited as a pregnancy complication such as vaginal bleeding (Curry, et al., 1998).

1) Physical and health

Unlike other domestic violence, where the head is usually attacked, battering of pregnant women tend to be directed at the breast, abdomen or genitals. The physical affects of violence during pregnancy include rupture of uterus, liver, or spleen, broken pelvis and placenta abruption (Muhajarine & D'Arcy, 1999 cited by Thananowan, 2004: 33). Besides that insufficient weight gain during pregnancy, infections of the vagina, cervix, and kidney, hemorrhage, abdominal trauma, vaginal bleeding and complication during labor had been observed (McFarlane, et al., 1996: "Abuse of Pregnant women and Adverse Birth Outcome.", 1992: 267 cited by http//www.planetwire/files.fcgi/2368_violencepregnancy.PDF).

2) The mental health or psychological effects

Pregnancy is supposed to be a time of peace and safety. Unfortunately for many women, pregnancy can be the beginning of a violent time in their lives and increase of psychological stress (Thananowan, 2004: 33). Campbell et

al., (1992: 267) examined 488 pregnant women, who were abused by their partners during pregnancy and found that these women have a higher risk suffering from stress, depression, anxiety and addiction to tobacco, alcohol and drugs. The long term psychological consequences of violence during pregnancy can have severely detrimental effect on a child's psychological development ("Abuse of Pregnant women and Adverse Birth Outcome.", 1992: 267 cited by http//www.planetwire/ files.fcgi/2368_violencepregnancy.PDF).

3) Fetal effects

Abuse of women during pregnancy occurs in many forms and ranges from minor injuries to major trauma. Unfortunately, the effect of such violence on pregnant women is compounded because there are two victims: the mother and the fetus. Intimate partner abuse of pregnant women may be linked to the delivery of low-birth weight infants and substance abuse and poor nutrition of the mothers ("Abuse of Pregnant women and Adverse Birth Outcome.", cited by http//www.planetwire/files. fcgi/2368_violencepregnancy.PDF). Wanee Diewisares et al., (2001; (2-93), studied domestic violence in pregnant women and maternal and child health in the eastern part of Thailand and found that the average weight of new born babies of non-abused women was higher than of babies whose mother were abused. The average weight of new born infants of women with low level of abuse was higher in comparison to infant of women with a high level of abuse.

2.6 Consequence of domestic violence in relation to HIV/AIDS infection of pregnant women

Domestic violence affects the women health and their reproductive health as well. Women forced to have sex are at risk to have sexually transmitted disease and HIV/AIDS infection which is mainly acquired through heterosexual relations. Domestic violence has serious implications for the mother-to-child HIV transmission. Perceived risk of or existing violence may influence disclosure or partner notification by HIV positive women. It may also influence the use of preventive measures for re-infection such as negotiating the use of barrier methods or abstinence, or the choice between breastfeeding and formula feeding.

Today, half or more of than 40 millions people infected with HIV in the world are women. When focus on violence against women and HIV/AIDS, it is impossible to talk about HIV/AIDS without talking about domestic and sexual violence (WHO, 2002; Garcia-Moreno and Watts, 2000, Heise et al., 1999). Domestic violence is gender-based violence, cause by the imbalance of gender power, and gender inequality.

Results of studies conducted in America and South Africa found that the increase in HIV/AIDS infection of housewife and steady sexual partner are due to domestic violence, forced sex, and lack of power to negotiate for safe sexual activities (Innocenti Digest 6-Domestic Violence cited by Wacharin Patjakewinyoosakul et al., 2003: 64). Also studies undertaken in the United States and South Africa hinted towards the positive relationship between HIV/AIDS and domestic violence. A multi-center study in Latin America and the Caribbean showed a positive association between sexually transmitted diseases and domestic violence.

Additionally, Maman, Mbwambo, and colleagues (2000) from Tanzania suggested that for some women the experience of violence could be a strong predictor of HIV. The epidemic of HIV/AIDS is widespread among family institutions and this health problem needs solution with more sensitive and complicated techniques.

Twenty six percent of married women in Zimbabwe aged 18 years who were forced to have sex with their husbands, who are likely to have other sexual partners unknown to their wives are HIV/AIDS positive themselves or their husbands are infected. Women are unable to negotiate condom use or ask for monogamous relationships because they are afraid that this will stimulate a violence situation (Innocenti Digest 6-Domestic Violence cited by Wacharin Patjakewinyoosakul et al., 2003: 64).

Domestic violence is well recognized to be a gross violation to human rights and great public health problem. Violence can lead to criminal and social problems and effects the country's economic situation in that money from the national budget is spend for HIV/AIDS treatment and loss of active people of the labor (Pimpawan, 1998). The fact that domestic violence is associated with HIV/AIDS infection of great concern for public health managers and gas an direct and indirect effects on health management and the health service system, the health policy and the health services

provided to the people in the society (Chotima Kanjanakul, Sunsanee Ruangsorn, 1999).

2.7 The connections between domestic violence and HIV/AIDS

The links between domestic violence and HIV/AIDS can be explained by biological- as well as socio-cultural- and economic factors (Vetten and Bhana, 2004; Mamam et al., 2000; 16 Days of Activism Against Violence against Women, 2005).

1) Direct transmission through sexual violence: Forced or coercive of sexual activity with an HIV infected partner is one of the routes of transmission for HIV and sexually transmitted disease (STD) to women. The biological risk of transmission in a violent sexual encounter is determined by type of sexual exposure (vaginal, and or oral). HIV transmission risk is also generally higher in presence of other STD and with exposure to sexual secretions and/or blood. Risk of transmission is also increased with the degree of trauma, vaginal lacerations, and abrasions that occur when force is used. Where sexual violence occurs in girls and young women, risk of transmission is also likely to be higher because girls' vaginal tracts are immature and tear easily during sexual intercourse. Evidence of direct transmission of STD and HIV following sexual violence is difficult to establish. Two studies from the USA suggest that while women who are raped are at high risk for pre-existing STD, sexual assault itself presents a small but substantial additional risk of acquiring STD. Women are more susceptible than men to infection from HIV in any given heterosexual encounter, due to the greater area of mucous membrane exposed during sex in women than in men; the two to four times (some studies 8 or 20 times) greater quantity of fluids transferred from men to women; the higher viral content in male sexual fluids; and the micro-tears that can occur in vaginal (or rectal) tissue from sexual penetration. (T. Turmen, 2003: 412).

2) Indirect transmission through sexual risk taking: There is growing evidence that the relationship between violence against women and HIV infection in women and girls may be indirectly mediated by HIV risk-taking behavior. Studies show that women's experience of violence is linked to increased risk-taking including having multiple partners, non-primary partners or partnership outside marriage or engaging in transactional sex. For example, one study in South Africa showed that

women who experienced intimate partner violence were two to three times more likely to engage in transactional sex than women who did not experience violence. Sexual abuse during childhood and forced sexual initiation during adolescence are also associated with increased HIV risk-taking among women. For example, in the United States of America several studies show that experience of childhood sexual assault is associated in adults with early sexual initiation, sex with unfamiliar partners, and low rate of condom use. In Nicaragua, one study found that women who were severely sexually abused in their childhood and adolescent years made their sexual debut more than two years earlier and reported a higher number of sexual partners than those who had experienced moderate or no sexual abuse.

3) Indirect transmission through inability to negotiate condom use: While the evidence is not conclusive, research suggests that violence limits women's ability to negotiate condom use. For example, in a study from the U.S.A., African-American women who had physically abusive partners were four times more likely to be verbally abused and nine times more likely to be threatened with physical abuse when they asked their primary partner to use condoms compared to those who did not have abusive partners. In a study from South Africa, women who experience forced sex were found to be nearly six times more likely to use condoms inconsistently than those who did not experience coercion and in turn, women with inconsistent condom use were 1.6 times more likely to be HIV infected than those who used condoms consistently. Certainly, qualitative data from studies in Uganda, India, and elsewhere indicate that women find it difficult to suggest or insist on condom use in face of or threat of violence. One Ugandan study participant said "My husband hated condom use. He never allowed it. He would beat me often. He used to beat me when I refused to sleep with him. He wouldn't use a condom. He said when we are married, how can we use a condom?" (Human Right Watch 2003).

4) Indirect transmission by partnering with riskier/older men: A review of over 40 studies from Sub-Saharan Africa suggests that a significant proportion of adolescent girls have sexual relations with men five to ten years older than themselves. While girls are able to initially choose the older sexual partner, once in the relationship, it is the older men who control the sexual relationship including condom and contraceptive use in some situations through the use of violence. Emerging

evidence from a study conducted among young women aged range 16-23 years in South Africa suggest that women who have partners older than them (i.e. age difference of three or more years) have 1.6 fold higher odds of being HIV infected and young women with older partners are 1.5 times more likely to experience physical and sexual violence than women with partners in the peer age group. The researchers suggest that partner violence may be a feature of relationships with older men and that age difference between partners increases young women 's HIV risk because older men have a much higher prevalence of HIV.

Several studies also highlight that men's use of violence is linked to their own sexual risk taking and hence, their own as well as their partner's risk of STD and HIV. For example, in India, a study showed that men who had extramarital sex were six times more likely to report sexual abuse of their wives than men who remained faithful. Moreover, men who reported a STD were 2.5 times more likely to report abuse of wives than men who did not report a STD. The researcher concluded that abusive men were more likely to engage in extramarital sex, acquire STD, and place their wives at higher risk for STD possibly through sexual abuse. In another study from Cape Town, South Africa, men who reported use of sexual violence against intimate partners were nearly twice as likely to have multiple partners compared to those who did not use sexual violence.

The study of domestic violence, sexual ownership, and HIV risk in women in the American Deep South revealed that older men were the partners of choice for younger women, due to the fact, that older men initially provided young women with money, social status and sense of being special. Family approval, lengthy acquaintance or the courtesy of older men did not protect women from being abused or infected. Age mixing has also been linked to domestic violence because of power differentials that exist between older men and young women, mainly because older men are more likely to infect young women than the reverse (Brewer, 1993, Omolade, 1994 cited by B. Lichtenstein, 2005: 712).

It can be concluded from the studies mentioned above that women who have older intimate partner are likely at risk to be infected with HIV, due to the influence

older men have over sexual relationships such as negotiation of condom use and contraceptives. The older men are more likely to engage in extramarital sex and have a much higher prevalence of HIV.

5) Violence as a consequence of being HIV positive because violence or fear of violence has been implicated as a barrier to women seeking HIV testing, prevent disclosure of their status, and delay their access to AIDS treatment and other services.

2.8 Power and domestic violence

At the International Conference on Population and Development held in Cairo, Egypt, the researchers and the project planner who participated in the conference realized the importance of power in relationships. The role of gender-based power in sexual relationships affects the sexual and reproductive health. (K. Blanc, 2001 cited by Suwajee Janthanom Good, 2004: 200). Violence is a persistent problem in the lives of many women and has been identified as an important risk factor for HIV infection. Power and control in intimate relationships influenced women's exposure to sexual violence (Dobash & Dobash 1979 cited by Sa 2004: 3).

The relationship of the family member is related to the power within the family. Power is defined in terms of who is able to influence others to get their way in the family, and who is able to block others from getting their way (Center and Raven, 1971, cited by Kaewkoon, 2004: 22). The domestic violence or family violence is related to the power within the family, and the more power men have over women the more the risk for violence increase (Ornwadee Chotisawat, 2003: 4). A family structure in which the couple share decision –making (equalitarian type) will have the lowest incidence of violence, whereas a structure in which the husband has the right to make most of decisions (the male dominant type) will have the highest incidence of violence (Straus et al., (1980: 192-193).

The gender based power imbalance based on the social and cultural structure, usually favors men who have more power than women. Power differentials are reflected in women's intimate relationships and sexual behavior. Differences in women and men's access to power, is also reflected in economic inequality, male

partner control of relationships and decision-making (Kritaya Archavanitkul, 1999). Domestic violence reflects the gender based power imbalance.

The marital imbalance in power of husband and wife can cause violence in the family (Blanc, (2001 cited by Suwajee, 2004: 219). From the world population survey conducted in 50 areas from a great number of countries it is known that 10-67 % of women experienced physical intimate partner violence in their lifetime. The United Nation recommendation on Women and Gender Equality (cited by Poonsuk Chuaythong et al., 1998: 403-407) pointed out that the misuse of power through men causes of domestic violence. It is demanded that men should realize the importance of gender equality.

None of the quantitative studies in Thailand measured marital power related to domestic violence. Because power is extremely difficult to quantify and measure with adequate construct validity. Only one measure that is reliable and valid to measure power in sexual relationships (Blanc 2001) is the Sexual Relationship Power Scale: (SRPS), which was developed by Pulerwitz,et al., (2000) which also investigate the role of relationship power in sexual decision making and HIV risk. The SRPS contains two subscales that address two conceptual dimensions of relationship power: Relationship control and decision making dominance. Besides power in sexual relationships also household decision making power plays a role in domestic violence.

Domestic violence is now recognized to be a serious social problem, which is linked to household decision-making and marital power. Some studies indicated that the decision-making authority of one partner to make important decision for the family play an important role in the marital structure and domestic violence. In families where husbands dominate decision making wives are at greater risk to face violence in comparison with families where wives and husbands decide together about family matters (Autchara Sakoontaniyom, 1998: 25). The study of Kim & Emery (2003), surveyed married men (the married category includes those simply cohabiting) of 20 years and older. The findings indicated that the violence perpetrated by the husband against the wife. The incidence of husband-to-wife violence was very high in the family with a male dominant power type. Although domestic violence is prevalent across national and cultural boundaries, substantial variations have been found in the rate and severity of violence occurring both within and among countries.

A study of domestic violence in 90 societies in the developing countries, (including one society in a rural area of central Thailand) was undertaken, and it was found that domestic violence is a serious issue. Women reported having been abused by their husbands under conditions of pronounced gender inequality and dependence of women on men (Levinson, 1989 cited by Kritaya Archavanitkul, 1999: 501; Sa, 2004: 3). According to the community based- survey in developing country of Jejeebhoy & Cook, Hindin & Adair (1997), household decision-making was related to domestic violence. Others also found that families with men decision-making dominance have a high occurrence of husband and wife abuse (Campbell (cited by Ornwadee Chotisawat, 2003: 6).

Contrary to the results of the studies quoted above others found that household decision-making had no influence on the domestic violence (Autchara Sakoontaniyom, (1998)). The author investigated 122 of married couples living outside the municipal area of Bangkok and it was found that the decision-making in the family was not related to the domestic violence. Also Ketsara Sriphityakarn, et al., (2002) came to the result that there was no relationship between household decision-making and domestic violence.

However from the concept of power and domestic violence as mentioned in numerous quotations above, it can be concluded that in case of marital power imbalance between men and women, women have less power, due to the social and cultural norms as well as the family structure that favor men to be superiority in power. Power in sexual relationship might be one of the factors that cause domestic violence. Thus is why in this study, the researcher aimed to investigate the factors related to power and domestic violence, such as household decision-making power, sexual relationship authority and the socio-economic status of women and husbands or partners.

2.9 Factors of power and domestic violence

2.9.1 Demographic background and socio-economic status of pregnant women and their husbands or partners

Power factors and domestic violence

1) Demographic background and socio-economic status of pregnant women, husbands or partners

- **Age.** Studies in sub-Saharan Africa on age differences between girls (15 to 19) and their sexual partners show a gap of six or more years, which limits their power to resist unsafe sexual practices (Luke & Kurz, 2002 cited by 16 Days of Activism Against Violence Against Women, Conference: 2005). The older the men are the more power they have (Lichtenstein, 2005: 171-172). The process of sexual activity of young women were controlled by their husbands or partners and sometimes being coerced into having sex (The conclusion from the 16 Days of Activism Against Violence Against Women, Conference, 2005).

- **Education, occupation, income.** The resources theory was developed by Blood & Wolfe, 1960 (cited by Scanzoni, 1988: 367; Sopikul, 2005: 23). The basic tenet of the resource states that the decision-making power of each spouse is directly dependent upon the extent to which that spouse contributes valued resources to the marriage. The theory of resources which assumes that the relative power of husbands and wives in making family decisions depend upon the relative resources such as education, employment, occupational status which each spouse brings into the marriage. Husbands usually have higher power because they control a greater number of these resources. The wife's power in decision-making is assumed to increase as her resources increase (Blood & Wolfe, 1960 cited by Prapaphan Ouonob, 1995: 46). In the intervening decade, several studies have been carried out in Denmark, United State and abroad to test this theory. Data now are available for Germany (Lamouse, 1960; Lupri, 1969), France (Michel, 1967). The resources such as education, occupation and income were related to marital power in the family. The distribution of marital power depends on the balance of value resources among husbands and wives. According to Sopikul (2005: 23), the couples with high income refers to their high level of education and results in high-status occupation; they have high marital power in the family.

In this study, the researcher focused on the education, occupation, and income of the pregnant women related to power.

- **Education** is an important means to gain knowledge and to develop skills which result in a good income and high-status occupation (Sopikul, 2005: 23). Wives with low education and low income may indicate that their economic statuses depend on husbands which might be the reason why husbands are superior and wives are subordinate. (Benja Yoddumnern-Attig, 1992 cited by Rewadee Lertsintanapat, 1998: 23).

The Thai government now follows the policy to support the educational system of the country. Boys and girls in rural and urban areas are treated equally in the educational approach. But still girls are found in urban areas who have more opportunity to learn than girls in rural and remote areas. The reasons for this are limitation in the economic status. Those with a low educational level have less opportunity to select a high rewarded occupation compared to those girls from richer families. Girls from the rural area might work as a daily worker in a factory are employee service jobs with low payment or are unemployment. Their economic statuses depend on their husbands, and this reduces their power in the family (Poonsuk Choaythong, et al., 1998: 411).

- **Occupation.** There are many types of career person who can earn a living, but different types of occupation results in difference of income and living conditions (Busarin Klongphayabal, 1999: 163). The occupation is an indicator of the person's social status (Supang Janthawanit, 1985 cited by Laddawan Panya, 2005: 23). The success in the career and in prestigious occupation depends on a person's good educational background. The more money and prestige the men have the more power they exercise. The occupation then is the basic factor related to the power of pregnant women (Poonsuk Choaythong, et al., 1998: 411; Babcock et al., 1993 cited by Ornwadee Chotisawat, 2003: 3).

- **Income**. Besides their role as a house wife, women nowadays have to work outside the home because of the change in the economic condition of the country and changes in the social environment. Due to the inequity in gender, women are being paid less than men. Since husbands typically are specialized in their occupation and jobs, wives are homemakers or low income workers. Therefore

husbands have greater bargaining power as the ruler of the family (Donya Thanaudom, 1996: 19).

Saranthon Kaewkoon (2004) studied the gender issues and decision making power related to sexual activities in a qualitative and quantitative research approach. 138 women working in the factory, of the Samutsakon province participated in the study, 108 women were investigated with a quantitative method and 30 women participated in a qualitative research attempt. The result of the study indicated that the income of husband had an influence on the power in sexual activity.

A low educational level, low income and unemployment of pregnant women are the important factors which reduce the power in sexual relationships of women and this might go together with violence in the family. Due to their economical dependence, they can not divorce or leave the violent relationship (Heise et al., 1994 cited by Chotima Kanjanakul, 1999: 557).

- **Marital status**

The marital status, when man and woman legally registered their marriage seemed to secure their marital status. But some couples aren't interest in the registration of their marriage; they just live together as husband and wife. These cohabitants have no legal obligation to care for each other or relatives in the family (Wannee Diewisares et al., 2001: 103). Women who live with partners without marriage registration are more likely to be abused than women who in a legal binding marriage situation (Donya Thanaudom, 1996: 112; Wannee Diewisares and et al., 2001: 92-93; Kritaya Archavanitkul, et al., 2003: 48). The marital status might relate to marital power of pregnant women.

2) Demographic background and socio-economic status of pregnant women and domestic violence

When investigating the violence against pregnant women, it is necessary to know about the demographic background and socio-economic status of pregnant women such as age, education, occupation, income and marital status. The information about the demographic background and socio-economic status of women who experienced domestic violence and women who did not were analyzed by Kritaya Archavanitkul, et al., (2003: 48).

- **Age** is one of the factors related to domestic violence. Pensri Phichaisanit found that gender differences in power in marital relationships are the product of Thai social and cultural values. Women marry older man, who will be the leader of the family and can protect them. This becomes very obvious when the wife calls her husband "Pee" which means the elder brother (Yoddumnern-Attig, 1992 cited by Rewadee Lertsintanapat, 1998: 23). This kind of marital relationship is based on an inequality gender role and differences in gender-based power. Women who are living in a power-imbalanced relationship with older husbands will face dominance and domestic violence (B. Lichtenstein, 2005: 712).

Pregnant women aged ≥ 30 years are more likely to be exposed to physical and psychological/emotional abuse than pregnant women aged below 30 or younger (Donya Thanaudom (1996: 67). Others found that pregnant women age < 25 years experience higher physical and psychological or emotional abuse than pregnant women aged > 25 years (Kuning, et al., (2004). Accordance to the study of Kritaya Archavanitkul, et al., (2003: 48), who investigated intimate violence and women's health in Bangkok and one province in the central region of Thailand found that age had a reverse relationship with the violence. In both provinces; women in the younger age group suffered from a higher incidence of violence episodes than women of older age groups. Chuenchom Charoenyouth, et al., (1999) investigated domestic violence and the health impact of abused women in the age range of 20 to 39 years old, who came to the emergency unit of a hospital in Bangkok. She found that pregnant women who were abused are mostly aged below 20 years old (Amaro et al., 1990; Barenson, 1991 and Campbell, 1992 cited by Thananowan, 2004: 21).

- **Education.** The level of education is a significant predictor of gender roles (Mason 1984 & 1987; Gage,. 1995 cited by Sa, 2004: 4; Rahman, 2005: 10). Women with higher education have better opportunities to have a good occupation and a good income which results in good social status (Napaporn Hawanon, 1977; Blood &7 Wolfe, 1960 cited by Prapaphan Ouonob). Women with higher education and a prestigious occupation have better opportunities to get out of violent relationships (Heise et al., 1994 cited by Chotima Kanjanakul, Sunsanee Rueangsorn, 1999: 557; Sa, 2004: 4).

Most studies found that abused women have a low education (Chuenchom Charoenyouth, et al., (1999)). Wannee Diewisares, et al., (2001: 86) investigated the violence against pregnant women in the eastern region of the country, with 481 participants and found that 86 % of them finished high school. Pregnant women with only a primary school education were statistically significantly more often physically and psychologically/emotionally abused than pregnant women, who finished a high school education or women who had a university grade (Donya Thanaudom ((1996: 67) while abused women in Bangkok finished secondary school education only (Kritaya Archavanitkul, et al., (2003: 48). As found in one province of the central region, abused women with low education experienced violence more often than women with a higher education.

Women with a lower education than husbands are more likely to be physically abused prior to their pregnancy (Kuning, et al., 2004). The risk of Bangladeshi women to be abused decrease if they have a higher education (Koenig, et al., 2003 cited by Sa, 2004: 4). Women with higher education have a greater chance to choose an occupation with good income and being financial secured, and their economic autonomy allows them to leave a violent relationship (Hindin & Adair, 2002).

- **Occupation** is also one of the factors related to domestic violence. The unemployed women are at risk to violence (Tjaden & Thoennes, 2000a; Heise & Garcia-Moreno, 2002; Crendall, et al., 2004; Stith, et al., 2004; cited by Fact Sheet, http://www.cdc.gov/ncipc/factsheets/ipvfacts.htm).

Unemployed pregnant women or those who work in the manual labor force had a higher chance to be physically and psychologically abused than pregnant women who are working in an other field (Donya Thanaudom (1996: 75). Abused women often are house wives or they are unemployed (Chuenchom Charoenyouth, et al., (1999).

- **Income** Pregnant women with no income or low income were more likely to be physically and psychologically abused than pregnant women with a moderate and high income (Donya Thanaudom (1996: 75)). Byrne, et al., (1999 cited by Thananowan, 2004: 26), studied domestic violence in 2,863 American women, and found that there is an increased risk for victimization when the women's income is

below the poverty level. 35.6 % of women, who murdered their husbands, had a very low income of 500-1,500 Baht only as being found when studying the 69 subjects in a women prison (Monthip Darasrisak (1994)).

- **Marital status** Some couples prefer to live together without being legally married because they want to avoid high costs in case of a divorce. Some women did not tell their relatives that they are not legally married (Wannee Diewisares, et al., (2001: 103). When conflicts occur in the family, men may use violence to solve the problem because they don't consider women's feeling since no relatives are involved (Donya Thanaudom, 1996: 133). Pregnant women who are not married are likely to experience violence more often than legally married pregnant women (Donya Thanaudom, 1996: 112). Missing marriage registration is an indicator for pending violence against pregnant women (Wannee Diewisares, et al., (2001: 92-93)). It was found that 78 % of pregnant study participants, who were not legally married, were abused. From the study of the Women who are living together with partners and are not married have a higher risk to face violence than married women (Kritaya Archavanitkul, et al., (2003: 48)).

2.9.2 Risk of acquiring HIV/AIDS infection of pregnant women and their husbands and partners

- **Alcohol and drug use**

Women who have been exposed to violence or are living together with a dominant husband or partner are at high risk to be infected with HIV (Dunkle et al., (2003: 9). The abusive men are more likely to have HIV and impose risky sexual practices on their partners. Studies conducted in developed countries indicated that physical and sexual violence in childhood is associated with higher risky sexual behavior in adolescence or adulthood. According to Heise et al., (1999, cited by Wanee Diewisares, et al., 2001: 74), abused women are often suffering from depression and stress. They try to solve their problems by using licit or illicit drugs or substances, and alcohol. Gordon & Mitchell (1988) notified that women consume alcohol or use drugs or substances are unable to make rational decisions. They may have unprotected sex with strangers which may place them at risk of being infected with HIV/AIDS. Alcohol consumption indirectly increases the risk of being infected

with HIV. Under the influence of alcohol women loose self control, and are less able to avoid unsafe sexual acts (Blanken, 1993: 26 cited by Kanjana Patiyouth, 1998: 47).

- **Extramarital sex**

Several studies also highlight that men's use of violence is linked to their own sexual risk taking and hence, their own as well as their partner's risk of STD and HIV increases. For example, in India, a study showed that men who had extramarital sex were six times more likely to report sexual abuse of their wives than men who remained faithful. Moreover, men who reported an STD were 2.5 times more likely to report abuse of wives than men who did not report an STD (Vetten and Bhana, 2004).

Violent men are likely to have more sexual partners and extramarital sex (Luke, N. & Kurz, K. 2002). According to the study of Martin, S., Kilgallen, B., Tsui A.O. et al., (1999), domestic violence has a negative impact on health, including sexual and reproductive health of women. Abusive men were more likely to engage in extramarital sex, acquire STD, and place their wives at higher risk for STD and HIV/AIDS possibly through sexual abuse. Violent men often also have violent sexual activities before marriage and continue doing so after marriage and their sexual behaviours places women at high risk of STD and HIV/AIDS infection (Passorn Limanon (2001: 167).

The relationship of extramarital sex and domestic violence has not been studied yet in Thailand. One study found that women, who are married to husbands having minor wives, don't want to have sex with them and this lead to sexual violence (Widyaningrum (2005: 95)).

- **Inability to negotiate for condom use**. Most women knew or suspected that their husbands had also been in a concurrent relationship with other women. These promiscuous men are at risk of HIV infection, and they may physically force their wives to have sex against their will even when there is the possibility of HIV infection. Women who cannot negotiate safe sex and cannot refuse unwanted sex because lack of sufficient power in their relationships, are afraid that their husbands might beat them. When wives ask their husbands to use condoms, it means that they accuse them to have extramarital sex or a promiscuous behavior (Passorn Limanon, 2001: 170; Blanc, et al., 1996; Varga, 1997: 45-67; Fapohunda &Rutenberg, 1999

cited by Blanc, 2001: Kaewkoon, 2004: 98). Already the fear of being abused might women to give in to sex with infected husbands (WHO, 1998). Several studies conducted in the United States of America and also in Sub-Saharan countries confirmed that women are not able to negotiate condom use due to fear of violence (Eby, et al., 1995; Wingood & Diclemente, 1997; Cabral, et al., 1998; Lichtenstein, 2005; Turmen, 2003). They also fear of conflicts in their relationship (Kaewkoon, 2004: 98). Besides that economically dependent women may surrender to sex with husbands who may be HIV positive and are unable to negotiate for condom use. Women, who are most dependent on the spouse for economic reasons and having children to take care of, are afraid of leaving their marriage because that increases their financial burden tremendously. (Mane, Rao Gupta et al., 1994; Heise and Elias, 1995 cited by Dunkle, et al., 2003).

Even when wives suspect that their husbands had extramarital sex they are afraid to ask them to use a condom (Pimpawan Boonmongkol (1999)). This might be due to the fact that women, according to their social behaviour, are polite, and do not argue with their husbands or question their behaviour. This adds to the subordination of women such as younger age compared with their husbands and economic dependence.

2.10 Preceding research

2.10.1 Domestic violence

Donya Thanaudom (1996) studied the relationship of basic factors**,** family type, stress problems, and perception toward gender roles and physical and psychological as well as emotional abuse of pregnant women. 400 pregnant women who came to the antenatal care clinic of a Mother and Child Hospital were asked to participate in the study. The findings revealed that 12 % of pregnant women were physically abused, 22.5 % were psychologically and emotionally abused. Factors which were significantly related to physical and psychological abuse were educational level, income, occupation, behaviour of alcohol and substance use, gambling, number of children, marital status, family type, sexual relationship, stress problem and the perception toward the gender role of pregnant women.

Gells (1988) examined domestic violence during pregnancy, in selecting a total of 11,904 interview partners including 6,002 being sexually experienced young women. In a sub sample the effects of sexual power on both HIV serostatus and condom use consistency were assessed by using data from a nationally representative sample of sexually experienced young women, 15–24 years of age, in South Africa.35.6 % of pregnant women had higher risks of being physically abuse than non pregnant women. During the first four months of pregnancy the rate of women being abused were 154: 1,000, while five to nine months of pregnancy the rate of abused women increased to 170: 1,000.

Poonsuk Chauythong, et al., (1998) studied domestic violence and factors involved in a group of 400 women aged 15-44 years who visited the outpatient department of Chai Nat hospital, Chai Nat province. The investigation was a cross sectional survey, and the data were collected from 2–30 January, 1997. 68.8 % of women were abused; the proportion of women with psychological and emotional abuse was higher than those being physically and sexually abused. Occupation, income and self-value were related to physical abuse; education and marital status were related to psychological and emotional abuse; age, education, marital status and self-esteem were associated with sexual abuse. The type of cloth wearing, the perception of women towards violence, and the perception of women towards gender roles had no influence on domestic violence.

2.10.2 Power

- Up to now no quantitative research in Thailand about marital power had been conducted**.** Only a qualitative study of Rewadee Lertsintanapat (1998) about gender power relation and safe sexual activity negotiation of house wives had been done. Few studies conducted abroad tried to measure directly the gender power, most of those investigated the power related to decision-making for family planning or condom use**.** None of the research clearly measured the relationship of power and domestic violence, and risk of HIV/AIDS infection.

Rewadee Lertsintanapat (1998) examined in a group of middle class housewives of a rather low socio-economic status the beliefs about sex, sexual behavior, sexual relationship based on gender and power and how they could

negotiate safe sexual practices. The participants visited the mother and child health clinic, of the Public Health Center 61, in Bangkok. The study was a qualitative research. Information was obtained during November 1995 to May 1996. The ability to negotiate to have a safe sexual relationship was low. Most of the women knew that in their sexual relationship they are subordinated, and that their sexual activities depend on the men's sexual desire. The effects were related to age, number of years of living together, and whether the women were economically and financially independent. Women usually did not talk about sexual issues and had no part in decisions about sexual activities. The general idea was, that condom use should be only practiced when the spouse had a sexual intercourse with another women but not when to be together with his wife. The knowledge about sexual transmitted diseases was low.

Saranthon Kaewkoon (2004) studied gender issues and decision power related to sexual activity in a qualitative and quantitative research approach. 138 women working in a factory, of the Samutsakon province participated in the study, 108 women were investigated with a quantitative method and 30 women participated in a qualitative research. The findings indicated that 63.33 % (19 women) never negotiated safe sexual activities with the spouse, 36.66 % (11 women) ever did so but only 7 women succeeded in asking their spouse to use a condom giving as reason to prevent a pregnancy and the infection with a sexually transmitted diseases. 19 women who never negotiated safe sexual activities with their spouse gave as reason, that if they ask the spouse to use a condom he might mean that they don't trust his faithfulness and they were afraid, that he may get angry and leave them. The income and personal characteristics of husbands play an important role in sexual relationships.

Le Ngoc Hai (1996) investigated gender inequality in Vietnam's patriarchal society, 25 female sex workers infected with HIV in Hochiminh city volunteered for the interview. Male dominant role in gender relationship gives men the power to decide about condom use. Beside that the importance of social and cultural factors which were related to condom use among female sex workers and their clients had been addressed. Female sex workers neither have sufficient economic resources nor negotiation power to demand condom use from a potential paying client.

Pulerwitz, et al., (2000) The Relationship Power Scale (SRPS) was developed by Pulerwitz, Gortmaker, and DeJong to measure the power in sexual relationships and to investigate the role of relationship power in sexual decision-making and HIV risk of poor Latina and African American women who visited a community health clinic in America. The interpersonal power influenced others' behavior unilaterally by controlling their resources. The SRPS contains two subscales that address two conceptual dimensions of relationship power: relationship to control and dominance in decision-making. Both Spanish and English versions of the scale were developed. Among others, the scale includes questions about control over decision-making, commitment to the relationship, condom negotiation ability, and freedom of action within the relationship. The SRPS was inversely associated with physical violence and directly associated with education and consistent condom use

Audrey E. Pettifor, et al., (2004) examined the sexual power and HIV risk in South Africa. Participants who are South African women attending antenatal clinics were selected thorough stratified, disproportionate, systematic sampling in the country's nine provinces. A total of 11,904 interviews were completed, including 4,066 with sexually experienced young women, being the sub-sample used in this analysis. Gender power inequities are believed to play a key role in the HIV epidemic through their effects on women's power in sexual relationships. The lack of sexual power was measured by a four-point relationship control scale and by a woman's experience of forced sex with her most recent partner. Forced sex decreased the likelihood of consistent condom use and increases the risk for HIV infection among sexually experienced women in South Africa. While limited sexual power was not directly associated with HIV, it was associated with inconsistent condom use. Women with low relationship control were significantly more likely to report inconsistent condom use, and women reporting forced sex with their most recent sexual partner were also significantly less likely to report consistent condoms use.

The result of the study of Audrey E. Pettifor, et al., (2004) indicated that there was an indirect association between sexual power and HIV infection, which suggests that the primary mechanism through which sexual power exerts effects on HIV risk is condom use consistency. Sexual refusal or negotiation may result in suspicions of

infidelity and carry the risk of violent reactions (Innocenti Digest 6 –Domestic Violence cited by Wacharin, et al., 2003: 64).

2.10.3 Domestic violence and risk of HIV infection

The relevant research about domestic violence and risk of HIV infection are listed below.

Dunkle, K.L. et al., (2004) did a cross-sectional study about gender-based violence, relationship power and risk of HIV infection of 1,366 women visiting antenatal care at four health centers in Soweto, South Africa. Women with violent or controlling male partners are at increased risk of HIV infection. The abusive men are more likely to have HIV or STDs and impose risky sexual practices on partners**.**

Lichtenstein (2004) studied the domestic violence, sexual ownership, and HIV risk in African American women in the American Deep South. Two focus groups were convened to develop a definition of domestic violence as HIV risk, 50 in-depth individual interviews of HIV-positive women were subsequently conducted for specific information on the topic. A final focus group was conducted for verification and feedback. The main finding was that the women lacked the ability to control sexual activities including condom use in abusive relationships with HIV-positive men. The women used various strategies to escape abusive partners and obtain treatment for HIV/AIDS. The study concluded that the links between gender inequity, domestic violence and HIV transmission should appear in prevention materials to encourage domestic violence screening in health settings, and to provide abused women with information on the not-so-obvious risks of being infected in abusive relationships.

Turmen (2003) examined the impact of gender on HIV/AIDS which is an important dimension in understanding the evolution of the epidemic. (How have gender inequality and discrimination against women affected the course of the HIV epidemic?) The study outlines the biological, social and cultural determinants that put women and adolescent girls at greater risk of HIV infection than men. Violence against women or the threat of violence often increases women's vulnerability to HIV/AIDS. An analysis of the impact of gender on HIV/AIDS demonstrates the importance of integrating gender into HIV programming and finding ways to

strengthen women by implementing policies and programs that increase their access to education and information. Women's empowerment is vital to reversing the epidemic.

Dunkle, et al., (2004) studied gender-based violence and HIV infection among 1,366 pregnant women visiting antenatal care at four health centers in Soweto, South Africa, who accepted routine antenatal HIV testing. Private face-to-face interviews were done in the local languages and included assessment of socio-demographic characteristics, experience of gender-based violence, the South African adaptation of the Sexual Relationship Power Scale (SRPS), and risk behaviors including multiple, concurrent, and casual male partners, and transactional sex. A high levels of male control in a woman's current relationship as measured by the SRPS were associated with HIV seropositivity. Dunkle concluded that intimate partner violence, gender-based power inequality and risk behavior of HIV infection of husbands are urgently needed to be studied.

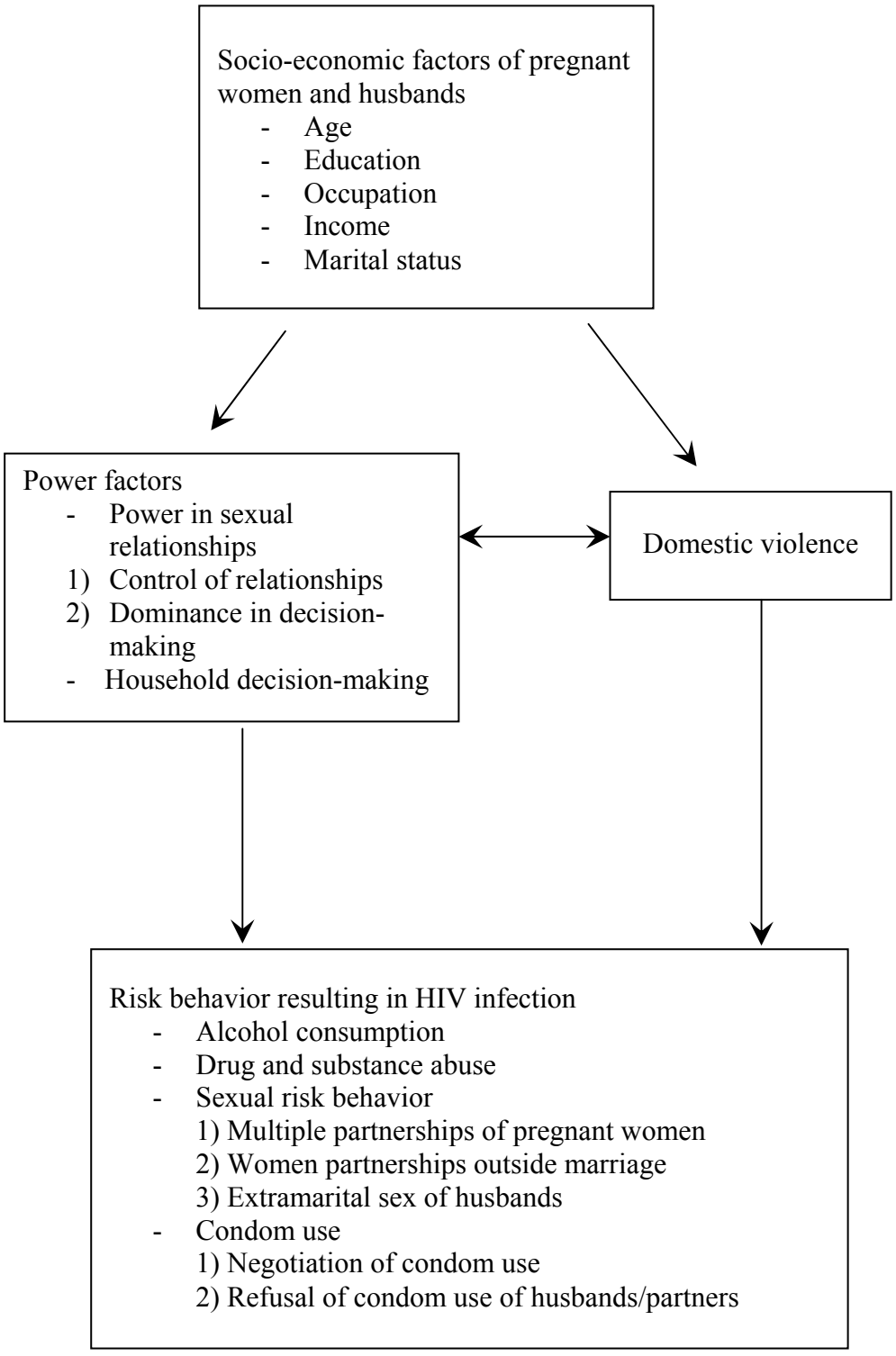
Jewkes, et al., (2003) investigated the associations between a range of markers of gender inequity, including financial, psychological and physical violence, and two proximal practices in HIV prevention, namely discussion of HIV between partners and the woman suggesting condom use. The paper presents an analysis of data from a cross-sectional study of a representative sample of 1,306 women from three South Africa Provinces aged 18-49 years who were interviewed. 1,164 women had a partner in the previous year and were asked questions related to HIV prevention and gender inequalities in the relationship. The result indicate that discussion of HIV was significantly positively associated with education, living in Mpumalaga province, the man being a migrant, the women having multiple partners in the past year, the relationship being poor and there being a substantial age difference between partners. It was concluded that some indicators of gender inequalities are significantly associated with discussion of HIV and condom use.

From the previous researches mentioned above it can be concluded that gender-based power imbalance particularly the marital power and domestic violence are associated with risk of HIV infection. It is hard to find a scale to measure the power in sexual relationships. However it seems to be obvious that the marital power imbalance exists in married life of women and men. The feminist theory based on the

patriarchal society show the gender inequality in sexual relationship including financial, psychological and physical violence. Some studies measured that gender and power is related to condom and contraceptive use. The relationship of power and domestic violence should be further studied because violence in the family damage communication and relationship of husband and wife as well as their health, family planning and child rearing.

Besides that women with violent or dominating male partners are at increased risk of HIV infection, due to limited sexual power to negotiate condom use. The researcher therefore decided to study the power in sexual relationships, domestic violence and risk of HIV infection in pregnant women. The result of this study might be useful in providing information for health personnel for better health services and counseling of abused women as well as to emphasize that intimate partner violence and gender-based power inequalities in relationships are associated with an increased risk of HIV infection.

Conceptional framework



CHAPTER III
METHODOLOGY

This study was conducted as a cross-sectional survey. Information was collected by means of a questionnaire. Pregnant women were asked about their power in sexual relationships, power in decision making in family affairs, violence in the family, and risky behavior in relation to HIV infection. Demographic data and the socio-economic status also had been assessed. Details about the research methodology applied are given below.

Population

Pregnant women visiting the antenatal care clinic of the Rajvithi Hospital were asked to participate in the study. From the research of (Wanee Diewisares, et al., (2002) it is known that pregnant women can be at high risk to experience domestic violence. It was found that 35.6 % of pregnant women were at higher risk for suffering from domestic violence in comparison to non-pregnant women (Gelles, R. 1988 quoted in Donya Thanaudom, 1996: 23). The pregnant women therefore are then the appropriate population for this study.

Sampling

A purposive sampling method was used to select participants for this study. This method is suitable for the selection of a sample because it represents a certain study group according to the research standard selected (Pichit Ritjaroon, 2004: 103). The sample included:

1. Pregnant women who are their first pregnancy but also those who are going through the second, third or fourth pregnancy.
2. Married pregnant women or pregnant women in a not legally binding partnership
3. Willing to participate in the study

Sample size

The sample size was calculated based on the study of Busarin Klongphayabal (1999), who estimated that domestic violence in women in the area of the Muang District of the Sa Kaeo province, amounts to 35.9 % of wives who were sexually abused.

$$n = pqZ/E$$ (Waranya Patharasuk, 2002: 141)

n = sample size
p = proportion of domestic violence = 0.359
q = remaining proportion = 1-p = 0.641
Z = statistical standard value under the normal curve = 1.96
E = error being allowed = 0.05

Formulation $n = 0.359 \times 0.641 \times 1.96/0.0025$

$n = 353.61$

The sample size should not be lower than 354 persons and in this study amounted to 360 pregnant women.

Research instruments

The questionnaire was developed based on the information collected through the literature review and previous research. Experts and advisors had been consulted to verify the accuracy and validity of the content of the questionnaire.

The content of the questionnaire was divided into 5 domains:

Domain 1 The questions of this domain assessed the demographic- and socio-economic background of the respondents and husbands. The questions were designed as multiple choice and open questions.

1. **Age** recorded for the full year in years
2. **Education** defined as highest level one individual had reached in formal or non-formal education respectively such as illiteracy, primary school, secondary school, vocational education, diploma, bachelor degree and master degree or higher.

3. Occupation was assessed as the type of the work being paid for and the participants were categorized into unemployed, general employee, agricultural worker, industrial/factory worker, private office employee, civil servant/state enterprise employee, commercial/trading/private business and others

4. Income was measured by the money earned from working as the average income per month; that might have been salary; revenue; wages; or daily allowances;

5. Marital status was referred to be in a registered marital relationship and not-married in just living together as partners.

Domain 2 In order to inquiry the risk behavior of husbands/partners of the respondents to HIV infection, the investigator used the information obtained from the literature review to choose the appropriate questions for the questionnaire. The content of the questionnaire included alcohol consumption, drug and substance abuse, sexual activity with prostitutes, sexual intercourse with other women.

1. As far as alcohol consumption of husband/partner was concerned the choices for the answers were divided into two groups, 'yes, drink' and 'no, don't drink'. The question referred to all alcoholic beverages. Also the frequency of alcohol drinking was asked, as

- regularly (more than 4 times/week)
- often (3-4 times/week)
- sometimes (1-2 times/week).

2. Drug and substance abuse of husband/partners: The choices for answering the questions were divided into two groups, 'yes, use of drug and substances' and 'no, don't use'. In case of drug and substances use the type of drug and substances used was questioned as well.

3. Sexual intercourse with prostitutes by husband or partner, could be answered with 'yes' or 'no' answer

4. Sexual intercourse with other women could be answered with 'yes' or 'no'. If the answer was 'yes' the questionnaire was continued with question no. 5.

5. Women whose husband/partner had sexual intercourse with other women were asked about the category of women they visited for extramarital sex being 1. a casual sex partner 2. minor wife or 3. others (specify…..).

Domain 3 The investigator used the information obtained from the literature review to design the questions related to risky behavior of pregnant women to acquire HIV infection. The questionnaire consisted of 6 issues such as alcohol consumption, drug and substance abuse, multiple partnerships in the past, partnership outside their marriage, negotiation of condom use, and refusal of husbands/partners to use condoms. Altogether 8 questions were asked:

1. Alcohol consumption of respondents: The choices for answering was divided into two groups, 'yes, drink' and 'no, don't drink'. The question referred to all alcoholic beverages. Also the frequency of alcohol drinking was asked, as
   - regularly (more than 4 times/week)
   - often (3-4 times/week)
   - sometime (1-2 times/week)
2. Drug and substance abuse of respondents, divided into two groups, 'yes, use of drug and substances' and 'no, don't use', in case of a 'yes' answer the type of drugs and substances used was also questioned..
3. Multiple partnerships in the past: It was asked whether the respondents had sexual relationships with other partners besides their husband or permanent partner and also the numbers of sexual partners was asked for. The answers were divided into 4 groups, 'never, no multiple partnerships besides husband/partner', 'boy friend (how many?)', 'lover/partner (how many', and others (to be specified). If the respondents answer was 'yes' meaning that she had a multiple partnerships, the questionnaire was continued with the question no. 4.
4. For answering the question 'Condom use during intercourse with partners in the past' the answers 'never used', 'sometimes', and 'use consistently' were possible.
5. Partnership outside marriage. The answers were divided into 'no, never had a partnership outside marriage' and 'yes, had a partnership outside marriage'.
6. To negotiate condom use could be answered with 'yes' or 'no'.
7. Refusal of husband/partner to use condom could be answered with 'yes' or 'no'.
8. When asked about the reaction of husband/partner when being asked to use condoms, the respondents had the following choices for answering and could

select more then one choice: 1. husband/partner said that he never used a condom. 2. Shouting and being angry 3. Acted as to hurt/hit the participants. 4. Threaten to leave or evict the respondent. 5. Hitting. 6. Seize/damage the condom. 7. Accusing of disloyalty. 8. Laugh as it is a nonsense matter. 9. Saying that it is not necessary to use a condom and 10. Others….specify.

Domain 4 The questionnaire for this domain assessed the power factors

4.1 The questionnaire was used to measure the power in sexual relationships of the participants based on the Sexual Relationship Power Scale: SRPS of Pulerwitz, et al., (2000). The SRPS contains 23 items with two subscales, one subscale with 15 items related to the control of relationship, individual items assessed by using a four-point Likert scale ranging from 1 to 4 points, and 8 items related to dominance in decision-making. Each item was assessed with a score ranging from 1-3 points.

In order to know about the power in the sexual relationships of participants, the scores of the relationship control scale and decision-making dominance scale had to be assessed and interpreted using the scoring procedure of Pulerwitz.

1) The user should calculate the scores related to the control of relationships and dominance in decision-making scales and merge them in order to use it for the Sexual Relationship Power Scale: SRPS.

1.1) The total score of the relationship control scale ranged from 15-60 points and the total score of the dominance of decision-making scale ranged from 8-24 points.

1.2) The mean score of the individual scale had to be calculated by dividing the total score of the scale through the numbers of completed answers.

1.3) The mean score of both scales had to be rescaled to 1 to 4 points using the formula of (mean score-minimum score)/(maximum score-minimum score) X3+1.

2) The mean score of both scales had an equal weighting of 1 to 4 points, the mean score of the relationship control scale and the dominance decision-making scale

was merged and used for calculating the total score of the Sexual Relationship Power Scale (SRPS) using the formula as being explained below:

Total score of the Sexual Relationship Power Scale (SRPS) = mean score of the relationship control scale + mean score of the dominance in decision-making scale/2

2.1) The total score of Sexual Relationship Power Scale (SRPS) was rescaled to 1 to 4 points by using the formula: Total score of the (sexual relationship power scale-minimum score) / (maximum score-minimum score) X3+1

2.2) The score of Sexual Relationship Power Scale (SRPS) was categorized into a low, moderate and high level.

The low sexual power had a score of 1 – 2.430

The moderate sexual power had a score of 2.431 – 2.820

The high sexual power had a score of 2.821 – 4

The relationship control and dominance in decision-making of participants were also measured.

1) The relationship control scale comprised of 15 questions related to husbands/partners way to control participants such as in matters of condom use, wearing cloth and appearance in the public. Each item was scored on a 4-point Likert scale, with the following meaning 1 = Strongly agree, 2 = Agree, 3 = Disagree, and 4 = Strongly disagree. The total score of the relationship control scale ranged from 15 to 60 points. In case a participant had a high total score on the relationship control scale that indicated that participants had a low level of relationship control and participants with a low total score of relationship control scale had a high level of relationship control.

The scores of the relationship control scale could have 15 to 60 points and were divided into 3 groups using the mathematical average ($\overline{X}$ = 40.41) and standard deviation (S.D. = 5.266). The score ≤ $\overline{X}$ -0.5 S.D (<37 points). = high control of relationships, score between $\overline{X}$ + 0.5 S.D. (38-43 points) = moderate level of relationships control, and ≥ + 0.5 S.D. (≥ 44 points) = low control in relationships.

2) The dominance in decision-making scale consisted of 8 questions related to who had the power to make decisions in sexual relationships and the friendships of

wives. The choices of answer were: 1 point = husband/partner only, 2 points = husband/partner and wife, and 3 points = wife only. The total score of dominance in decision-making scale ranged from 8 to 24 points, and participants with high total score of dominance in decision-making indicated that the wife was dominant in the decision-making, while when the husband/partner were dominant the participant had a low total score on the scale.

The score of decision-making dominance scale was 8 to 24 points and was divided into 3 groups using the mathematical average ($\overline{X}$ = 15.03) and standard deviation (S.D. = 2.784). The score ≤ $\overline{X}$ -0.5 S.D (≤ 13 points). = husbands/partners dominate the decision-making, score between $\overline{X}$ +0.5 S.D. (14-16 points) = participants and husbands/partners, both have equal decision-making power, and ≥ + 0.5 S.D. (≥ 17 points) = wives/participants dominate the decision-making.

4.2 Household decision making was measured by 10 questions asking who made the final decision in the family issue such as buying a car, a house, having a child, selecting a new home, invest in business, care for family members being sick and the decide about children's matter. The questionnaire was modified from the couple decision making power questionnaire of Autchara Sakoontaniyom, (1998) which was based on the couple decision making power model of Strauss et al., (1980). The response categories were husband only = 1 point, husband and wife equally = 2 points, and wife only = 3 points.

The score of the household decision-making scale ranged from 10 to 30 points, participants with a high score of household decision making were regarded as wives/participants who dominate the decision-making process, while participants with a low score were indicative of the fact that the husbands/partners dominate the decision-making. The scores of household decision making scale were classified based on the criteria of Wichien Katesing (1995: 9).

Interval = maximum score – minimum score/ number of response in category

= 30–10 /3 = 6.5 = 7

The scores were divided into 3 groups

Husband only	=	10-16 points
Husband and wife equally	=	17-23 points

Wife only = 24-30 points

- Husband only means that husband mostly makes a decision about the family issue.
- Husband and wife equally mean that husband and wife share their opinion in the decision-making process equally.
- Wife only means that wife mostly makes a decision about family matters.

Domain 5 The questionnaire for the domain 5 was modified from the women's health and life events questionnaire to measure the domestic violence. The content of the questionnaire was divided into 3 parts, psychological/emotional violence (question no. 1-4), physical violence (question no. 5-10), and sexual violence (question no. 11-13). The women were asked to determine their life time and current (12 months before the interview) experience with physical, psychological/emotional and sexual intimate partner violence,and the frequency of violence, once or 2-5 times or more than 5 times.

Data collection

Information was collected using the following procedure:

1. A letter was issued from the Faculty of Social Sciences and Humanities to the Director of the Rajvithi Hospital asking for cooperation and permission to collect the information for this study.
2. The thesis proposal and questionnaire was submitted to The Committee on Human Rights Related to Human Experimentation for consideration to conduct the study.
3. After receiving the letter of permission to collect the information and conduct the study, the investigator went to see the head of the antenatal care clinic and other persons involved, explaining them the objective of the study and the features of the questionnaire.
4. The investigator selected the pregnant women for an interview and introduced herself and explained the objective of the study to the women, Those who were willing to participate were asked for permission to be interviewed, if they don't want to participate in the study they left the place of interview. The investigator told

them whether they participate or not in the study that this will not affect the services they receive from the antenatal care clinic presently or in future. The validity of information was checked before analyzing them.

5. Data were collected from the 29 January 2007 to 28 February 2007 during 8.00 -12.00 hour every Monday to Friday, 360 pregnant women participated in the study.

Research tools

A questionnaire was used as a research tool. The literature was reviewed in order to gain an insight into the research question. The content validity was assured by an expert and qualified research advisors. For a trial 30 sets of the questionnaire were given to the pregnant women who visited the antenatal care clinic of Rajvithi Hospital and pregnant women who lived in the community of Thikamporn village outside the study area, who were asked to answer each item in order to test the language used. For assessing the reliability of the questionnaire Cronbach's alpha coefficient was used. The questionnaires were applied after some modification.

1. The reliability of the questionnaire related to the sexual relationship power scale was 0.5593, the reliability of two subscales:

1.1 The relationship control scale, the reliability was 0.5380

1.2 The decision-making dominance scale, the reliability was 0.6167

2. The reliability of the questionnaire related to household decision-making was 0.6583

3. The reliability of the questionnaire related to domestic violence was 0.8620 and the reliability of three subscales:

3.1 Psychological/emotional abuse scale, the reliability was 0.7016.

3.2 Physical abuse scale, the reliability was 0.7738

3.3 Sexual abuse scale, the reliability was 0.7438

The reliability of sexual relationship power scale was rather low, 0.5593; the investigator modified the language used in the questionnaire, after the modification the questionnaires were applied again in asking 30 pregnant women who visited the antenatal care clinic of Rajvithi Hospital.

1. The reliability of the questionnaire related to sexual relationship power scale was changed to 0.7411, and the reliability of two subscales was also changed.

1.1 The relationship control scale, the reliability was 0.7534

1.2. The decision-making dominance scale, the reliability was 0.7040

The statistical software program SPSS/PC+ (Statistical Package for the Social Science was used for the reliability analysis.

Data analysis

The information obtained were coded and transferred into a data spreadsheet before the statistical analysis by using the statistical software program SPSS/PC+ (Statistical Package for the Social Science Personal Computer) version 11.5, with statistical significant at 0.05. The data set was analyzed by applying the following statistical techniques:

1. Descriptive statistic: Demographic and socio-economic variables were assessed using descriptive statistics such as frequency; percentage; mean value; standard deviation (SD) maximum and minimum values.

2. Analytical statistics: Chi-square tests had been performed for analyzing the relationship between independent variables and dependent variables, with statistical significant at 0.05.

$H_{0:}$ independent variables do not correlate with dependent variables

H_1: independent variables correlate with dependent variables

In case the independent variables had high correlation with the dependent variables, the coefficient V (coefficient of Cramer's) and ∅ (Phi Coefficient) value is 1 or -1.

Coefficient value of V (Cramer's V): independent and dependent variables have 2 groups of sampling, equally number of sampling (information in Table 2x2)

Coefficient value of ∅ (Phi Coefficient): independent and dependent variables with more than 2 groups of sampling (information was not in Table 2x2)

The correlation of independent and dependent variables was analyzed.

1) The information of demographic background, socio-economic status of pregnant women and husbands/partners, relationship power and domestic violence contain independent and dependent variables. Independent variables are age,

education, occupation, income and marital status. Dependent variables are sexual relationship power and domestic violence

2) The information of power factors, domestic violence, and risk behavior of pregnant women and husbands/partners to HIV infection were analyzed. The independent variables are sexual relationship power and household decision-making. Dependent variables are:

1. Domestic violence and
2. Risk behavior of pregnant women in relation to HIV infection.
   - 2.1 Alcohol consumption
   - 2.2 Drug and substance abuse
   - 2.3 Partnership outside marriage
   - 2.4 Condom use negotiation
   - 2.5 Refusal to use condom of husband/partner
3. Risky behavior of husband/partner of pregnant women to HIV infection
   - 3.1 Alcohol consumption
   - 3.2 Drug and substance abuse
   - 3.3 Sexual activity with prostitute
   - 3.4 Sexual activity with other women

CHAPTER IV
RESULTS

This study aims to investigate power in sexual relationships, dominance in decision making, factors related to domestic violence and risk behavior related to HIV/AIDS infection of pregnant women who visited the antenatal care clinic of Rajvithi Hospital, Bangkok. The results of seven different aspects of the study are given as follows:

4.1 The demographic background and socio-economic status of pregnant women and their husbands or partners.

4.2 Domestic violence

4.3 Power of pregnant women in sexual relationships

4.4 Risk behavior of pregnant women and husbands or partners in connection with HIV/AIDS infection

4.5 The relationship of the demographic background, socio-economic status to the power of pregnant women and their husbands or partners and to domestic violence.

4.6 The power in sexual relationships, household decision-making, domestic violence and risky behavior of pregnant women and husbands/partners in connection with HIV/AIDS infection

4.7 The relationship of domestic violence and risky behavior of pregnant women in connection with HIV/AIDS infection.

4.1 The demographic background and socio-economic status of pregnant women and husbands or partners.

The demography as well as the socio-economic status including age, education, occupation, income and marital status of pregnant women and husbands or partners had been assessed from 360 pregnant women who came to visit the antenatal care clinic of Rajvithi Hospital.

The average age of the pregnant women was 26 years. Nearly half of them, 48.1 % were in the age range of 16-25 years; and 42.5 % in the range of 26-35 years; and 0.8 % were only <15 years old and 0.6 % aged > 46 years. 48.1 % of pregnant women finished secondary school; 18.9 % had a primary school education; 15.8 % graduated with a bachelor degree; 1.4 % had no education, and 0.6 % graduated with a master degree. 27.5 % of pregnant women worked as private office employee; 26.9 % were unemployed; 22.8 % were general workers, 7.2 % were civil servants and 0.8 % worked as state enterprise employees. None of the pregnant women were agricultural worker because they lived in Bangkok. The income of pregnant women related to their occupation; 40 % had an income of 5,001-10,000 Baht/month; 26.9 % of them had no income; 0.8 % had an income of 30,001-40,000 Baht/month, 0.8 % had an even higher income of 40,001-50,000 Baht/month and the income of 0.8 % of them was in the range of ≥ 50,001 Baht. The average income of pregnant women was 8,640 Baht/month (Table 1).

The average age of the husbands or partners of the pregnant women was 30 years; 52.8 % of them aged 26-35 years; 25 % were in the age ranged of 16-25 years; 2.5 % were ≥ 46 years old. 39.7 % of the husbands or partners of pregnant women finished secondary school; 22.8 % had a primary school education; 0.8 % had no education, and 1.7 % graduated with a master degree. The educational level as well as the occupation of pregnant women and husbands or partners was quite similar; 32.2 % of husbands or partners worked as private office employee; 30.6 % were unskilled workers; 16.4 % worked in a commercial/trading/private business, and 3.6 % were unemployed. The average income of husbands or partners was 15,203 Baht.52.8 % of them had an income of 5,001-10,000 Baht per month; 22.8 % had 10,001-20,000 Baht/month; 3.6 % had no income; the income of 1.7 % was 30,001-40,000 Baht/month; of 1.9 % even higher with 40,001-50,000 Baht/month, and 1.7 % had an income of > 50,001 Baht/month (Table 1).

Table 1 Demographic background, socio-economic status of pregnant women and their husbands or partners

Variable	Pregnant women		Husbands/partners	
	Number	Percentage	Number	Percentage
Age				
≤ 15	3	0.8	0	0.0
16-25	173	48.1	90	25.0
26-35	153	42.5	190	52.8
36-45	29	8.1	71	19.7
≥ 46	2	0.5	9	2.5
Total	360	100.0	360	100.0
	$\overline{X}$ = 26.45 S.D. = 5.875		$\overline{X}$ = 30.25 S.D. = 6.901	
	MAX = 46 MIN = 14		MAX = 56 MIN = 16	
Education				
Illiterate	5	1.4	3	0.8
Primary school	68	18.9	82	22.8
Secondary school	173	48.1	143	39.7
Vocational education	26	7.2	23	6.4
Diploma	29	8.1	44	12.2
Bachelor degree	57	15.8	59	16.4
Master degree and higher	2	0.5	6	1.7
Total	360	100.0	360	100.0
Occupation				
Unemployed	97	26.9	13	3.6
Unskilled worker	82	22.8	111	30.8
Agricultural worker	0	0.0	1	0.3
Industrial/factory worker	7	1.9	7	1.9
Private office employee	99	27.5	116	32.2
Civil servant	26	7.2	37	10.3

Table 1 Demographic background, socio-economic status of pregnant women and their husbands or partners (cont.)

Variable	Pregnant women		Husbands/partners	
	Number	Percentage	Number	Percentage
Commercial/trading/ Private business	46	12.8	59	16.4
Others	3	0.8	16	4.4
Total	360	100.0	360	100.0
Income				
No income	97	26.9	13	3.6
≥ 5,000	46	12.8	29	8.1
5,001 – 10,000	144	40.0	190	52.8
10,001 – 20,000	55	15.3	82	22.8
20,001 – 30,000	9	2.5	27	7.5
30,001 – 40,000	3	0.8	6	1.7
40,001 – 50,000	3	0.8	7	1.9
≥ 50,001	3	0.8	6	1.7
$\overline{X}$ = 8,640.47 S.D. = 14,523.867			$\overline{X}$ = 15,202.78 S.D.= 34,537.41	
MAX = 200,000 MIN = 1,800			MAX = 600,000 MIN = 2,200	
Marital status				
Not registered	259	71.9		
Registered	101	28.1	-	
Total	360	100.0		

4.2 Domestic violence

Domestic violence includes physical, psychological/emotional, and sexual abuse. In this study, the investigator measured domestic violence by questioning the participants whether they were abused at some point in their lives and in the past 12 months by their husband or partner or not. Frequency of abuse and violence also was assessed as once or 2-5 times or more than 5 times.

4.2.1 Domestic violence and pregnant women

4.2.1.1 Psychological/emotional abuse

4.2.1.2 Physical abuse

4.2.1.3 Sexual abuse

4.2.1.1 Psychological/emotional abuse

From the participants 72.2 % experienced psychological/ emotional abuse, 65.0 % had been insulted or made to feel bad about themselves, 11.7 % had been threatened to harm them directly or indirectly in the form of threatening to hurt them or someone the participants cared about were threatened to be harmed (See Appendix, Table 6). 27.8 % of participants never experienced psychological/ emotional abuse (Table 2).

4.2.1.2 Physical abuse

From the participants 49.7 % at least experienced one kind of physical abuse (Table 2). 30.0 % were pushed or shoved; 10.3 % were kicked, dragged, or beaten (See Appendix, Table 9).50.3 % of participants never experienced physical abuse,

4.2.1.3 Sexual abuse

From the participants 46.1 % at least experienced one type of sexual abuse (Table 2). 41.7 % of them had to give in to sexual intercourse against their will because they were afraid about the reaction of their partners, 11.4 % being forced to a kind of sexual act they found degrading or humiliating (See Appendix, Table 12). 53.9 % of participants were not sexually abused.

Table 2 Domestic violence and pregnant women

Domestic violence	Pregnant women (360)	Percentage (100.0)
Psychological/emotional abuse		
No	100	27.8
Yes	260	72.2
Physical abuse		
No	181	50.3
Yes	179	49.7
Sexual abuse		
No	194	53.9
Yes	166	46.1

Remark: Woman may be abused in more than one aspect

4.2.2 Combination of types of domestic violence

It is not only the wounds the victim gets from physical violence such as hitting, pushing, shoving, use of weapons causing wounds but the victim's mental or psychological condition also is affected. The physical abuse may also lead to sexual abuse. In this study, the participants had been categorized into 8 groups for measuring abuse. 1) Psychological/emotional abuse only, 2) physical abuse only, 3) sexual abuse only, 4) psychological/emotional and physical abuse, 5) psychological/emotional and sexual abuse, 6) physical and sexual abuse, 7) psychological/emotional, physical and sexual abuse, and 8) never experienced domestic violence neither psychological/ emotional abuse nor physical abuse or sexual abuse. 84.2 % of participants experienced domestic violence, only 15.8 % never experienced some kind of domestic violence, 31.4 % of participants had abused psychologically/emotionally, physically and sexually, 20.5 % were psychologically/emotionally abused, 18.8 % were psychologically/emotionally and physically abused, 5.3 % were sexually abused, and 3.0 % physically and sexually (Table 3).

From the 36.5 % of participants who were psychologically/emotionally abused were also be physically and sexually abused, 23.9 % were psychologically/ emotionally abused, 53.1 % were physically, psychologically/emotionally and

sexually abused, 31.8 % experienced physical and psychological/emotional abuse; 10.1 % were physically abused; 57.3 % had experience with sexual, psychological/ emotional and physical abuse, and 27.7 % experienced sexual and psychological/ emotional abuse (See Appendix, Table 1).

Table 3 Effects of domestic violence and pregnant women

Effects of domestic violence	**Number of pregnancy women**	**Percentage**
No	57	15.8
Yes	303	84.2
Psychological/emotional abuse	62	20.5
Physical abuse	18	5.9
Sexual abuse	16	5.3
Psychological/emotional and physical abuse	57	18.8
Psychological/emotional and sexual abuse	46	15.2
Physical and sexual abuse	9	3.0
Psychological/emotional, physical and sexual abuse	95	31.4
Total	303	100.0
Total	**360**	**100.0**

4.3 Power of pregnant women in sexual relationships

Power of pregnant women was assessed in terms of sexual relationships, control of relationships, and dominance in decision-making and household decision-making power.

4.3.1 Power in sexual relationships

The power of participants related to sexual relationships was measured by the Sexual Relationship Power Scale (SRPS) of Pulerwitz, et al., (2000). The score

of the Sexual Relationship Power Scale (SRPS) of participants ranged from 1.427-3.446 points (from the score of 1-4 points) and scores were categorized according to the level of the power of sexual relationship based on the Pulerwitz criteria. 42.2 % of participants were moderately satisfied with their sexual relationship, 37.5 % expressed a low level of satisfaction and 20.3 % were highly satisfied with their sexual relationship (Table 4).

4.3.2 Power in controlling relationships

For measuring the power in controlling relationships scores ranging from 25-57 points were used. The scores were determined by calculating the mathematical average and standard deviation to identify the level of the control over the relationship. 40.8 % of participants had a moderate level of control over relationships, 31.9 % a high level, and 27.2 % a low level (Table 4).

4.3.3 Dominance in decision making

The total score for this item ranged from 8 to 23 points. The scores were calculated by the mathematical average and standard deviation to categorize the level of dominance in decision making. 43.6 % participants and husbands/partners were equally in decision making, for 27.8 % of participants only the husband/partner made the decision and 28.6 % the participant decided alone (Table 4).

4.3.4 Household decision making

The total score for household decision making was in the range of 10-30 points; the scores were calculated using the mathematical average and standard deviation to classify the level of household decision making power. 75 % participants and husbands/partners decided equally about household affairs, for 15 % of the husband/partner decided and only 10 % of the participants decided (See Appendix, Table 5).

Table 4 Power in sexual relationships, control over relationships, dominance in household decision making

Power factors	Number of pregnant women	Percentage
Power in sexual relationship		
Low (1-2.430 points)	135	37.5
Moderate (2.43-2.820 points)	152	42.2
High (2.821-4 points)	73	20.3
Total	360	100.0
$\overline{X}$ = 2.506 S.D. = 0.369	MAX = 3.446 MIN = 1.427	
Relationship control		
High (≤ 37 points)	115	31.9
Moderate (38-43 points	147	40.8
Low (≥ 44 points)	98	27.2
Total	360	100.0
$\overline{X}$ = 40.41 S.D. = 5.266	MAX = 57 MIN = 25	
Decision-making dominance		
Husband/partner (≤ 13 points)	100	27.8
Husband/partner and participant (14-16 points)	157	43.6
Participant (≥ 17 points)	103	28.6
Total	360	100.0
$\overline{X}$ = 15.03 S.D. = 2.784	MAX = 23 MIN =8	
Household decision-making		
Husband/partner (10-16 points)	54	15.0
Husband/partner and participant (17-23 points)	270	75.0
Participant (24- 30 points)	36	10.0
Total	360	100.0
$\overline{X}$ = 19.71 S.D. = 3.377	MAX = 30 MIN = 10	

4.4 Risk behavior of pregnant women and husbands or partners in connection with HIV/AIDS infection

4.4.1 Risk behavior of pregnant women related to HIV infection

Risky behavior of pregnant women related to HIV infection included alcohol consumption, drug and substance abuse, having a partnership outside their marriage, lack of negotiation power for the use of condoms, refusal of husbands/ partners to use a condom.

1) Alcohol consumption

87.5 % of participants didn't drink alcohol, only 12.5 % consumed alcohol, 10.3 % drank alcohol sometimes (<1-2 times/week), 1.9 % often (3-4 times/week), and 0.3 % regularly (> 4 times/week) (Table 5).

2) Drug and substance abuse

99.4 % of participants didn't use drug and substances, 0.6 % used drug and substance, 0.3 % used pain reliever pills, 0.3 % used diuretics, 4.2 % of participants did smoke, but smoking cigarette were not included into addicted substance abuse (Table 5).

3) Partnership outside the marriage

94.7 % of participants didn't have a partnership outside their marriage, and only 5.3 % of them had such a relationship (Table 5).

4) Negotiation of condom use

70 % of participants asked their husbands/partners to use a condom, and 30 % never asked them (Table 5).

5) Refusal of condom use

42.8 % of husbands/partners of participants refused to use a condom, and only 27.2 % of them agreed to use one (Table 5).

6) The reaction of husbands/partners after the refusal to use a condom

Participants could give more than one answer. 22.5 % of husbands/ partners told they never used condom, 16.4 % of them were angry and shouted at the women, 15.8 % thought it was unnecessary to use condom, 6.1 % laughed as it was nonsense, 2.5 % accused the wife to be disloyal, 1.4 % seized/damaged the condom, and 0.6 % acted as to hurt/hit the women (Table 5).

The risky behavior of pregnant women prior to their marriage

1) Multiple partnerships

62.2 % of participants never had a multiple partnerships, 37.8 % had multiple partnerships prior to their marriage, 31.4 % had a lover/partner, and 6.4 had a boy friend (Table 5).

2) Condom use

The husbands/partners of 27.8 % of participants never used condom, 5.8 % husbands used condoms inconsistently, and 4.2 % used condoms consistently (Table 5).

4.4.2 Risky behavior of husbands/partners related to HIV infection

Risky behavior of men related to HIV infection may be associated with violence in the family, and also increase the women's risk to be infected with HIV through forced sex. The risky behavior of husbands/partners included drinking alcohol, drug and substance abuse, sexual intercourse with prostitutes, sexual intercourse with other women than spouse.

1) Alcohol consumption

64.4 % of husbands/partners consumed alcohol, 35.6 % did not consume alcohol, 34.7 % drank sometimes (<1-2 times/week), 17.2 % drank often (3-4 times/ week), and 12.5 % drank regularly (> 4 times/week) (Table 5).

2) Drug and substance abuse

98.8 % of husbands/partners did not abuse drugs and substances, 0.6 % smoked cigarettes and use of amphetamines, 0.3 % used pain reliever pill, 0.3 % used of sleeping pills. 43.8 % of husbands/partners who did not use drugs and substances but did smoke cigarettes (Table 5).

3) Sexual intercourse with prostitutes

The majority of participants trusted their husbands/partners and believed that they were in a faithful monogamous relationship. 75.6 % of participants reported that their husbands/partners didn’t visit prostitutes, 24.4 % accepted that their husbands/partners visited prostitutes (Table 5).

4) Sexual intercourse with other women

Most of the participants had been of the belief that their husbands/partners are in a monogamous relationship. 69.7 % of participants were confident that their

husbands/partners don't have sexual intercourse with other women, 30.3 % admitted that their husbands/partners had sexual intercourse with other women. 23.1 % of husbands had a casual sex partner, and 7.2 % a minor wife (Table 5).

Table 5 Risky behavior of pregnant women and husbands/partners related to HIV infection

Variables	No. of pregnant women	Percentage
Risky behavior of pregnant women related to HIV infection		
Alcohol consumption		
No	315	87.5
Yes	45	12.5
➢ >4 times/week	1	0.3
➢ 3-4 times/week	7	1.9
➢ <1-2 times/week	37	10.3
Total	360	100.0
Drug and substance abuse		
No	358	99.4
Yes	2	0.6
Pain relieve pills	1	0.3
Diuretics	1	0.3
Total	360	100.0
Partnership outside marriage		
No	341	94.7
Yes	19	5.3
Total	360	100.0
Negotiation of condom use		
No	108	30.0
Yes	252	70.0
Total	360	100.0

Table 5 Risky behavior of pregnant women and husbands/partners related to HIV infection (cont.)

Variables	No. of pregnant women	Percentage
Refusal of condom use		
No	98	27.2
Yes	154	42.8
Total	252	70.0
The reaction of husbands/partners after the refusal to use condoms		
- Being told he never used condom	81	22.5
- Shouting/angry	59	16.4
- Act as to hurt/hit	20	5.6
- Threatening to leave participant or evict participant from the home	11	3.1
- Hurt/batter	2	0.6
- Seize/damage the condom	5	1.4
- Accusing of disloyalty	9	2.5
- Laugh as it was a nonsense matter	22	6.1
- Thought it was unnecessary to use condom	57	15.8
Remark: More than one answer could be given		
Risk behavior of husbands/ partners related to HIV infection		
Alcohol consumption		
No	128	35.6
Yes	232	64.4

Table 5 Risky behavior of pregnant women and husbands/partners related to HIV infection (cont.)

Variables	No. of pregnant women	Percentage
Alcohol consumption		
➢ >4 times/week	45	12.5
➢ 3-4 times/week	62	17.2
➢ <1-2 times/week	125	34.7
Total	360	100.0
Drug and substance abuse		
No	356	
Yes	4	
Cigarette, amphetamine	2	0.6
Pain reliever pill	1	0.3
Sleeping pill	1	0.3
Total	360	100.0
Sexual intercourse with prostitute		
No	272	75.6
Yes	88	24.4
Total	360	100.0
Sexual intercourse with other women		
No	251	69.7
Yes	109	30.3
Casual sex partner	83	23.1
Minor wife	26	7.2
Total	360	100.0

4.5 The relationship of the demographic background, socio-economic status to the power of pregnant women and their husbands or partners and to domestic violence.

4.5.1 The relationship of the demographic background, and the socio-economic status of pregnant women and their husbands/partners to women's power

The demographic background and socio-economic status of pregnant women had been investigated as well as their power in sexual relationships and household decision-making.

1) The demographic background and socio-economic status of pregnant women and their power in sexual relationships and household decision-making

Education, occupation and income of pregnant women had a significant relationship with the power in sexual relationships (P=0.05). Pregnant women with higher education had higher power in sexual relationship, and pregnant women whose education was lower also had lower power in sexual relationships. The education of pregnant women were significantly related with the power in sexual relationships (p-value = 0.018, coefficient Cramer's V = 0.206 or 20.6 %). Pregnant women who were unemployed had lower power in sexual relationships than those pregnant women who were employed. Occupation of pregnant women was significantly related to the power of sexual relationships (p-value = 0.004). Unemployed pregnant women had low power in sexual relationships. Thus the income of pregnant women was significantly associated with power in sexual relationships (p-value = 0.008) (Table 6).

Age and marital status were not associated with the power in sexual relationships (p-value = 0.099 and p-value =0.592) (Table 6).

Occupation of pregnant women was statistically significantly related to household decision-making (P=0.05, p-value = 0.002). Age, education and marital status were not associated with the household decision-making (p-value= 0.556, p-value = 0.485, and p-value = 0.390 respectively) (Table 6).

2) The demographic background and socio-economic status of husbands/partners and their power in sexual relationship and household decision-making

Only educational level of husbands/partners was directly associated with power in sexual relationships (P = 0.05, p-value = 0.039). Age, occupation and income of husbands/partners were not associated with the power in sexual relationships (p-value = 0.750, p-value = 0.225 and p-value=0.089 respectively) (Table 6).

Age, education, occupation and income of husbands/partners had no relationship with household decision-making (p-value = 0.494. p-value = 0.457, p-value = 0.059 and p-value = 0.052 respectively) (Table 6).

Table 6 Demographic background and socio-economic status, power in sexual relationships and power in household decision-making of pregnant women and husbands/partners

Demographic background and socio-economic status	Power factors					
	Sexual relationship			Household decision-making		
	High	Moderate	Low	Husband	H&W	Wife
Pregnant women						
Age						
≤ 15-25 years	77(43.8)	62(35.2)	37(21.0)	30(17.0)	128(72.7)	18(10.2)
26-35 years	49(32.0)	74(48.4)	30(31.0)	18(11.8)	121(79.1)	14(9.2)
≥ 36 years	9(29.0)	16(51.6)	6(19.4)	6(19.4)*	21(67.7)	4(12.9)
	X^2 = 7.798, p-value = 0.099			X^2 = 3.011, p-value = 0.556		
				E_{ij} * < 5 = 2 cells (22.2 %)		
Education						
Illiteracy/primary school	38(52.1)	25(34.2)	10(13.7)	15(20.5)	50(68.5)	8(11.0)
Secondary school	66(38.2)	74(42.8)	33(19.1)	26(15.0)	130(75.1)	17(9.8)

Table 6 Demographic background and socio-economic status, power in sexual relationships and power in household decision-making of pregnant women and husbands/partners (cont.)

Demographic background and socio-economic status	Power factors					
	Sexual relationship			Household decision-making		
	High	Moderate	Low	Husband	H&W	Wife
Diploma/vocation education	19(34.5)	22(40.0)	14(25.5)	8(14.5)	40(72.7)	7(12.7)
Bachelor and higher	12(20.3)	31(52.5)	16(27.1)	5(8.5)	50(84.7)	4(6.8)
	X^2 = 15.340, p-value = 0.018 V = 0.206			X^2 = 5.471, p-value = 0.485		
Occupation*						
Unemployed	47(48.5)	37(38.1)	13(13.4)	19(19.6)	74(76.3)	4(4.1)
Unskilled worker	39(47.6)	25(30.5)	18(22.0)	18(22.0)	53(64.6)	11(13.4)
Factory worker/ Private office employee	30(28.3)	50(47.2)	26(24.5)	11(10.4)	86(81.1)	9(8.5)
Civil servant	4(15.4)	17(65.4)	5(19.2)	1(3.8)*	24(92.3)	1(3.8)*
Commercial/trading/ Private business/others	15(30.6)	23(46.9)	11(22.4)	5(10.2)	33(67.3)	11(22.4)*
	X^2 = 22.399, p-value = 0.004 V = 0.176			X^2 = 24.695, p-value= 0.002 V =0.185 E_{ij} * < 5 = 3 cells (20.0 %)		
Income						
No income	47(48.5)	37(38.1)	13(13.4)	19(19.6)	74(76.3)	4(4.1)
≤ 5,000 Baht	22(47.8)	15(32.6)	9(19.6)	9(19.6)	30(65.2)	7(15.2)*
5,001-10,000 Baht	52(36.1)	58(40.3)	34(23.6)	9(13.2)	107(74.3)	18(12.5)
10,001-20,000 Baht	9(16.4)	33(60.0)	13(23.6)	7(12.7)	43(78.2)	5(9.1)
>20,001 Baht	5(27.8)	9(50.0)	4(22.2)*	0*(0)	16(88.9)	2(11.1)*

Table 6 Demographic background and socio-economic status, power in sexual relationships and power in household decision-making of pregnant women and husbands/partners (cont.)

Demographic background and socio-economic status	Power factors					
	Sexual relationship			Household decision-making		
	High	Moderate	Low	Husband	H&W	Wife
	X^2 = 20.786, p-value = 0.008 V = 0170 E_{ij} < 5 = 1 cell (6.7 %)			*****Too few samples for analysis		
Marital status						
Unregistered	96(37.1)	107(41.3)	56(21.6)	43(16.6)	191(73.7)	25(9.7)
Registered	39(38.6)	45(44.6)	17(16.8)	11(10.9)	79(78.2)	11(10.9)
	X^2 = 1.049, p-value = 0.592			X^2 = 1.885, p-value= 0.390		
Husbands/partners						
Age						
≤ 15-25 years	37(41.1)	33(36.7)	20(22.2)	12(13.3)	67(74.4)	11(12.2)
26-35 years	67(35.3)	86(45.3)	37(19.5)	26(13.7)	148(77.9)	16(8.4)
≥ 36 years	31(38.8)	33(41.3)	16(20.0)	16(20.0)	55(68.8)	9(11.3)
	X^2 = 1.923, p-value = 0.750			X^2 = 3.395, p-value = 0.494		
Education						
Illiteracy/primary school	34(40.0)	39(45.9)	12(14.1)	12(14.1)	60(70.6)	13(15.3)
Secondary school	65(45.5)	51(35.7)	27(18.9)	25(17.5)	104(72.7)	14(9.8)
Diploma/vocation education	19(28.4)	29(43.3)	19(28.4)	8(11.9)	54(80.6)	5(7.5)
Bachelor and higher	17(26.2)	33(50.8)	15(23.1)	9(13.8)	52(80.0)	4(6.2)
	X^2 = 13.285*, p-value = 0.039 V = 0.136			X^2 = 5.705, p-value = 0.457		

Table 6 Demographic background and socio-economic status, power in sexual relationships and power in household decision-making of pregnant women and husbands/partners (cont.)

Demographic background and socio-economic status	Power factors					
	Sexual relationship			Household decision-making		
	High	Moderate	Low	Husband	H&W	Wife
<u>Occupation*</u>						
Unemployed/unskilled worker/agricultural worker	54(44.0)	48(38.4)	22(17.6)	18(14.4)	88(70.4)	19(15.2)
Factory worker/ private office employee	35(28.5)	60(48.8)	28(22.8)	15(12.2)	102(82.9)	6(4.9)
Civil servant/state enterprise employee	16(43.2)	12(32.4)	9(24.3)	9(24.3)	26(70.3)	2(5.4)*
Commercial/trading/ private business/others	29(38.7)	32(42.7)	14(18.7)	12(16.0)	54(72.0)	..9(12.0)
	X^2 = 8.185, p-value = 0.225			X^2 = 12.141, p-value= 0.059		
				E_{ij} * < 5 = 1 cell (8.3 %)		
<u>Income</u>						
0-5,000 Baht	13(31.0)	21(50.0)	8(19.0)	8(19.0)	24(57.1)	10(23.8)*
5,001-10,000 Baht	82(43.2)	65(34.2)	43(22.6)	27(14.2)	145(76.3)	18(9.5)
10,001-20,000 Baht	26(31.7)	43(52.4)	13(15.9)	12(14.6)	65(79.3)	5(6.1)
>20,001 Baht	14(30.4)	23(50.0)	9(19.6)	7(15.2)	36(78.3)	3(6.5)*
	X^2 = 10.978, p-value = 0.089			X^2 = 12.508, p-value = 0.052		
				E_{ij} < 5 = 2 cells (16.7 %)		

V = coefficient of Cramer's V

4.5.2 The relationship of demographic background and socio-economic status of pregnant women and their husbands/partners to domestic violence

1) The relationship of the demographic background and socio-economic status of pregnant women to domestic violence. Education, occupation, income and marital status were significantly related to domestic violence (P = 0.05). The pregnant women who had a higher level of education were more likely to experience less violence in the family compared with those women with a lower educational level. Education was significantly associated with domestic violence (p-value = 0.000). Unemployed pregnant women had high level of experience with domestic violence. Pregnant women in a secure working condition such as civil servant had low experience in domestic violence compared to women in other occupations. Occupation of pregnant women were statistically significantly related to domestic violence (p-value = 0.001). Pregnant women with a higher income had a lower level of domestic violence. Income was significantly related to domestic violence (p-value = 0.000). Pregnant women living in unregistered marriages experienced more domestic violence than pregnant women living in registered marriage. The marital status was significantly associated with the experience in domestic violence (p-value = 0.010, Phi coefficient ∅ = 0.136 or 13.6 %)(Table 7). Age was not related to domestic violence (p-value = 0.368) (Table 7).

2) The relationship of the demographic background and socio-economic status of husbands/partners to domestic violence

Education and income of husbands/partners were significantly related to domestic violence (P = 0.05). Pregnant women whose husbands/partners had a low education were more likely to face domestic violence than pregnant women whose husbands/partners had a higher education. Education of husbands/partners was associated with domestic violence (p-value = 0.000). The income of husbands/ partners reflected the occurrence of domestic violence. Pregnant women faced less violence when their husbands/partners had higher income. Income had influence on the occurrence of domestic violence (p-value = 0.003). (Table 7).

Age and occupation of husbands/partners were not related to domestic violence (p-value = 0.366 and 0.132 respectively) (Table 7).

Table 7 Demographic background and socio-economic status and domestic violence

Demographic background and socio-economic status	Domestic violence		X^2	p-value
	No	Yes		
Pregnant women				
Age				
≤ 15-25 years	23(13.1)	153(86.9)	1.997	0.368
26-35 years	28(18.3)	125(81.7)		
≥ 36 years	6(19.4)*	25(80.6)		
E_{cij} < 5 = 1 cell (16.7 %)				
Education				
Illiteracy/primary school	5(6.8)	68(93.2)	26.035	0.000
Secondary school	23(13.3)	150(86.7)		
Diploma/vocation education	7(12.7)	48(87.3)		V = 0.269
Bachelor and higher	22(37.3)	37(62.7)		
Occupation*				
Unemployed	7(7.2)*	90(92.8)	18.065	0.001
Unskilled worker	8(9.8)	74(90.2)		
Factory worker/ private office employee	23(21.7)	83(78.3)		V = 0.224
Civil servant	9(34.6)	17(65.4)		
Commercial/trading/ private business/others	10(20.4)	39(79.6)		
E_{cij} < 5 = 1 cell (10.0 %)				
Income				
No income	7(7.2)	90(92.8)	23.185	0.000
≤ 5,000 Baht	1(2.2)*	45(97.8)		
5,001-10,000 Baht	28(19.4)	116(80.6)		V = 0.254

Table 7 Demographic background and socio-economic status and domestic violence (cont.)

Demographic background and socio-economic status	Domestic violence		X^2	p-value
	No	Yes		
10,001-20,000 Baht	17(30.9)	38(69.1)		
>20,001 Baht	4(22.2)	14(77.8)		
$E_{ij} < 5 = 1$ cell (10.0 %)				
Marital status				
Not registered	33(12.7)	226(87.3)	6.623	0.010
Registered	24(23.8)	77(76.2)		∅ = 0.136
Husbands/partners				
Age				
≤ 15-25 years	10(11.1)	80(88.9)	2.009	0.366
26-35 years	33(17.4)	157(82.6)		
≥ 36 years	14(17.5)	66(82.5)		
Education				
Illiteracy/primary school	10(11.8)	75(88.2)	20.818	0.000
Secondary school	14(9.8)	129(90.2)		
Diploma/vocation education	11(16.4)	56(83.6)	V= 0.240	
Bachelor and higher	22(33.8)	43(66.2)		
Occupation				
Unemployed/unskilled worker/agricultural worker	12(9.6)	113(90.4)	5.610	0.132
Factory worker/private office employee	24(19.5)	99(80.5)		
Civil servant/state enterprise employee	7(18.9)	30(81.1)		

Table 7 Demographic background and socio-economic status and domestic violence (cont.)

Demographic background and socio-economic status	Domestic violence		X^2	p-value
	No	Yes		
Commercial/trading/ private business/others	14(18.7)	61(81.3)		
Income				
0-5,000 Baht	2(4.8)	40(95.2)	13.952	0.003
5,001-10,000 Baht	27(14.2)	163(85.8)		
10,001-20,000 Baht	13(15.9)	69(84.1)	V = 0.197	
>20,001 Baht	15(32.6)	31(67.4)		

V = coefficient of Cramer's V, ∅ = Phi Coefficient

4.6 The power in sexual relationships, household decision-making, domestic violence and risky behavior of pregnant women and husbands/partners in connection with HIV/AIDS infection

Sexual relationship and household decision-making power of pregnant women and husbands/partners were related to domestic violence and risky behavior related to HIV infection.

1) Power in sexual relationships, household decision-making and domestic violence

Pregnant women with low power in sexual relationships were most likely to face domestic violence. The imbalance in the power of sexual relationships had an influence on domestic violence. Power in sexual relationships was significantly related to domestic violence (P = 0.05, p-value = 0.000). (Table 8).

A family structure in which the couple share decision –making equally (equalitarian type) will have the lowest incidence of violence, whereas a structure in which the husband has the right to make most of decision (the male dominant type) will have a highest incidence of violence.

Pregnant women within a family structure in which the husbands/partners have the right to make most of decision in the family, are more to face a high incidence of domestic violence. Household decision-making power had an influence on domestic violence (P = 0.05, p-value = 0.000). (Table 8).

2) Power in sexual relationships, household decision-making and risk behavior of pregnant women in relation to HIV/AIDS infection

The behavior of pregnant women such as having partnerships outside their marriage and the refusal of the husband/partner to use a condom was significantly related to HIV/AIDS infection (P = 0.05). Pregnant women who had a partnership outside marriage had low power in sexual relationships. The power in sexual relationships were associated with the partnerships outside the marriage (p-value = 0.001). Pregnant women who had a low power in sexual relationships also had less power to negotiate condom use, which resulted in high level of refusal of the husbands/partners to use a condom. The power in sexual relationships had an influence on refusal of condom use (p-value = 0.000). (Table 8).

Alcohol consumption and negotiation of condom use were not related to the power in sexual relationships (p-value = 0.396, and p-value = 0.496).

Household decision-making was not related to risky behavior of pregnant women to acquire HIV/AIDS infection. Household decision making had no influence on alcohol consumption (p-value =0.000), negotiation of condom use (p-value = 0.458) as well as refusal to use condoms by husbands/partners (p-value = 0.052) (Table 8).

3) Power in sexual relationships, household decision-making and risky behavior of husbands/partners related to HIV/AIDS infection

The power in sexual relationships related to risky behavior to acquire HIV/AIDS infection such as alcohol consumption, sexual intercourse with prostitutes, and sexual intercourse with other women (P= 0.05). Pregnant women who had low power in sexual relationships, had husbands/partners who consumed alcohol (p-value = 0.011). Pregnant women with low power in sexual relationship were likely to have husbands/partners who have sexual intercourse with prostitutes than husbands or partners of pregnant women who had a moderate and high power in sexual relationships. The power in sexual relationships was therefore related to sexual

intercourse with prostitutes (p-value =0.000). Pregnant women who had low power in sexual relationships had husbands/partners likely to have intercourse with other women (p-value =0.000). (Table 8).

Household decision making was significantly related to risky behavior of husbands/partners to be infected with HIV/AIDS such as intercourse with other women (P = 0.05, p-value = 0.020). This indicated that husbands/partners had authority in decision making within the family. But household decision making was not related to alcohol consumption (p-value =0.748) and intercourse with prostitutes (p-value =0.374) (Table 8).

Table 8 The power in sexual relationships, household decision-making power, domestic violence and risky behavior of pregnant women and husbands/partners towards HIV/AIDS infection

Factors	Power					
	Sexual relationship			Household decision-making		
	Low	Moderate	High	Husband	Husband&Wife	Wife
Domestic Violence						
No	7(5.2)	28(18.4)	22(30.1)	1(1.9)	55(20.4)	1(2.8)
Yes	128(94.8)	124(81.6)	51(69.9)	53(98.1)	215(79.6)	35(97.2)
	X^2 = 23.457, p-value=0.000			X^2 = 16.696, p-value=0.000		
	V=0.255			V=0.215		
Risk behavior of pregnant women to HIV/AIDS infection						
Alcohol consumption						
No	114(84.4)	136(89.5)	65(89.0)	42(77.8)	241(89.3)	32(88.9)
Yes	21(15.6)	16(10.5)	8(11.0)	12(22.2)	29(10.7)	4(11.1)*
	X^2 = 1.892, p-value=0.396			X^2 = 5.494, p-value=0.064		
				$E_{ij} < 5$ = 1 cell (16.7 %)		

Table 8 The power in sexual relationships, household decision-making power, domestic violence and risky behavior of pregnant women and husbands/partners towards HIV/AIDS infection (cont.)

Factors	Power					
	Sexual relationship			Household decision-making		
	Low	Moderate	High	Husband	Husband&Wife	Wife
<u>Drug and substance abuse</u>						
No	134(99.3)	151(99.3)	73(100.0)	53(98.1)	269(99.6)	36(100.0)
Yes	1(0.7)*	1(0.7)*	0(0)*	1(1.9)*	1(0.4)*	0(0)*
	* Too few samples for analysis			* Too few samples for analysis		
<u>Partnership outside marriage</u>						
No	120(88.9)	150(98.7)	71(97.3)	50(92.6)	256(94.8)	35(97.2)
Yes	15(11.1)	2(1.3)	2(2.7)	4(7.4)*	14(5.2)	1(2.8)*
	X^2 = 14.902, p-value = 0.001			* Too few samples for analysis		
	V = 0.203					
	E_{ij} < 5 = 1 cell (16.7 %)					
<u>Condom use negotiation</u>						
No	36(26.7)	47(30.9)	25(34.2)	20(37.0)	77(28.5)	11(30.6)
Yes	99(73.3)	105(69.1)	48(65.8)	34(63.0)	193(71.5)	25(69.4)
	X^2 = 1.403, p-value = 0.496			X^2 = 1.561, p-value = 0.458		
<u>Refusal of condom use</u>						
No	18(18.2)	53(50.5)	27(56.3)	7(20.6)	82(42.5)	9(36.0)
Yes	81(81.8)	52(49.5)	21(43.8)	27(79.4)	111(57.5)	16(64.0)
	X^2 = 29.882, p-value = 0.000			X^2 = 5.931, p-value = 0.052		
	V = 0.344					

Table 8 The power in sexual relationships, household decision-making power, domestic violence and risky behavior of pregnant women and husbands/partners towards HIV/AIDS infection (cont.)

Factors	Power					
	Sexual relationship			Household decision-making		
	Low	Moderate	High	Husband	Husband&Wife	Wife
Risky behavior of husbands/partners towards HIV/AIDS infection						
Alcohol consumption						
No	35(25.9)	61(40.1)	32(43.8)	21(38.9)	93(34.4)	14(38.9)
Yes	100(74.1)	91(59.9)	41(56.2)	33(61.1)	177(65.6)	22(61.1)
	X^2 = 9.037, p-value = 0.011 V = 0.158			X^2 = 0.582, p-value = 0.748		
Drug and substance abuse						
No	134(99.3)	151(99.3)	71(97.3)	54(100.0)	266(98.5)	36(100.0)
Yes	1(0.7)*	1(0.7)*	2(2.7)	0(0)*	4(1.5)*	0(0)*
	* Too few samples for analysis			* Too few samples for analysis		
Intercourse with prostitutes						
No	83(61.5)	125(82.2)	64(87.7)	38(70.4)	204(75.6)	30(83.3)
Yes	52(38.5)	27(17.8)	9(12.3)	16(29.6)	66(24.4)	6(16.7)
	X^2 = 23.954, p-value = 0.000 V = 0.258			X^2 = 1.965, p-value = 0.374		
Intercourse with other women						
No	78(57.8)	111(73.0)	62(84.9)	29(53.7)	195(72.2)	27(75.0)
Yes	57(42.2)	41(27.0)	11(15.1)	25(46.3)	75(27.8)	9(25.0)
	X^2 = 17.909, p-value = 0.000 V = 0.223			X^2 = 7.838, p-value = 0.020 V = 0.148		

V = coefficient of Cramer's V

4.7 The relationship of domestic violence and risky behavior of pregnant women in connection with HIV/AIDS infection.

The risky behavior of pregnant women towards HIV/AIDS infection such as alcohol consumption as well as the refusal to use condoms by husbands/partners were related to domestic violence (P = 0.05). Pregnant women experiencing domestic violence consumed more alcohol than pregnant women who never experienced domestic violence. Alcohol consumption of pregnant women influenced domestic violence (p-value = 0.001). Pregnant women who experienced domestic violence had less power to negotiate condom use, the proportion of husbands/partners who refused to use condoms were higher for the group of women facing domestic violence in comparison with women who never experienced domestic violence. Domestic violence was significantly related to the refusal of condom use of husbands/partners (p-value = 0.000). (Table 9).

Table 9 Domestic violence and risky behavior of pregnant women towards HIV/AIDS infection

Risky behavior of pregnant women towards HIV/AIDS infection	Domestic violence		X^2	p-value
	No	Yes		
Alcohol consumption				
No	55(96.5)	260(85.8)	5.006	0.025
Yes	2(3.5)	43(14.2)	∅ = 0.118	
Drug and substance abuse				
No	57(100.0)	301(99.3)		
Yes	0(0)*	2(0.7)*		
* Too few samples for analysis				
Partnership outside marriage				
No	57(100.0)	284(93.7)	3.773	0.052
Yes	0(0)*	19(6.3)		
$E_{ij} < 5$ = 1 cell (25.0 %)				

Table 9 Domestic violence and risky behavior of pregnant women towards HIV/AIDS infection (cont.)

Risky behavior of pregnant women towards HIV/AIDS infection	Domestic violence		X^2	p-value
	No	Yes		
Condom use negotiation				
No	20(35.1)	88(29.0)	0.835	0.361
Yes	37(64.9)	215(71.0)		
Refusal to use condom of husbands/partners				
No	25(67.6)	73(34.0)	15.008	0.000
Yes	12(32.4)	142(66.0)	∅ = 0.244	

∅ = Phi Coefficient

The power in sexual relationships and household decision-making:

- The variables of power in sexual relationships included education, occupation, income, partnership outside marriage of pregnant women, domestic violence; education of husbands/partners; refusal to use condoms, alcohol consumption of husbands/partners; sexual intercourse with prostitutes and sexual intercourse with other women.
- The variable of decision-making power consists of occupation of pregnant women, domestic violence and sexual intercourse with other women.
- Domestic violence is related to education, occupation, income, marital status, and alcohol consumption of pregnant women; education and income of husbands/partners, and refusal to use condoms by husbands/partners.

Table 10 Variables of sexual relations and household decision-making power

Variables	Power	
	Sexual relationship	Household decision-making
	p- value	
Pregnant women		
Education	0.018	-
Occupation	0.004	0.002
Income	0.008	-
Partnership outside marriage	0.001	-
Refusal to use condom	0.000	-
Domestic violence	0.000	0.000
Husbands/partners		
Education	0.039	-
Alcohol consumption	0.011	-
Sexual act with prostitute	0.000	-
Sexual act with other women	0.000	0.020

Table 10.1 Variables of domestic violence

Variables	Domestic violence
	p-value
Pregnant women	
Education	0.000
Occupation	0.001
Income	0.000
Marital status	0.010
Alcohol consumption	0.025

Table 10.1 Variables of domestic violence (cont.)

Variables	Domestic violence
	p-value
Refusal to use condom	0.000
Husbands/partners	
Education	0.000
Income	0.003

CHAPTER V
DISCUSSION

The imbalance in power between genders influence the socio-economic status and may lead to domestic violence, which is the most extreme result of gender inequality and is the direct result of social norms that allows male to act violently against women, which , some claim, is a acceptable way by the society to control an intimate partner (Helpguide, Wikipedia). Women may experience violence while being pregnant. In fact this is the time supposed to be peaceful and safe. A time the family turns its thoughts towards rising the next generation and raising a healthy baby. Unfortunately for many women, pregnancy can be the beginning of a violent time in their lives (Jintana Wacharasin, 1990: 1; Karaoglu, 2005: 149; Medical text book on high risk of pregnancy 2000 cited by Phommachan, 2005: 5). Physical and sexual violence have a significant negative impact on health, including sexual and reproductive health of victims as well as the health of fetus. Besides that victims are also at an increased risk of HIV infection (Maman et al., 2000). In Thailand, not only drug addicted persons or commercial sex workers are at risk to be infected with HIV/AIDS but also abused women. Abusive men are more likely to be infected with HIV/AIDS because of their risky behaviors and this puts their wives into danger as well.

A few studies in Thailand investigated the power in sexual relationships and the influence of male dominance on domestic violence and HIV/AIDS infection. This study aimed to explore the power in sexual relationships of pregnant women, and the effects of this to domestic violence and risky behavior of pregnant women and their husbands and partners towards HIV/AIDS infection. In the following the results of the study will be discussed.

5.1 Research methodology

The power in sexual relationships, domestic violence and risky behavior with the possibility to result in an HIV/AIDS infection and other factors linked to the problem such as the demographic background and the socio-economic status of the study participants were investigated. A purposive sampling method was applied to select a group of 360 pregnant women visiting the antenatal care clinic of the Rajvithi Hospital and they were asked to participate in the investigation. A limitation of this study is that the socio-economic status of the study participants indicates that most of them belong to the lower middle class. The information derived from the study cannot be generalized and also cannot be applied to a group of disadvantaged woman with a low socio-economic status such as migrants. The results are also not representative for women with a high socio-economic status. In this study only 0.6 % of study participants graduated with a Master Degree.

The questionnaire used as tool for this research consisted of five domains. The domains assessed the sexual relationship, risky behavior towards HIV/AIDS infection, and the demographic pattern and socio-economic status. The researcher spent 3 to 5 minutes explaining the objective of the study to the participants as well as talking to them in order to make them familiar with the investigator and vice versa. The researcher asked the participants to sign a consent form before being interviewed. The researcher interviewed the study subjects by herself. If the women had a question or did not understand the content of the question, they directly could ask the researcher. For convenience and to spare time, the researcher gave one set of the questionnaire to the participants to read the questions before the actual interview because some questions had five choices to be answered; participants had some difficulties to remember the choices. Some questions dealt with sensitive issues such as sexual intercourse or domestic violence. The researcher assured the participants that the information obtained from the questionnaire will be kept confidential.

5.2 Sexual relationship power, relationship control, decision making dominance and household decision making authority of pregnant women

5.2.1 Power in sexual relationships

42.2 % of participants were moderately satisfied with their sexual relationships, but 37.5 % were not very much satisfied, and only 20.3 % of pregnant women were highly satisfied with their sexual relationship. Women nowadays have a rather good education; good career opportunities with a higher income and some of them have the opportunity to serve the society as a member of a political party. But these developments doesn't mean that man and woman have equal power in sexual relationships, women still have a lower power than men, and this might be due to the fact that the Thai society is a patriarchal one which favors male authority, so that women are subordinated in power, and men are superiority (Chotima Kanjanakul, Sunsanee Ruangsorn, 1999: 556).

5.2.2 Relationship control

40.8 % of the women participants were more or less controlled by their husbands/partners, 31.9 % were more or less under strict control and for 27.3 % of the women the control of husbands over their sexual relationships was rather low. In general however husbands/partners control their families (Heise, et al., 1993: 1170 cited in Kritaya Archavanitkul, 1999: 502). It seems to the investigator that quite a number of participants fully agree with the fact that their husbands/partners make most the decision about important issues, and they seem to fully agree that for the outside participants follow their husbands in all what the male partner wants them to do. Women appear to be good listeners and seem to fully understand that husbands/partners angrily reacted when participants ask them to use a condom. Participants also seem to appreciate that their husbands/partners advice them about the style of cloth they wear. It is obvious that in the Thai society, a woman as wife is controlled by man/husband in matters of sexual relationship and decision making. Women were brought up according to the gender role in accepting that power, rights, and responsibilities are being different for women in comparison with men (Turmen, 2003:411). Women and men are expected to behave according to social and cultural norms and to play their roles accordingly, in that women are feminine and follow the men and men are masculine and act as the leader, following the Thai proverb "men

are the front legs of the elephant, and women are the back legs of the elephant" (Sunya Sunyawiwat, 2001: 76). Because of the imbalance of power in sexual relations many women have less control than men over when, where, why, and how sexual acts take place. This inequality in sexual decision making is perpetuated by gender norms of femininity and masculinity that curtail women's sexual autonomy and expand men's sexual privilege, place greater emphasis on male pleasure over female pleasure, and cast women in the role of passive recipient rather than active actors. Besides that men often don't feel responsible for the prevention of HIV/AIDS infection (Pimpawan Boonmongkol, 1999: 179).

5.2.3 Dominance in decision-making

As found in this study 43.6 % of women participants and husbands/ partners decided together, while 28.6 % the participants dominated the process of decision making, and for 27.8 % the husbands/partners dominated. When considering the issue of husbands dominance, it was mostly related to sexual relationships and condom use such as the initiation of sexual acts; who is going to follow whom and discussions about condom use. In these cases men might have more sexual power over sexual issues than women (International Women's Health Coalition, 1994 quoted in Pimpawan Boonmongkol, 1999: 179). Power imbalance in relationships of husband and wife might more often favor the husband (Anuchit Sawangchang, (2003: 128-131). Husbands might be of the opinion that is his duty to control the initiation of sexual acts as well as the positions, while it is the duty of the wives to follow what husbands want. They are unable to refuse unwanted sex. In fact however sexual intercourse should be based on the mutual will and desire of both, husband and wife, and should result in a sufficient climax for both.

Imbalance in sexual power may also lead to male control over the process of negotiations for safer sex. Women with less power in sexual relationships are less likely to successfully suggest and are at a higher risk of having HIV (E. Pettifor et al., 2004: 1996). This was confirmed by the statement of the US Department of Health and Human Service, 2006, who pointed to the fact that most women infected with HIV/AIDS acquired the disease through unsafe sexual practices with their husbands/partners (cited by CDC HIV/AIDS Fact sheet, 2007: 3). In the

social context of Thailand women feel that it is the duty of wives to respond to husbands/partners sexual desire. Because of gender inequity and imbalance in sexual power, women are unable to negotiate condom use or refuse to have sex with husbands/partners. Besides that they fear to face a conflict in their relationship and even are exposed to violence in case the raise the issue of condom use. The women of this group might be of the wrong impression that they are not exposed to the risk of HIV/AIDS since they attribute the risk to be infected with HIV/AIDS solely to females addicted to drugs or to female commercial sex workers. But actually the epidemic of HIV/AIDS reached the group of ordinary family wives nowadays as well.

5.2.4 Household decision making

For 75 % of participants they and their husbands decided together about household and family matters while either 15 % of husbands/partners or 10 % of the women alone made decisions. Husband and wife together shared responsibility for family members and family matters. It seems that today women have greater possibilities to take part in decision making than before. In a study with male participants the wish was expressed to involve the wives equally in decision making (Anuchit Sawangchang, (2003: 95)). In a study with married couples most of them shared the final decision making related to the family issues (Autchara Sakoontaniyom, (1998; 89 and Blood & Wolfe cited by Sopikul, 2005: 23)) But husbands/partners had a final say in three issues such as family expenses, buying a car, and business investment or a new job, while wives finally decided about taking care of family members such as bringing the family member to the hospital in case of sickness, give advice or punishment, choosing the school for the children and planning for their further education. Husbands decide about the expenses of the family and buying things for the family (Autchara Sakoontaniyom). Household decision making authority of men and women is based on the gender role dependent on the social structure. Inequality in the power of gender is very obvious and according to the different roles it is determined what women and men can do or not (Jantharat Rabiebloke, et al., 2003: 11). Men are brought up in the belief that they are the chief of the family and it is to them to make decisions in important issue such as spending money (Anuchit Sawangchang, (2003: 93). While women are expected to be

responsible for activities within the home (Engels quoted in Donya Thanaudom, 1996: 22), therefore their decision making is related to taking care of family members as well as make their life convenient.

5.3 Domestic violence and pregnant women

Domestic violence included three types of abuses such as psychological/ emotional-, physical-, and sexual abuse. In this study, participants who experienced domestic violence are those who experienced at least one kind of domestic violence either physical- or psychological/emotional- or sexual abuse.

5.3.1 Psychological/emotional abuse

From the participants 72.2 % were psychologically/emotionally abused. 65 % had been insulted or made to feel bad about themselves, 49.2 % were abused in the previous year (12 months prior to interview), and 5.8 % were abused at some point of their lives. 37.8 % were being humiliated or belittled in front of others, 27.8 % of them were abused in the past 12 months, and for only 10 % the abuse occurred in some years before. In this study, the participants were abused in psychological or emotional way much more than compared to the study of Donya Thanaudom 1996: 61), in which 22.5 % of pregnant women were psychologically/ emotionally abused. The study of Donya Thanaudom used the Index of Spouse Abuse (ISA) which assess violence based on the frequency of violent acts. Kishor & Johnson (2004: 160), investigated domestic violence during pregnancy in 5 countries, Cambodia, Colombia, Dominican Republic, Haiti and Nicaragua and found that pregnant women of those countries had been psychologically/emotionally abused to 13.5 % in Cambodia, 11.5 % in Columbia, 17.7 % in the Dominican Republic, 13.2 % in Haiti and 29.0 % in Nicaragua. The authors used the Conflict Tactics Scale to measure violence which is also based on the frequency of violence. The results of this study are similar to the study of Nijawan Weerawatnodom (1997: 71), in that 62.5 % of women who came to the outpatient department of Chai Nat Hospital had been abused. Also the results of the investigation of Busarin Khlongpayabal (1999: 109-110) are in the same range as found in this study in that 85.5 % of women living in the area of the Muang district, Sa Kaeo province had been psychologically or emotionally abused. Domestic violence faced by Turkish pregnant women, in the Malatya

province were also high with 78.2 % of pregnant women psychologically/emotionally abused before becoming pregnant and 84.3 % had been psychologically/emotionally abused during pregnancy (Karaoglu, et al., (2005: 151). Psychological or emotional abuse is an indirect physical attack, with no injury or wound and it happens more often compared to physical and sexual violence (Nijawan Weerawatnodom, 1997: 126). Women in conflict with husbands/partners are very likely to be psychologically/ emotionally abused. The abuse is in the form to be insulted or made to feel bad about themselves; being humiliated or belittled in front of others; or being intimidated or scared on purpose by a partner yelling and smashing things. Very often men are of the opinion that such behavior is not violence (Siriwan Grisurapong, 2007: 107) since the women are not directly physically assaulted (Nijawan Weerawatnodom, 1997: 126). The psychological/emotional abuse is the most common act of violence that happens in a family. Pornpen Petsuksiri (1996: 63) examined the domestic violence in asking adolescents about violence in the family and found that 88.8 % of the young people reported that their fathers blamed their mothers during the past 3 months, and 68.7 % told that their mothers were scolded by their fathers. When women become pregnant they change physically as well as psychologically/emotionally. They might be under stress, and in an unstable mood. All these factors may lead to conflicts in the family and result in psychologically/emotionally abuse of pregnant women (Jintana Wacharasin, 1990: 1). Most of the pregnant women were psychologically/emotionally abused in the previous 12 months. It seems that husbands/partners avoid physical abuse which may affect not only the women but also the fetus. Karaoglu et al., (2005: 153) studied about Domestic violence by psychological/emotional abuse for Turkish pregnant women occurred before they became pregnant and violence increased during pregnancy.

5.3.2 Physical abuse

Of the participants 50.3 % never experienced domestic violence, and 49.7 % were abused at least once. 30.0 % were physically abused by pushing/shoving, 19.7 % were abused in the previous 12 months, and 10.3 % were abused at some point of their lives. 22.2 % of participants were physically abused by slapping or throwing

thing that may hurt or injure them, and 14.2 % of physical abuse occurred in the previous year.

Other studies found that only 10.7 % or 12.0 % of pregnant women were physically abused (Donya Thanaudom (1996: 61); Thananowan (2004: i)). Higher proportion of abused pregnant women with 29.6 % were recorded from the Pattani province, Ma-a-lee (2007: 48), 29.6 % of pregnant women had physical abuse or the study in Cambodia 16.4 %, in the Dominican Republic 18.4 %, in Haiti 17.3 % in Nicaragua 27.6 % and in Columbia 40.0 % of pregnant women were physically abused (Kishor & Johnson (2004: 14-15). The proportion of pregnant women being physically abused in this study was rather high. This might due to the method used based on the Women's Health and Life Events Questionnaire in which 6 questions asked about physical abuse. If pregnant women had experienced at least one kind from six kinds of physical abuse this was counted whereas for the study of Donya Thanaudom (1996: 61), and Thananowan (2004: i), the Index of Spouse Abuse (ISA) of Hudson & Mcintosh was applied. The study of Kishor & Johnson (2004) used the Conflict Tactics Scale (CTS) of Straus to assess the level of physical abuse. The ISA and CTS scales have been used to measure the physical abuse based on the frequency of abuse, and if the number of abuse reach the designed score then those pregnant women are considered to be physically abused. High proportion of pregnant women was pushed/shoved, others were slapped or thrown things at. Still this aggressive behavior of the husbands might be considered as acceptable level of violence in view of much worse incidences of abuse Kritaya Archavanitkul, 2003: 39). Although women usually are not seriously injured by these acts but they happened most frequently (Donya Thanaudom, 1996: 114; Jintana Wacharasin, 1997: 125; Kritaya Archavanitkul, 2003: 41). During pregnancy women are at higher risk being physically abused than before becoming pregnant. This might be due to the physical changes during pregnancy as well as psychological/emotional and social alterations during that time, besides that they have to prepare themselves to be mothers soon. All this may lead to the violence (Jintana Wacharasin, 1990: 1). The function and responsibility of pregnant women within the household may not as good as before the pregnancy which might be the reasons for conflicts with the husbands/partners and results physical abuse during pregnancy while this did not happen before

(Phommachanh, 2007: 5-6). Violence against women more and more is a topic discussed within the societies and draws public interest. The issue is linked to human rights and women's rights (Chuenchom Charoenyouth, et al., 2000: 53). Pregnant women who were abused are now aware about their rights and seek assistance; instead of keeping and try to cope with the violence alone.

Within the Thai society, domestic violence is regarded as a family problem, and should not be revealed to outsiders (Donya Thanaudom, (1996: 127). The high proportion reported from the pregnant women in this study might be due to the way the participants had been asked. The researcher choose a quiet place far from the service area, and explained the objective of the study and details about the questionnaires to the participants and assured them that what ever they say will be kept confidential. The participants felt more comfortable during the interview and disclosed more facts about their physical abuse then they would have done otherwise. This might result in the high proportion of physical as well as the psychological/ emotional abuse in this investigation.

5.3.3 Sexual abuse

Sexual abuse was never experienced by 53.9 % of the participants, but 46.1 % experienced at least one kind of sexual abuse. 41.7 % agreed into unwanted sexual intercourse because they were afraid of their husband's/partner's reaction, if they will not give in, 11.9 % were forced to have sex, and 11.4 % being forced to act in some way they did not like or found degrading or humiliating.

The proportion of sexual abuse found in this study was rather high compared to other studies such as the study of Nijawan Weerawatnodom (1997: 71-72), with 34.0 % of sexually abused women, or Busarin Khlongpayabal (1999: 109-110), with 35.9 % of sexual abused wives. Husbands/partners may not realize that they force their wives to have sex with them because they are of the opinion that is the duty of wives to respond to husbands/partners sexual desire. Many women with a high social and economic status as well as a high position in the community are also of the opinion that the wife must give in any time to the husband's sexual desire (Pimpawan Boonmongkol, 1999: 179). Men think that women should not refuse having sexual intercourse except they are sick, and that it is their right to have sex with his wife

(Siriwan Grisurapong, 2007: 104). To some men marriage is the license to sexually violate the wife at any time (Kritaya Archavanitkul, 1999: 528). In this study, the questionnaire about sexual abuse was adjusted to the values of the Thai society. The result was that the participants had rather high level of sexual abuse. The finding of this study was similar to the result of the study of Kritaya Archavanitkul, (2003: 43-44), who found that a high proportion of women had sexual intercourse because they were afraid of what their husbands/partners might do otherwise. Husbands did not physically force their wives to have sex with them, but forced them indirectly by psychological means, because if they refuse, they will worry or are afraid that husbands won't love them any longer, or they are afraid that husbands will look for another sexual partner. Married Thai women are of the opinion that having sex with their husbands is unavoidable in a marriage. While 11.9 % of participants were forced to have sex, this might be linked to believe in sexual relationship values that it is the wife's duty to respond to husband's sexual desire and that men, who force their wives to have sex with them do not regard this as a violent act (Siriwan Grisurapong, 2007: 107). During pregnancy, women are rather sensitive, move or walk slower than before, need more care both physically and psychologically/emotionally (Medical textbook on high risk of pregnancy 2000 cited by Phommachanh, (2007: 5). Pregnant women have to play their roles according to the social and cultural norms, their responsibility within the household is to care for the husband particularly in sexual relationships even they are reluctant to do so (Wannee Diewisares, et al., 2001: 91). Pregnant women are at risk to experience sexual violence during their pregnancy. This is also confirmed by the study of Karaoglu (2005: 150-151), who found that sexual abuse increased during pregnancy, in that 30.7 % of pregnant women were sexually abused during pregnancy, while a remarkable lower proportion of 22.6 % of the women were sexually abused before being pregnant. In the Thai society, domestic violence is s family problem; and it is shameful especially when it is linked to sexual abuse (Donya Thanaudom, 1996: 127). In studying intimate violence and women health in Thailand it was found that 30 % of women in Bangkok experienced sexual abuse by their spouses/partners, and 29 % of women in one province of the central region (Kritaya Archavanitkul, (2003: 44)). These women were suffering from the violence in the family and they were reluctant to disclose their problems.

A high proportion of women in this study were psychologically/ emotionally abused followed by physical- and sexual abuse which is of the same magnitude as found by other investigations (Donya Thanaudom (1996); Busarin Khlongpayabal (1999) and Karaoglu (2005)).

5.4 Demographic background and socio-economic status of pregnant women and husbands/partners, related to power in sexual relationships, household decision making and domestic violence

Education, occupation and income were associated with the power in sexual relationships. Occupation was related to household decision making. Pregnant women with a higher education and income would have greater power in their intimate relationships than women with less or no education and income. The educational level was significantly linked with greater power in sexual relationships; pregnant women with a higher education seem to face lower domestic violence. This is because women with a higher educational level might be more critical whom they marry, if at all and are able to negotiate greater autonomy and control of resources within their marriage. Women who have a higher education have a better insight in problems including family problems and will find means to cope with the problems better than less educated women. Education is a source of empowerment of women (Kishor & Johnson, 2004: 31). According to the study of Hollerbach (1980 cited by Passorn Limanon, 2001: 138), in traditional, patriarchal authority structure, the male as head of the household (the husband) make all the essential decisions and the wife is obliged to diligently fulfill the roles appointed to her by the husband. The factor to help women to have authority and the role in taking part in communication with husbands/partners and share decision making is higher education of women. Women with a higher education have a better chance to get a good job with a good income. Employed women have more power in decision making about the money or family issues than unemployed women (Malhotra & Mather (1997) cited by Kishor & Johnson, 2004: 32). Higher education, occupation and income are factors which support pregnant women to have more marital power.

Illiterate, unemployed pregnant women with no income and in a not registered marriage are more likely to be exposed to violence. Some of the participants of this

study were illiterate but most of the participants, 68.4 % completed a secondary school education. 51.3 % were unemployed, and 40 % had a low income. Many studies indicated that pregnant women experiencing domestic violence are mostly less educated (Chuenchom Charoenyouth, et al., 1999; Wannee Diewisares, et al., 2001: 86). A low educational level also means a low income (Donya Thanaudom, 1996: 71). Women with a higher education have a greater chance to choose an occupation with a good income and resulting in a secure financial situation which pregnant women with a low education are missing. Being financially independent from the husband/partner makes it easier to leave him incase of misbehavior (Donya Thanaudom, 1996: 128). Education helps women to improve their financial and social status (Napaporn Hawanon, 1977; Blood & Wolfe, 1960 cited by Prapaphan Ouonob). They can develop a high level of self esteem and self-respect (Nijawan Weerawatnodom, 1997: 120), and they can solve problems effectively or leave a violent relationship (Kishor, 2004: 31). Women with higher education and chances for a good career and good income may live a life of good quality. Occupation is one of the indicators of the position in society (Straus, et al., 1980: 148-149). The economic statuses of unemployed women, with no income or with a low income, depend on their husbands/partners. They are more at risk to face domestic violence than employed women who have their own income (Donya Thanaudom, 1996: 130); Nijawan Weerawatnodom, 1997: 118-119). Similar result were found by the study of Chuenchom Charoenyouth, et al., (2000: 29), in that mostly housewives were abused; followed by women working as unskilled workers. Women working as civil servants or state enterprise employees had a low level of experience with domestic violence. Many couples just simply live together as husband and wife without having their marriage be registered. Their partnership is neither legally secured nor are relatives involved (Wannee Diewisares, et al., 2001: 103). In case of a conflict within the partnership men might use violence to solve the problem. They don’t have to be considerate for the feeling of women’s relatives since there were no relatives involved in their partnership (Donya Thanaudom, 1996: 130).

The demographic background, socio-economic status of husbands/partners and domestic violence, education and income were associated with domestic violence. Pregnant women with less educated husbands/partners are more likely to be exposed

to domestic violence than pregnant women who have a husband with higher education. Individuals with a goods education generally are knowledgeable, are wiser and able to reflect reasonable considerations which helps them to have a good family life (Kasame Tantiphlacheewa and Kulya Tantiphlacheewa, 1997 cited by Busarin Khlongpayabal 1999: 143). In case well educated husbands/partners face a conflict or a problem with their wives, they don't resort to violence to solve the problems. Education is defined by the social and financial status of women (Mason 1984 & 1987; Gage, 1995 cited by Sa, 2004: 4; Rahman, 2005: 10). That is also true for husbands/partners with higher education who have greater opportunity to choose a good occupation; have good career chances with a good income, so they don't have to pressure or stress for solving financial problems and results in small chances for violence in the family (Donya Thanaudom, 1996: 128). The income issue is related to domestic violence which occurs in the families with low income more often than in families with a higher income (Autchara Sakoontaniyom, 1998: 110). In case a financial problem comes up which is linked to a conflict with the husbands/partners violence is often used to solve the problem. Besides that when husbands/partners are under stress because of an insufficient income, they might start to drink alcohol, resort to gambling and are visiting prostitutes. In following this pattern they might accumulate even more debts and the chances of domestic violence increases (Donya Thanaudom, 1996: 130; Autchara Sakoontaniyom: 1998: 33).

5.5 Power in sexual relationships, household decision making, domestic violence and risky behavior of pregnant women and husbands/partners towards HIV/AIDS infection

Power in sexual relationships and power in household decision making was found to be related to domestic violence. Pregnant women with low power in sexual relationships and dominant husbands/partners who dictate household decisions had a high experience of domestic violence. Gender is important as a culturally defined status marker for differential power for men and women. Gender based power allows for the domination of masculinity over femininity through the attribution of specific gender-related characteristics (Blanc, 2001 quoted by Suwajee, 2004: 202). In the social context, it lacks human right awareness and the equity in basic rights, which

results in the fact that one person has power over the other is considered as a common phenomenon. The power of women and children is less than for men; there is an inequality in power and rights, which make them vulnerable for violence and disadvantages. In the family context, husbands have power over wives, and if they face a conflict in the family, husbands violate wives in order to solve the problem (Siripet Siriwatana, 1995 quoted in Friends of Women Foundation, 2003: 25). Intimate violence is mostly the result of the marital power imbalance in the family (Blanc, 2001 quoted by Suwajee, 2004: 219; Straus, et al., (1980: 192-193)). The more men dominate, the greater the chance for domestic violence against women and there is less violence in a family with balanced power between wife and husband. Women who accept the power of men have over them; they also accept the imbalance in power in a sexual relationship; so they might also accept violence from their intimate partners (Kishor & Johnson, 2004: 54). Power in sexual relationships is related to physical violence (Pulerwitz, et al., (2000). Also Dunkle, K.L., et al., (2004: 1419) found that gender-based violence, power in relationships, and risk of HIV infection are related. The authors investigated women attending antenatal clinics in South Africa and found that women whose husband's had a high relationship control were significantly more likely to report experience of violence in the past or currently. Kingkan Kongsakon (2007: 125), studied domestic violence and safe sex negotiation power of women with HIV/AIDS in Rayong Hospital using the scores of the Sexual Relationship Power Scale (SRPS) and found that domestic violence was related to a low opportunities of women to negotiate safe sex.

In this study, it was found that husbands or partners of pregnant women with low power of sexual relationships had limited chances to negotiate with the husbands or partners the use of condoms. This is due to gender inequity and imbalance in power of sexual relationships. Women under these circumstances might be forced to have sex with their partners or husbands. Intimate partner violence is linked to HIV risky behaviors of women (Vetten and Bhana, 2004; Mamam, et al.,2000; 16 Days of Activism Against Violence against Women, 2005; Dunkle, et al., 2003; (International Humanist and Ethical Union, 2007 cited by Global Campaign for Microbicides, 2007 cited by Global on Women and AIDS & WHO). Women who faced psychological/ emotional abuse for a longer time might develop health problems in suffering from

depression, post traumatic stress, and anxiety disorder (Browne & Finkelhor, 1986; Burnam, Stein, et al., 1988; Winfielde, Gorge, et al., 1990; Breslau, Davis, et al., 1991 cited by Dunkle, et al., 2003). Other risky behavior of women towards HIV/AIDS might be related to a low level of condom use, and partnerships outside her marriage (Miller, 1999).

Imbalance in the power of sexual relationships is associated with domestic violence and domestic violence influence risky behavior towards HIV/AIDS infection. If husbands/partners and wives have equal power in the relationship, risky behavior towards HIV/AIDS infection decrease. It was found in this study that women who never had a partnership outside marriage had high power in sexual relationships. They are able to negotiate the use of condoms. Several studies related to power in sexual relationships and HIV/AIDS infection such as the study of Bowleg, Belgrave & Reisen, (2000), who studied black and Latina women's HIV/AIDS behaviors found that the gender roles are significantly associated with discussions of HIV and condom use. The study of Jemmott & Jemmott, 1992, Kline & VaLandingham, 1994; Sikkema, et al., (1995 cited by Bowleg, Belgrave & Reisen, 2000) have found women's perceived self-efficacy to be significantly related to condom use.

The power in sexual relationships and the refusal of condom use can be explained with the inequality that characterizes the social and economic spheres of a society, in which women have less access to productive resources than men, which is often mirrored in sexual interactions, and is creating an unequal balance of power in sexual relations. As a result, many women have less control than men over when, where, why, and how sex takes place (International Women's Health Coalition, 1994 cited by Pimpawan Boonmongkol, 1999: 179; Berer & Ray translated by Prasert Tansakul, Veerasit Sitthitri and Kitti Noppakhun, 1996: 318). When women assume that they are at risk to be infected with HIV/AIDS through sexual intercourse, they might discuss with their husbands or partners the use of condoms or they refuse to have sex with them. Such an act challenge the sexual power of husbands/partners or women infringe the gender role that is designed by the social structure, since there is always a distinct difference between women's and men's roles, obligations and privileges, particularly in terms of access to productive resources, and decision

making authority. This inequality in sexual decision making is perpetuated by gender norms of femininity and masculinity that curtail women's sexual autonomy and expand men's sexual privilege, place greater emphasis on male pleasure over female pleasure. Men are superiority in sexual relationships and are the sexual controller. Women as the subordinator and the follower have to respond to men's sexual desire. With the sexual relationship power imbalance, the ability to negotiate condom use of women decreases. Many studies had reflected this fact such as the studies of Mantell, et al., (1995) and Pulerwitz, et al., (2000) who indicated that women with less power in sexual relation had a lower likelihood to convince husbands to use a condom, while women with high power in a positive relationships could motivate husbands to use one. Pettifor et al., (2004) studied sexual power and HIV/AIDS risk; and found that South African women aged 15-24 years with low relationship control were significantly more likely to report inconsistent condom use. Men have relationship power and control the process of sexual activity. Women are unable to control men's behavior related to their faithfulness to monogamous relationships, extramarital sex as well as condom use (International Humanist and Ethical Union, 2007 cited by http://www.iheu.org). Traditional attitudes dictate that women are the physical properties of their husbands deprive them of any authority over marital sexual relations. Women then belief that it is men's duty make the decisions in sexual affairs as well in condom use (Global Campaign for Microbicides, 2997 cited by www.global-campaign.org)

Imbalance in the power of sexual relationships is regarded as gender inequality and can lead to domestic violence. Forced sex may place women at high risk towards HIV/AIDS infection; women who have higher power in sexual relationship were able to negotiate safe sex.

Power imbalance can manifest itself in the control over sexual initiation and refusal. Power inequities not only may result in different sexual behaviors for men versus women, but may also lead to male control over the process of safe sex negotiation. Women with low power in sexual relationship were unable to control the risk behavior of husbands/partners to HIV/AIDS infection such as alcohol consumption, drug abuse or extramarital sex. Those risky behaviors are acceptable in

the society (Pimpawan Boonmongkon, 1999: 199-200). Risky behaviors of husbands/partners lead to violence in the family.

The power in sexual relationships and risky behavior of husbands/partners towards HIV/AIDS infection was assessed in this investigation. Power in sexual relationship was related to alcohol consumption, sexual relationships with prostitutes and sexual relationship with another woman. Women with low relationship satisfaction had a husband/partner with higher risky behavior such as alcohol consumption, sexual relationship with prostitutes and having another sexual partner than husbands/partners of women who had a moderate and high level of satisfaction in their relationship. The women who had a high level of satisfaction with their relationship had more ability and chance to talk or discuss with their husbands/partners about the risky behavior that may lead to sexually transmitted disease and HIV/AIDS infection in comparison to women who had a low level of satisfaction with their relationship. Communication between husbands/partners and wives may reduce the frequency of alcohol consumption of husbands/partners as well as extramarital sex that husbands/partners may have. According to Pimpawan Boonmongkon, (1999: 184-185), there are three groups of women, the first group is comprised of women with low relationship satisfaction and lack of power to negotiate condom use or refuse to have sexual activity. They don't know about the extramarital sex of their husbands/partners, they are at risk to be infected with HIV/AIDS besides being exposed to domestic violence. The second group of women, who had moderate relationship satisfaction, often asks their husbands/partners whether they visit prostitutes or not, and whether they are faithful to a monogamous relationship or not. Anyhow, women believe what their husbands or partners are telling them even if they are lying. The third group, women with high level of relationship satisfaction, dare to ask their husbands/partners for the truth whenever they suspect their husbands/partners to have sexual intercourse with another women, because such a behavior might lead to HIV/AIDS infection. They have the gut to refuse and know how to refuse having sex with their husbands/partners. They and their husbands or partners make decision equally, both participate in the family activities, discuss and exchange the point of view about issues related to married life. Communication

between husbands and wives may help to reduce the conflict in the family and the risky behavior of husbands/partners may decrease.

5.6 Domestic violence and risky behavior of pregnant women towards HIV/AIDS infection

Domestic violence and risky behavior of pregnant women towards HIV/AIDS infection were indicated by alcohol consumption and the refusal of their husbands to use condoms. Participants who experienced domestic violence had an alcohol abuse problem and their husbands/partners refused to use condoms in contrast to women who never experienced domestic violence. Domestic violence and risky behavior of pregnant women to HIV/AIDS infection are linked to gender inequality and gender based violence. Violence in the family may induce women to consume alcohol; because they are frustrated and try to escape from the violent relationship. In addition, to alcohol consumption they might suffer from post-traumatic stress and psychiatric disorder. Several studies had been conducted about domestic violence and alcohol consumption such as the study of Kyriacou, et al., (1999), in a USA. In this study 915 injured women admitted to the emergency room had been questioned; 65 % of them who were injured by their partners had partners with an alcohol abuse problem. The study of Mirrless-Black (1999 cited by www.homeoffice.gov.uk/rds/pdfs04/r216.pdf), the 1996 BCS) showed that men and women who drink heavily are more likely to report partner violence victimization than those who do not. The study of Robert, et al., (1997), found that among 242 men and women attending a major Australian emergency department, which those with domestic violence injuries were more likely to have alcohol problems at the time they attended and over the previous five years than non-victim controls.

Women who faced domestic violence may be under severe stress and might drink alcohol to solve their problems. It is known for a long time, that alcohol consumption influences the function of the brain. Under the influence of alcohol women loose self control, and with unclear mind, their ability to make rational decisions decrease, they might engage in unsafe sexual activity with an unfamiliar men, which results in the risk to be infected with HIV/AIDS (Gordon & Mitchell, 1988).

Participants who experienced domestic violence had likely more refusals of condom use of husbands/partners than participants who never experienced domestic violence. Women in this study explained that they could not insist on condom use because they did not have sufficient power in their relationships, also they were afraid of being threatened of physical abuse, and were afraid to be of abandoned. These are significant barriers for women to negotiate the use of a condoms (Weiss & Rao Gupta, 1998; Maman et al., 200: Jacobs, 2003, quoted by Prasert Tansakul, et al., 1996: 319; Vetten and Bhana, 2004; UNAIDS & WHO; Global Campaign for Microbicides, 2007 cited by campaign.org/download.htm; International Humanist and Ethical Union, 2007, cited by http://www.iheu.org/node/2777). Economically dependent women may submit to sex with husbands who refuse to use condom out of a fear of eviction and abandonment. With low sexual relationship power women are less likely to succeed in negotiating protection and less likely to leave a relationship that they perceive to be risky (Heise and Ellberg & Gottemoeller, 1999 cited in Blanc, 2001quoted by Suwajee Janthanom Good, 2004:233). According to the study of Wingood & Dichlemente (1997), who investigated the effects of an abusive primary partner on condom use and sexual negotiation practices of African-American women found that women in abusive relationships were less likely than others to use condoms and were more likely to experience verbal abuse, emotional abuse, or threats of physical abuse when they discussed condom use. They were more fearful of asking their partners to use condoms, worried more about acquiring the human immunodeficiency virus (HIV), and felt more isolated than women not in abusive relationships. The study of Pettifor, et al., (2004), about sexual power and HIV risk in South Africa found that woman's experience of forced sex with her partner, would decrease the likelihood of consistent condom use. The qualitative data from studies in Uganda, India, and elsewhere indicated that women find it difficult to suggest or insist on condom use in face of or threat of violence. One Ugandan study participant said “My husband hated condom use. He never allowed it. He would beat me often. He used to beat me when I refused to sleep with him. He wouldn’t use a condom. He said when we are married, how can we use a condom?” (Go, et al., 2003; Human Right Watch, 2003) The study of Lichtenstein (2004), about domestic violence, sexual ownership, and HIV risk in women in the America Deep South who attended a public

health clinic found that the women lacked the ability to control sexual activity including condom use in abusive relationships with HIV positive men. The refusal to use condom of husbands/partners based on the traditional and cultural belief, which involved the infidelity issue. When women discuss safe sex or negotiate condom use, this might indicate that they don't trust their husbands/partners, doubt that their husbands/partners might not be faithful to the monogamous relationship, may have promiscuous behavior, have sex with other woman or prostitute or have unprotected sex act with an extramarital partners (Blanc, et al., 1996; Verga, 1997: 45-47; Fapohunda &Rutenberg, 1999 cited by Blanc, 2001, Suwajee Janthanom Good: 2004: 215, Pimpawan Boonmongkon, (1999: 200). Men mostly use condoms with their causal sex partners, but rarely, if ever with their wives or steady sex partners (Berer, 1993 cited by Prasert Tansakul, et al., 1996: 218). This finding is confirmed by the findings of other studies, which found that when women know their husbands/partners had another sexual partner; they discussed safe sex and condom use with their husbands or partners. But husbands/partners refuse to use condom with the reason that using condom is very strange for them and they should not use it with wives. Men have the opinion that condom use while having sex is unpleasant. Accordance to the findings of Srivanichakorn (1990 cited by Boonmongkon, et al., 2000: 11), who investigated the knowledge, and attitude of teenage males in Thailand about HIV/AIDS infection and found that the youngsters considered the use of condoms when have sexual intercourse was not pleasurable. The traditional social-cultural values typically promote an imbalance in power between women and men, with women being in a subordinate position, which men can control the sexual relationship. When women ask men to use condom, it is rather a matter of reduction of men power over women (Watkins; Rutenberg & Wilkinson, 1997; Bawah, et al., 1999: 54-66 cited by Blanc, 200, Suwajee Janthanom Good, 2004: 223). Men were socialized with the concept that is men have the right to control the sexual relationship process; women's duty is to respond to men's sexual desire (International Humanist and Ethical Union, 2007 cited by http:// www.iheu.org/node/2777). Men and women living under social and cultural norms, an unequal power balance in gender relations favors men, and that translates into an unequal power balance in heterosexual interactions, in which male pleasure supersedes female pleasure. Whenever women

insist on condom use for safe sex, it indicates that women infringe the social and cultural norms (Berer, 1993 (cited by Prasert Tansakul, 1996: 318). Women are expected to be modest, polite and do not question their partner's behavior (Pimpawan Boonmongkon, 1999: 200). A study conducted in Uganda, found that three-fourth of men and women agreed that married women should not ask their husbands to use a condom while having sexual intercourse because it was unacceptable in their society (International Humanist and Ethical Union, 2007 cited by http://www.iheu.org/node/2777). The male dominant role in the gender relationship gives men the power to make decision about condom use (Global Campaign for Microbicides cited by www.global-campaign.org/download.htm). Wives who are suspicious that their husbands are unfaithful are afraid of being infected with HIV/AIDS should discuss safe sex and condom use with their husbands/partners, in case of low bargaining power husbands/partners often refuse to use condoms.

Most of HIV/AIDS infections occurring in heterosexual relationships result from unprotected sex. HIV/AIDS prevention is the main topic in the discussion about HIV between partners when woman suggest condom use. Information about HIV/AIDS and its prevention should be provided to men and they should be convinced that using condom doesn’t mean that they are unfaithful and that they also may have pleasure in sexual intercourse while using a condom.

It can be concluded that an unequal power relationships render women into a subordinate position. Power inequities may result in limited control of safe sex negotiation, and women’s lack of ability to negotiate safe sex and refuse unwanted sex. Sexual refusal or negotiation may lead to the suspicion of infidelity and carry the risk of domestic violence. Unequal power relations increase women's risks and vulnerability to exploitation and acquisition of HIV infection.

CHAPTER VI
CONCLUSION AND RECOMMENDATIONS

6.1 Conclusion

This study was conducted as a cross-sectional survey. The study aimed to investigate factors related to power in sexual relationships, control over relationship, dominance in decision making in matters of sexual relationships as well as in household issues. The study analyzed as domestic violence and risky behavior of HIV/AIDS infection of pregnant women. A purposive sampling method was applied to select a group of 360 pregnant women visiting the antenatal care clinic of Rajvithi Hospital to participate in the investigation. Information was obtained from 29 January to 27 February 2007. Data were analyzed by using descriptive statistical tests, such as frequency, percentage, mean, standard deviation (SD), maximum and minimum values. The chi-square tests had been used for analyzing the relationship between independent- and dependent variables.

The age of nearly half of participants ranged from 16 to 25 years, with an average age of 26 years. Most participants finished secondary school education. One-fourth of participants worked as private office employee, and a similar proportion was unemployed. The majority of women reported a personal income of 5,001-10,000 Baht, while one-fourth of them had no income.

The average age of husbands/partners was 30 years; more than a half of them were 26 to 35 years old. The educational level of the husbands was similar to the study subjects. The majority of them completed secondary school and were private office employees. The average income of husbands/partners was 15,203 Bath. That was higher in comparison to their spouses. Only 28.1 % of participants were married and their marriage was registered. The rest lived in a non-legalized partnership.

The power of sexual relationships of women could be termed as moderate for two-fifth (42.2 %) of them, while the satisfaction with their sexual relationship was high for 37.5 % and 20.3 % were not very much satisfied. Most of the study subjects had a moderate control over their relationships, while 31.9 % were very much in

control and 27.2 % almost had no control over their relationships. Nearly half of the women and their husbands/partners shared their opinion in decision making, but 27.8 % of husbands/partners dominated the decision making and a slightly higher proportion, namely 28.6 % of the female study participants had the final say in decision making. The decision making in household matters was not entirely different from the above mentioned results in that the majority of women and their husbands/partners had equal chances in decision making, while 15 % of husbands/partners dominated in that and 10% women.

Domestic violence included psychological/emotional, physical and sexual abuse. 72.2 % of participants experienced of psychological/emotional abuse, and 27.8 % never was abused in this sense. Most abuse reported in psychological/ emotional matters referred to feel bad about them. Most of those abused were done so in the past 12 months, and only a minority of women was abused longer ago. The proportion of participants who experienced physical abuse was similar to the proportion of participants who never experienced physical abuse. Half (50.3 %) of the participants never experienced physical abuse and nearly half (49.7 %) of them had experienced physical abuse. Mostly those being abused were pushed or shoved around in the previous 12 months, and 10.3 % longer ago. More than a half (53.9 %) of participants never had been sexual abused; but the rest of them (46.1 %) experienced sexual abuse. 41.7 % unwillingly gave in to have sex because they were afraid of what their husband/partner might do otherwise. Most of these events happened some time ago and not recently during their pregnancy.

Most of participants' husbands/partner consumed alcohol, but said that they drink only occasionally such as at social events and during traditional festivals. More than a half of husbands/partners don't use drugs and substances, 45 % reported to drug and substance abuse. Most of them smoked cigarettes. One-fourth of the women accepted that their husbands or partners had visited a prostitute; the majority of participants had of the belief that their husbands/partners don't have another woman as sexual partner, but 30.3 % women disclosed that their husbands/partners had another sexual relationship, 23.1 % with a casual sex partner and 7.2 % had a minor wives.

Most of women never were living in a multiple partnerships before marriage, and only 37.8 % have done just that, 31.4 % had a lover/ex-partner, and 6.4 % a boy friends. The male partners of one-fourth of the women, who once were living in a multiple partnerships, never used a condom, 5.8 % of them used a condom inconsistently and 4.2 % always used one. The majority of study subjects didn't consume alcohol, and only a small number of them consumed alcohol occasionally such as at traditional festivals. Almost all of the women didn't use drugs and substances and never had a partnership outside their marriage.

Nearly half of husbands/partners refused to use a condom when they were asked by their wives. They most given reason was that they never used one. Some of the male partners reacted with shouting, being angry when were asked to use a condom, and some considered condom use as unnecessary and or some of them laughed as if it was a nonsense matter when were asked to use a condom.

Education, occupation and income of the women were significantly associated with their power in sexual relationships. Only the occupation of participants was related to household decision making. The education of husbands/partners influenced power in sexual relationships. Age, education, occupation, income and marital status of participants were significantly related to domestic violence. Education and income of husbands/partners were statistically significant associated with domestic violence.

The power of sexual relationship and household decision making were significantly related to domestic violence. The risk behaviors of participants such as to have a partner outside the marriage and refusal of husbands/partners to use a condom were directly related to power in sexual relationships. The risky behaviors of husbands/partners towards HIV/AIDS infection such as alcohol consumption; having sex with prostitutes and sexual relationship with other woman were associated with power in sexual relationships. Power in household decision making had an influence on whether husbands/partners had another female sexual partner or not.

The association of domestic violence and risky behavior of participants towards HIV/AIDS infection was assessed as well. Alcohol consumption and refusal to use a condom by husbands/partners were significantly associated with domestic violence.

6.2 Recommendation

1. Health personnel should provide information and counseling for abused women in order to prevent the risk to be infected with HIV/AIDS.

2. To assess and prevent domestic violence and for improvement of the situation as well as to prevention of HIV/AIDS infection women should not be the only target but their male partner should be involved as well.

3. Campaigns for condom use should not aim only on HIV/AIDS prevention but should also provide information that helps men to change their beliefs about their power in sexual relationships and change the negative concept about condom use.

4. Training courses about the gender issue should be held for the health personnel involved in order to enhance their understanding about the health problems of disadvantaged and abused women as well as women living with HIV/AIDS so that they can provide appropriate health services for those women.

6.3 Recommendations for further studies

1. Additional studies should be conducted about domestic violence and power of women involving other groups of women such as women from disadvantaged social groups and migrants. But also women from the middle class and the higher income groups should be included in surveys as well as women living with HIV/AIDS in order to assess the power and violence in the family of each individual group.

2. Further studies should investigate domestic violence, power of women and risky behavior to be infected with HIV/AIDS in women who are already positive and those who are not yet infected.

3. Further studies should also investigate the experience of sexual abuse in childhood and whether this is a risk factor for experiencing violence in adulthood and whether it is associated with high risky sexual behavior in adolescence/adulthood or not.

4. More studies should investigate the perception, sexual behavior and attitude of men towards domestic violence in order to know the men’s problem and their beliefs according to their gender role and power, which might help to solve the problem of violence in the family.

BIBLIOGRAPHY

AIDS Action Council. (2002). Policy Facts : Women and HIV/AIDS. [online]. Available : http://209.212.93.18/content/whatis/art33787.html.

All Africa News Agency. (1999). Violence on women reaches alarming levels. Says Minister. Harare. Available electronically. Available : Global Forum for Health Research.

Ann, K. Blance. (2001). The effect of power in sexual relationships on sexual and reproductive health : examination of the evidence (สุวจี จันทร์ถนอม กู๊ด ผู้แปล). ใน กฤตยา อาชวนิจกุล (บรรณาธิการ), ผู้หญิงในวาทกรรมทางการเมือง เรื่องเพศและสิทธิอนามัย เจริญพันธุ์ (พิมพ์ครั้งที่ 1). กรุงเทพฯ : ศูนย์สตรีศึกษา คณะสังคมศาสตร์ มหาวิทยาลัยเชียงใหม่.

Auerbach, J., Emily P.B.& Sonia M.K. (2005). Gender – Based Violence and HIV Among Women : Assessing the Evidence. [online]. Available : www.amfar.org.

Borkowski, M., Murch, M. & Walker, V. (1983). Marital violence : the community response. London : Tavistock.

Bracken, P. J., et al. (1992). Helping victims of violence in Uganda. Medicine and War, 8 : 155- 163. Available : Global Forum for Health Research.

Carla E. Stokes & Larry M. Gant. Turning the tables on the HIV/AIDS epidemic : HIP Hop as a tool for reaching African-American adolescent girls. Perspectives, 70-81.

CDC HIV/AIDS FACT SHEET. (2007). HIV/AIDS among women. [online]. Available : http://www.cdc.gov/hiv

Coker, A. L. & D. L. Richter. (1998) Violence against women in Sierra Leone : Frequency and correlates of intimate partner violence and forced sexual intercourse. African Journal of Reproductive Health, 2, 1 : 61-72. Available : Global Forum for Health Research.

Dan K. Kaye. (2004). Gender inequality and domestic violence : implications for human immunodeficiency virus (HIV) prevention. African Health Sciences, 14, 1 : 67-70.

Deyessa, N., M. Kassaye, et al. (1998). Magnitude, type and outcomes of physical violence against married women in Butajira, Southern Ethiopia. Ethiopian Medical Journal, 36, 2 : 83-92. Available : Global Forum for Health Research.

Dunkle, K. et al. (2003). Gender – Based Violence and HIV Infection among Pregnant Women in Soweto. A Technical Report to the Australian Agency for International Development. (Mimeographed).

Dunkle, K. et al. (2004). Gender – Based Violence, relationship power, and risk of HIV Infection in women attending antenatal clinics in South Africa. The Lancet, Vol 363, 1425-1410.

Davies, M. (1994). Women and Violence (viii). London : Zed Book

Gail E. Wyatt et al. (2002). Does a history of Trauma contribute to HIV risk for women of color? Implications for prevention and policy. American Journal of Public Health, 93, 4 : 660-665.

Global AIDS Alliance. (2007). Violence against women and children & HIV/AIDS. [online]. Available : http://www.globalaidsalliance.org/getinvolved.cfm.

Gordon, P. &, Mitchell, L. (1988) Safer Sex : A New Look at Sexual Pleasure. Great Britain : Richard Clay Ltd Bungay Suffolk.

J. Pulerwitz, H. Amaro, W. De Jong, S.L. Gortmaker & R. Rudd. (2002). Relationship power, condom use and HIV risk among women in the USA. Aids Care, 14, 6: 789-800.

Jacquelyn C Campbell. (2002). Health consequence of intimate partner violence. The lancet volume 359 issue 9314.

Janet Maia Wojcicki & Josephine Malala. (2001). Condom use, power and HIV/AIDS risk : sex-workers bargain for survival in Hillbrow/Joubert Park/Berea, Johannesburg. Social Science & Medicine, 53, 99-121.

Jewkes, R. (2000). Overview of sexual violence against women in South Africa. Consultation on Sexual Violence Against Women, Melbourne 18-20 May. Available : Global Forum for Health Research.

Jewkes, R.K., J.B. Levin, et al. (2003). Gender inequality, Intimate partner violence and HIV preventive practice : Finding of a South African cross-sectional study. Social Science & Medicine, Vol 56, 125-134.

Kristin Dunkle et al. (2003). Gender-based violence and HIV infection among pregnant women in Soweto. A Technical Report to the Australian Agency for International Development.

Laddawan Panya. (2005). Disparities in Health and Health Care between in Thai and Hill tribe people at Propra district, Tak Province. M.A.Thesis (Medical and Health Social science). Faculty of Graduate Studies, Mahidol University.

Lichtenstein, B. (2005). Domestic violence, sexual ownership, and HIV risk in women in the American deep south. Social Science & Medicine, Vol 60, 701-714.

Lorber, Judith and Susan A. Farrell (eds.)., (1991). The Social Construction of Gender. Newbury Park, London New Delhi : SAGE Publication. Mirrlees-Black, C. (1999).

Maman, C., J. Campbell, ea al. (2000). The intersection of HIV and Violence : directions for future Research and Interventions. Social Science & Medicine, 50, 459-478.

Marcia M. Neundorfer, Phyllis Braudy Harris, Paula J. Britton & Delores A. Lynch, Ba. (2005). HIV – risk factors for midlife and older women. The Gerontologist, 45, 5 : 617-625.

Mukangara, F. & B. Koda. (1997). Beyond inequality : women in Tanzania. Dar es Salaam, TGNP/SARDC. Available : Global Forum for Health Research.

Mullika Songkraw. (2001). Behavior Towards HIV Infection of Pregnant Women in Suphanburi Province. M.S. Thesis (Epidemiology). Faculty of Graduate Studies, Mahidol University.

Mulugeta, E., M. Kassaye, et al. (1998). Prevalence and outcomes of sexual violence among high school students. Ethiopian Medical Journal, 36, 3 : 167-74. Available : Global Forum for Health Research.

N. Muhajarine & C. D' Arcy. (1999). Physical abuse during pregnancy : prevalence and risk factors. Canadian Medical Association Journal, 160, 7 : 1007-1011.

Pulerwitz, J., S. Gortmaker & Dejong W. (2000). Measuring Sexual Relationship Power in HIV/STD Research. Sex roles : A Journal of Research.

Raj, Anita et al. (2006). Masculine gender roles associated with increased sexual risk and intimate partner violence perpetration among young adult men. Journal of Urban Health : Bulletin of the New York Academy of Medicine, 83, 4 : 575-585 (11).

Rebecca J. Cabral, Lea Vonne Pulley, Lynn M. Artz, Ilene Brill & Maurizio Macaluso. (1998). Women at risk of HIV/STD : The importance of male partners as barrier to condom use. AIDS and Bahavior, 2, 1 : 75-85.

Regional Sexual Assult Associations. Women, sexual assault & HIV : are you at risk. [online]. Available : http://www.actoronto.org/website/home.nsf/pages/assault.

Rewadee Lertsintanapat. (1998). Sexuality, gender power relations and negotiation for safer sex among lower-middle class married women : a case at Public Health Center 61, Bangkok Metropolitan Administration. M.A. Thesis (Health Social Science). Faculty of Graduate Studies, Mahidol University.

Richmond-Abbott, M. (1992). Masculine & feminine : gender roles over the life cycle. New York : McGraw-Hill.

Rita M. Melendez. et al. (2003). Intimate Partner Violence and Safer Sex Negotiation : Effects of a Gender-Specific Intervention. Archives of Sexual Behavior, 32, 6 : 499-511.

Rob Stephenson, Michael A. Koeing & Saifuddin Ahmed. (2006). Domestic Violence and Symptoms of Gynecologic Morbidity Among Women in North India. International Family Planning Perspectives, 32, 4 : 201-208.

Saranthon Kaewkoon. (2004). A study of gender power relation in sexuality : A case study of women factory workers in Aom-noi Subdistrict, Krathumbaen District, Samut Sakhon Province. M.A. Thesis (Rural Development Studies). Faculty of Graduate Studies, Mahidol University.

Sermsri Sopikul. (2005). Predicting husband-to-wife and wife-to-husband marital aggression : A study of Thai married persons in an academic institute. Ph.D. Thesis (Population Education). Faculty of Graduate Studies, Mahidol University.

Sidley, P. (1999). Doctors demand AIDS drugs for women who have been rape. BMJ, 318, 7197 : 1507. Available : Global Forum for Health Research.

Stella Babalola. (2005). Gender differences in the factors influencing consistent condom use among young people in Tanzania. Paper presented at the XXVth IUSSP International Population Conference held in Tour, France, 18-23 July 2005.

Straus, M.A., Gelles, R.J.& Steinmetz, S.K. (1980). Behind closed door : violence in the American family. Garden, N.Y. : Anchor Press/Doubleday.

Sub-Saharan Africa. (2007) Violence and HIV in Africa. International Humanist News. [online]. Available : http://www.iheu.org/node/2777.

Suneeta Krishnan. et al. Marriage and Motherhood : Influences on Women's Power in Sexual Relationships.

Swiss, S., P. J. Jennings, et al. (1998). Violence against women during the Liberian civil conflict. JAMA-Journal of the American Medical Association, 276, 8 : 625-629. Available : Global Forum for Health Research.

Tanya Jacobs. (2003). Domestic Violence and HIV/AIDS : An area for urgent intervention. Published by the Institute of Criminology, University of Cape Town.

The Thai Working Group on HIV/AIDS Projection. (2001). สถานการณ์โรคเอดส์ : วิเคราะห์ สถานการณ์. [online]. Available : http// www.aidsthai.org.

Turman, T. (2003).Gender and HIV/AIDS. International Journal of Gynecology and Obstetrics, 82, 411-418.

UNAIDS. (2004). Women and Aids. AIDS epidemic update report, December, 2004. [online]. Available : http//www.unaids.org.

UNAIDS. (2004). Women, girls and HIV/AIDS in Malawi. Fact Sheet , 2004, August.

William Sambisa & Sian L. Curtis. (2007). Gender inequality, Domestic violence and male partner characteristics as risk factors for HIV infection among women in Zimbabwe. [online]. Available :http://apha.confex.com/apha/ 135am/techprogram/paper_159114.htm [2007, November 06].

Wolff, B., Blance, A. & Gage, A. (2000). Who decides? Women status and negotiation of sex in Uganda. Culture, Health and Sexuality, 2, 3 : 303-322.

World Health Organization. (2004). Violence Against Women and HIV/AIDS : Critical Intersections Intimate Partner Violence and HIV/AIDS. Medical

Research Council, South Africa. (mimeographed). www.who.int

In Thai

กมลพร แพทย์ชีพ. (2542). ความรุนแรงในคู่ครองและผลกระทบต่อปัญหาด้านจิตใจในกลุ่มอาการความวิตกกังวล ความซึมเศร้าและความก้าวร้าว : กรณีศึกษาอำเภอเมือง จังหวัดราชบุรี. วิทยานิพนธ์ปริญญาวิทยาศาสตรมหาบัณฑิต (สาธารณสุขศาสตร์). บัณฑิตวิทยาลัย มหาวิทยาลัยมหิดล, นครปฐม.

กฤติยา อาชวนิจกุล และคณะ. (2546). ความรุนแรงในชีวิตคู่กับสุขภาพของผู้หญิง (พิมพ์ครั้งที่ 1). นครปฐม : สถาบันวิจัยประชากรและสังคม มหาวิทยาลัยมหิดล.

_____. (2542). ความรุนแรงต่อผู้หญิง : ภัยเงียบ ภัยมืด และภัยสว่าง บนทุกเส้นทางชีวิตผู้หญิง. ใน พิมพวัลย์ บุญมงคล, นิภรณ์ สัญหจริยา และศันสนีย์ เรืองสอน (บรรณาธิการ), รื้อสร้างองค์ความคิดผู้หญิงกับสุขภาพ. (พิมพ์ครั้งที่ 1). กรุงเทพฯ : สำนักพิมพ์เจนเดอร์เพลส.

กาญจนา ปฏิยุทธ. (2541). ค่านิยมเกี่ยวกับพฤติกรรมทางเพศและอำนาจแห่งตนในการควบคุมทางสุขภาพที่มีความสัมพันธ์กับพฤติกรรมที่เสี่ยงต่อการติดเชื้อโรคติดต่อทางเพศสัมพันธ์ ของนักเรียนวัยรุ่นในจังหวัดนครศรีธรรมราช. วิทยานิพนธ์ปริญญาสังคมศาสตรมหาบัณฑิต (สังคมศาสตร์การแพทย์และสาธารณสุข). บัณฑิตวิทยาลัย มหาวิทยาลัยมหิดล, นครปฐม.

จันทรัตน์ ระเบียบโลก, ภารดี ชาญสมร และสิริมน วิไลรัตน์. (2546). บทบาทหญิงชายกับงานอนามัยเจริญพันธุ์. (พิมพ์ครั้งที่ 2). กรุงเทพฯ : กองอนามัยการเจริญพันธุ์ กรมอนามัย กระทรวงสาธารณสุข.

ดนยา ธนะอุดม. (2539). ความรุนแรงในครอบครัว : ศึกษาในหญิงตั้งครรภ์. วิทยานิพนธ์ปริญญาวิทยาศาสตรมหาบัณฑิต (สาธารณสุขศาสตร์) สาขาวิชาเอกอนามัยครอบครัว, บัณฑิตวิทยาลัย มหาวิทยาลัยมหิดล, นครปฐม.

นภาภรณ์ หะวานนท์. (2542). ปัญหาทางเพศของวัยรุ่นและการทำแท้ง.ใน พิมพวัลย์ บุญมงคล, นิภรณ์ สัณหจริยา, และศันศนีย์ เรืองสอน (บรรณาธิการ), รื้อสร้างองค์ความคิดผู้หญิงกับสุขภาพ (พิมพ์ครั้งที่ 1) . กรุงเทพฯ : สำนักพิมพ์เจนเดอร์เพรส

นิจวรรณ วีรวัฒโนดม. (2540). ความรุนแรงต่อสตรี : ศึกษาในกลุ่มผู้หญิงอายุ 15-44 ปีที่มารับบริการ ณ แผนกผู้ป่วยนอก โรงพยาบาลชัยนาท จังหวัดชัยนาท. วิทยานิพนธ์ปริญญาวิทยาศาสตรมหาบัณฑิต (สาธารณสุขศาสตร์), บัณฑิตวิทยาลัย มหาวิทยาลัยมหิดล, นครปฐม.

มยุรี ยุพาวรรณ (เรียบเรียง). (2537). ผู้หญิงกับวิกฤตการณ์เอดส์. กรุงเทพฯ : รุ่งแสงการพิมพ์.

วัชรินทร์ ปัจเจกวิญญูสกุล, อุทัยวรรณ แจ่มสุธี และอำนาจ เนตยสุภา. (2546). รายงานการวิจัย การประเมินกระบวนการยุติธรรมในการคุ้มครองสวัสดิภาพบุคคลที่ได้รับความรุนแรงในครอบครัว(พิมพ์ครั้งที่ 1). กรุงเทพฯ : ห้างหุ้นส่วนจำกัดพิมพ์อักษร.

วรรณี เดียวอิศเรศ, มณีรัตน์ ภาคธูป และยุนี พงศ์จตุรวิทย์. (2544). การทารุณกรรมในหญิงตั้งครรภ์ในเขตภาคตะวันออก : การเผชิญปัญหาและสุขภาพมารดาและทารก. ในบุปผา ศิริรัศมี และจรรยา เศรษฐบุตร (บรรณาธิการ), รายงานการวิจัย โครงการพัฒนางานวิจัยด้านเพศภาวะ มิติทางเพศและอนามัยการเจริญพันธุ์ ชุดที่ 4 (พิมพ์ครั้งที่ 1). กรุงเทพฯ : สถาบันวิจัยประชากรและสังคม มหาวิทยาลัยมหิดล.

พนา พวงมะลิ. (2541). การผ่าตัดคลอดทางหน้าท้อง : ค่านิยมของหญิงตั้งครรภ์. วิทยานิพนธ์ปริญญาสังคมศาสตร์มหาบัณฑิต (สังคมศาสตร์การแพทย์และสาธารณสุข), บัณฑิตวิทยาลัย มหาวิทยาลัยมหิดล, นครปฐม.

เพ็ญจันทร์ ประดับมุข. (2542). ผู้หญิงกับการเผชิญปัญหาเอดส์. รื้อสร้างองค์ความคิดผู้หญิงกับสุขภาพ. ใน พิมพวัลย์ บุญมงคล, นิภรณ์ สัญหจริยา และศันสนีย์ เรืองสอน (บรรณาธิการ), รื้อสร้างองค์ความคิดผู้หญิงกับสุขภาพ. (พิมพ์ครั้งที่ 1). กรุงเทพฯ : สำนักพิมพ์เจนเดอร์เพลส.

พิชิต ฤทธิ์จรูญ. (2547). ระเบียบวิธีการวิจัยทางสังคมศาสตร์. กรุงเทพฯ ซ: เฮ้าส์ ออฟ เดอร์มีสท์.

พิมพวัลย์ บุญมงคล. (2541). ระบบความเชื่อและพฤติกรรมเกี่ยวกับความสัมพันธ์หญิงชายในครอบครัว : นัยยะและกลวิธีในระดับชุมชนเพื่อการป้องกันโรคติดเชื้อทางเพศสัมพันธ์และโรคเอดส์ในหญิงชนบทที่แต่งงานแล้ว. นนทบุรี : สถาบันวิจัยระบบสาธารณสุข.

พรสุข หุ่นนิรันดร์. (2543). รายงานการวิจัยเรื่องพฤติกรรมการป้องกันโรคเอดส์ของนักศึกษามหาวิทยาลัย. กรุงเทพฯ : ภาควิชาสุขศึกษา คณะพลศึกษา มหาวิทยาลัยศรีนครินทรวิโรฒประสานมิตร.

โชติมา กาญจนกุล และศันสนีย์ เรืองสอน (2542).การทำร้ายร่างกายภรรยา : อาชญากรรมเงียบภายใต้หลังคาบ้าน.ใน พิมพวัลย์ บุญมงคล, นิภรณ์ สัญหจริยา และศันสนีย์ เรืองสอน (บรรณาธิการ), รื้อสร้างองค์ความคิดผู้หญิงกับสุขภาพ (พิมพ์ครั้งที่ 1). กรุงเทพฯ : สำนักพิมพ์เจนเดอร์เพลส.

ภัสสร ลิมานนท์. (2544). สตรีกับปัญหาเอดส์. บทบาทเพศ สถานภาพสตรี กับการพัฒนา. กรุงเทพฯ : วิทยาลัยประชากรศาสตร์ จุฬาลงกรณ์มหาวิทยาลัย.

ชาย จิรวศัลย์ และรุ่งทิวา ประสานทอง. (2536). ปัจจัยเสี่ยงต่อการติดเชื้อเอดส์ในหญิงมีครรภ์ ภาคตะวันออก. ใน วิพุธ พูลเจริญ และคณะ (บรรณาธิการ), รวบรวมวิเคราะห์ผลงานวิจัย เกี่ยวกับโรคเอดส์ในประเทศไทย พ.ศ.2536-2540. กรุงเทพฯ : ม.ป.ท.

สุชาดา ทวีสิทธิ์. (2547). เพศภาวะ : กระบวนทัศน์เพื่อโลกใบใหม่ที่เท่าเทียม. ใน สุชาดา ทวีสิทธิ์ (บรรณาธิการ), เพศภาวะ : การท้าทายร่าง การค้นหาตัวตน (พิมพ์ครั้งที่ 1). กรุงเทพฯ : ศูนย์สตรีศึกษา คณะสังคมศาสตร์ มหาวิทยาลัยเชียงใหม่.

สุรศักดิ์ ฐานีพานิชสกุล, สุวชัย อินทรประเสริฐ และสัญญา ภัทราชัย (บรรณาธิการ). (2540). เอดส์ : ในสูติกรรมและวางแผนครอบครัว. กรุงเทพฯ : ภาควิชาสูติศาสตร์ นรีเวชวิทยา มหาวิทยาลัยมหิดล.

ลัดดาวัลย์ สุขุม. (2542). ทัศนคติของแพทย์และพยาบาลที่ปฏิบัติงานในห้องฉุกเฉินของโรงพยาบาลของรัฐในจังหวัดสงขลาต่อปัญหาความรุนแรงต่อผู้หญิง. วิทยานิพนธ์ปริญญาสังคมศาสตรมหาบัณฑิต (สังคมศาสตร์การแพทย์และสาธารณสุข), บัณฑิตวิทยาลัย มหาวิทยาลัยมหิดล, นครปฐม.

ศดานันท์ ปิยกุล. (2542). คุณภาพชีวิตของผู้ติดเชื้อและผู้ป่วยเอดส์ ในโรงพยาบาลสันป่าตองและโรงพยาบาลสันทราย จังหวัดเชียงใหม่. วิทยานิพนธ์ปริญญา สังคมศาสตรมหาบัณฑิต (สังคมศาสตร์การแพทย์และสาธารณสุข), บัณฑิตวิทยาลัย มหาวิทยาลัยมหิดล, นครปฐม.

อนุชิต สว่างแจ้ง. (2546). การให้ความหมายความเป็นชายและการมีเพศสัมพันธ์ที่ส่งผลต่อรูปแบบของพฤติกรรมการมีส่วนร่วมของผู้ชายในการวางแผนครอบครัว. วิทยานิพนธ์ปริญญาศิลปศาสตร์มหาบัณฑิต (สังคมศาสตร์การแพทย์และสาธารณสุข), บัณฑิตวิทยาลัย มหาวิทยาลัยมหิดล, นครปฐม.

APPENDIX

Table 1 Percentage, mean and standard deviation of the scores about the control of pregnant women in their sexual relationships

Relationship Control	Absolutely agree	Agree	Disagree	Absolutely disagree	$\overline{X}$	S.D.
	Number(%)	Number (%)	Number (%)	Number (%)		
1.If I ask my partner to use a condom, he would become violent.	18 (5.0)	52 (14.4)	200 (55.6)	90 (25)	3.01	0.772
2.If I ask my partner to use a condom, he would get angry.	32 (8.9)	70 (19.4)	179 (49.7)	79 (21.9)	2.85	0.865
3.Most of the time, we do what my partner wants to do.	23 (6.4)	153 (42.5)	163 (45.3)	21 (5.8)	2.51	7.04
4. My partner won't let me wear certain things.	32 (8.9)	77 (21.4)	173 (48.1)	78 (21.7)	2.83	0.870
5. When my partner and I are together, I am pretty quiet.	41 (11.4)	187 (51.9)	109 (30.3)	23 (6.4)	2.32	0.757
6. My partner has more to say than I do about important decisions that affect us.	59 (16.4)	115 (31.9)	153 (42.5)	33 (9.2)	2.44	0.872
7. My partner tells me with whom I can spend my time with.	4 (1.1)	36 (10.0)	161 (44.7)	159 (44.2)	3.32	0.697
8.If I asked my partner to use a condom, he would think that	12 (3.3)	50 (13.9)	193 (53.6)	105 (29.2)	3.09	0.747
9.I feel trapped or stuck in our relationship	5 (1.4)	55 (15.3)	200 (55.6)	100 (27.8)	3.10	0.691

Table 1 Percentage, mean and standard deviation of the scores about the control of pregnant women in their sexual relationships (cont.)

Relationship Control	Absolutely agree	Agree	Disagree	Absolutely disagree	$\overline{X}$	S.D.
	Number(%)	Number (%)	Number (%)	Number (%)		
10. My partner does what he wants, even if I do not want him to do certain things.	28 (7.8)	123 (34.2)	172 (47.8)	37 (10.3)	2.61	0.776
11. I am more committed to our relationship than my partner is.	93 (25.8)	154 (42.8)	86 (23.9)	27 (7.5)	2.13	0.885
12. When my partner and I disagree, he gets his way most of the time.	84 (23.3)	158 (43.9)	94 (26.1)	24 (6.7)	2.16	0.859
13. My partner gets more out of our relationship most of the time.	42 (11.7)	80 (22.2)	201 (55.8)	37 (10.3)	2.65	0.818
14. My partner always wants to know where I am	42 (11.7)	95 (26.4)	164 (45.6)	59 (16.4)	2.67	0.886
15. My partner might be having sex with someone else.	33 (9.2)	88 (24.4)	176 (48.9)	63 (175.5)	2.75	0.851

Table 2 Percentage, mean and standard deviation of the scores about decision-making dominance of pregnant women

Decision-making dominance	Decision maker			$\bar{X}$	S.D.
	husband/partner	pregnant women and husband/partner	Pregnant women		
	Number (%)	Number (%)	Number (%)		
1. Who usually has more to say about whose friends to go out with?	28 (7.8)	85 (23.6)	247 (68.6)	2.61	0.628
2. Who usually has more to say about whether you have sex or not?	201 (55.8)	139 (38.6)	20 (5.6)	1.50	0.602
3. Who usually has more to say about what you do together when having sex?	82 (22.8)	240 (66.7)	38 (10.6)	1.88	0.565
4. Who usually has more to say about how often you see one another?	65 (18.1)	200 (55.6)	95 (26.4)	2.08	0.662
5. Who usually has more to argue about when you talk about serious things?	132 (36.7)	148 (41.1)	80 (22.2)	1.86	0.755
6. In general, who do you think has more power in your relationship?	103 (28.6)	193 (53.6)	64 (17.8)	1.89	0.613
7. Who usually has more to say about whether your partner uses a condom?	160 (44.4)	114 (31.7)	86 (23.9)	1.79	0.802
8. Who usually has more to say about what kind of sexual acts you do?	223 (61.9)	121 (33.6)	16 (4.4)	1.43	0.578

Table 3 Percentage, means and standard deviation of the decision-making within the family of pregnant women

Issue	Decision maker			$\overline{X}$	S.D.
	husband/ pregnant	women and partner husband/ partner	Pregnant women		
	Number (%)	Number (%)	Number (%)		
1. Family expenses	125 (34.7)	159 (44.2)	76 (21.1)	1.86	0.736
2. Buying things for the family such as TV, refrigerator, washing machine, computer	69 (19.2)	215 (59.7)	76 (21.1)	2.02	0.635
3. Buying a car	124 (34.4)	206 (57.2)	30 (8.3)	1.74	0.601
4. Moving to a new apartment	73 (20.3)	242 (67.2)	45 (12.5)	1.92	0.568
5. Business investment or new career	90 (25.0)	241 (66.9)	29 (8.1)	1.83	0.550
6. Attend a wedding party, ordination ceremony	66 (18.3)	245 (68.1)	49 (13.6)	1.95	0.564
7.How to react to the sickness of a family member	50 (13.9)	193 (53.6)	117 (32.5)	2.19	0.656
8.The number of child you want to have	98 (27.2)	189 (52.5)	73 (20.3)	1.93	0.687
9. School and educational planning for the children	54 (15.0)	217 (60.3)	89 (24.7)	2.10	0.624
10. Punishment or advice given to the children	47 (13.1)	204 (56.7)	109 (30.3)	2.17	0.636

Table 4 The percentage of psychological abuse of pregnant women

Psychological abuse	No	Yes	In past 12 months	Life time
	Number (%)	Number (%)	Number (%)	Number (%)
1. Being insulted or made to feel bad about oneself	126 (35)	234 (65.0)	177 (49.2)	57 (5.8)
2.Being humiliated or belittled in front of others	224 (62.2)	136 (37.8)	100 (27.8)	36 (10.0)
3. Being intimidated or scared on purpose for example by a partner yelling and smashing things	238 (66.1)	122 (33.9)	91 (25.3)	31 (8.6)
4. Being threatened with harm directly or indirectly in the form of a threat to hurt someone the you cared about	318 (88.3)	42 (11.7)	31 (8.6)	11 (3.1)

Table 5 The percentage of psychological abuse of pregnant women in the past 12 months categorized according to the frequency

Psychological abuse		The frequency of psychological abuse in the past 12 month		
	Yes	1 time Number (%)	2-5 times Number (%)	> 5 times Number (%)
1. Being insulted or made to feel bad about oneself	**177 (49.2)**	20 (5.6)	68 (18.9)	89 (24.7)
2. Being humiliated or belittled in front of others	**100 (27.8)**	28 (7.8)	39 (10.8)	33 (9.2)
3. Being intimidated or scared on purpose for example by a partner yelling and smashing things	**91 (25.3)**	25 (6.9)	42 (11.7)	24 (6.7)
4. Being threatened with harm directly or indirectly in the form of a threat to hurt someone you cared about	**31 (8.6)**	14 (3.9)	7 (1.9)	10 (2.8)

Table 6 The percentage of psychological abuse in a life time of pregnant women classified according to the frequency

Psychological abuse	Yes	The frequency of psychological abuse in the life time		
		1 time Number (%)	2-5 times Number (%)	> 5 times Number (%)
1. Being insulted or made to feel bad about oneself	**57 (5.8)**	11 (3.1)	25 (6.9)	21 (5.8)
2. Being humiliated or belittled in front of others	**36 (10.0)**	14 (3.9)	11 (3.1)	11 (3.1)
3. Being intimidated or scared on purpose for example by a partner yelling and smashing things	**31 (8.6)**	11 (3.1)	13 (3.6)	7 (1.9)
4. Being threatened with harm directly or indirectly in the form of a threat to hurt someone you cared about	**11 (3.1)**	8 (2.2)	1 (0.3)	2 (0.6)

Table 7 The percentage of physical abuse of pregnant women

Physical abuse	No	Yes	In past 12 months	Life time
	Number (%)	Number (%)	Number (%)	Number (%)
1.Being slapped or thrown something at you that could hurt you	280 (77.8)	80 (22.2)	51 (14.2)	29 (8.1)
2. Being pushed or shoved	251 (70)	108 (30)	71 (19.7)	37 (10.3)
3. Being hit by a fist or something else that could hurt you	304 (84.4)	56 (15.6)	39 (10.8)	17 (4.7)
4. Being kicked, dragged or beaten	323 (89.7)	37 (10.3)	23 (6.4)	14 (3.9)
5. Being choked or burnt on purpose	318 (88.3)	42 (11.7)	22 (6.1)	20 (5.6)
6. Being threatened with a gun, knife or other weapon	302 (83.9)	58 (16.1)	33 (9.2)	25 (6.9)

Table 8 The percentage of physical abuse of pregnant women in the past 12 months divided according to the frequency

Physical abuse		The frequency of physical abuse in the past 12 months		
	Yes	1 time Number (%)	2-5 times Number (%)	> 5 times Number (%)
1. Being slapped or thrown something at that could hurt you	**51 (14.2)**	21 (5.8)	22 (6.1)	8 (2.2)
2. Being pushed or shoved	**71 (19.7)**	30 (8.3)	30 (8.3)	11 (3.1)
3. Being hit by a fist or something else that could hurt you	**39 (10.8)**	24 (6.7)	10 (2.8)	5 (1.4)
4. Being kicked, dragged or beaten	**23 (6.4)**	17 (4.7)	1 (0.3)	5 (1.4)
5. Being choked or burnt on purpose	**22 (6.1)**	14 (3.9)	7 (1.9)	1 (0.3)
6. Being threatened with a gun, knife or other weapon	**33 (9.2)**	21 (5.8)	7 (1.9)	5 (1.4**)**

Table 9 The percentage of physical abuse in a life time of pregnant women categorized according to the frequency

Physical abuse		The frequency of physical abuse in the life time		
	Yes	1 time Number (%)	2-5 times Number (%)	> 5 times Number (%)
1. Being slapped or thrown something at that could hurt you	**29 (8.1)**	18 (5.0)	5 (1.4)	6 (1.7)
2. Being pushed or shoved	**37 (10.3)**	28 (7.8)	6 (1.7)	3 (0.8)
3. Being hit by a fist or something else that could hurt you	**17 (4.7)**	12 (3.3)	3 (0.8)	2 (0.6)
4. Being kicked, dragged or beaten	**14 (3.9)**	10 (2.8)	2 (0.6)	2 (0.6)
5. Being choked or burnt on purpose	**20 (5.6)**	18 (5.0)	1 (0.3)	1 (0.3)
6. Being threatened with a gun, knife or other weapon	25 (6.9)	21 (5.8)	3 (0.8)	1 (0.3)

Table 10 The percentage of sexual abuse of pregnant women

Sexual abuse	No	Yes	In past 12 months	Life time
	Number (%)	Number (%)	Number (%)	Number (%)
11 Being physically forced to have sexual intercourse	317 (88.1)	43 (11.9)	17 (4.7)	26 (7.2)
12. Having sexual intercourse because of the fear that husband/partner might do something unpleasant to you	210 (58.3)	150 (41.7)	139 (38.6)	11 (3.1)
13. Being forced to do something in your sexual relationship you found degrading or humiliating	319 (88.6)	41 (11.4)	25 (6.9)	16 (4.4)

Table 11 The percentage of sexual abuse of pregnant women in the past 12 months divided according to the frequency

Sexual abuse		The frequency of sexual abuse in the past 12 months		
	Yes	1 time	2-5 times	> 5 times
		Number (%)	Number (%)	Number (%)
1. Being physically forced to have sexual intercourse	**17 (4.7)**	9 (2.5)	5 (1.4)	3 (0.8)
2. Having sexual intercourse because of the fear that husband/partner might do something unpleasant to you	**139 (38.6)**	10 (2.8)	53 (14.7)	76 (21.1)
3. Being forced to do something in your sexual relationship you found degrading or humiliating	**25 (6.9)**	17 (4.7)	5 (1.4)	3 (0.8)

Table 12 The percentage of sexual abuse in the life time of pregnant women classified according to the frequency

Sexual abuse		The frequency of sexual abuse in the life time		
	Yes	1 time Number (%)	2-5 times Number (%)	> 5 times Number (%)
1. Being physically forced to have sexual intercourse	**26 (7.2)**	24 (6.7)	1 (0.3)	1 (0.3)
2. Having sexual intercourse because of the fear that husband/partner might do something unpleasant to you	**11 (3.1)**	2 (0.6)	4 (1.1)	5 (1.4)
3. Being forced to do something in your sexual relationship you found degrading or humiliating	**16 (4.4)**	9 (2.5)	4 (1.1)	3 (0.8)

Table 13 Demographic background and socio-economic status of pregnant women and their husbands or partners and domestic violence

Socio-economic status	Domestic violence					
	Psychological abuse		Physical abuse		Sexual abuse	
	No	Yes	No	Yes	No	Yes
<u>Pregnant women</u>						
<u>Age</u>						
≤15-25 year	24.4	75.6	48.3	51.7	50.6	49.4
26-35 year	30.7	69.3	56.2	43.8	59.5	40.5
≥ 36 year	32.3	67.7	32.3	67.7	45.2	54.8
	χ^2= 4.039		χ^2 = 6.456		χ^2 = 3.654	
	p-value = 0.401		p-value = 0.040		p-value = 0.161	
			V = 0.134			

Table 13 Demographic background and socio-economic status of pregnant women and their husbands or partners and domestic violence (cont.)

Socio-economic status	Domestic violence					
	Psychological abuse		Physical abuse		Sexual abuse	
	No	Yes	No	Yes	No	Yes
Education						
Illiteracy/primary school	17.8	82.2	37.0	63.0	49.3	50.7
Secondary school	24.9	75.1	48.6	51.4	48.0	52.0
Vocational education/Diploma	29.1	70.9	47.3	52.7	67.3	32.7
Bachelor degree and higher	47.5	52.5	74.6	25.4	64.4	35.6
	χ^2 = 15.790		χ^2= 19.497		χ^2 = 9.639	
	p-value = 0.001		p-value = 0.000		p-value= 0.022	
	V = 0.209		V = 0.233		V = 0.164	
Occupation						
Unemployed	20.6	79.4	41.2	58.8	49.5	50.5
Unskilled worker	22.0	78.0	48.8	51.2	46.3	53.7
Factory worker/private office employee	33.0	67.0	54.7	45.3	55.7	44.3
Civil servant	42.3	57.7	65.4	34.6	69.2	30.8
Commercial/trading/private business/others	32.7	67.3	53.1	46.9	63.3	36.7
	χ^2= 8.634		χ^2 = 6.606		χ^2 = 6.967	
	p-value = 0.071		p-value = 0.158		p-value = 0.138	
Income						
No income	20.6	79.4	41.2	58.8	49.5	50.5
≤ 5,000 Baht	17.4	82.6	34.8	65.2	45.7	54.3
5,001 – 10,000 Baht	28.5	71.5	57.6	42.4	53.5	46.5
10,001 -20,000 Baht	41.8	58.2	54.5	45.5	70.9	29.1
≥ 20,001 Baht	44.4	55.6	66.7	33.3	50.0	50.0
	χ^2= 12.883		χ^2 = 13.045		χ^2 = 8.545	
	p-value = 0.012		p-value = 0.011		p-value = 0.074	
	V = 0.189		V = 0.190			

Table 13 Demographic background and socio-economic status of pregnant women and their husbands or partners and domestic violence (cont.)

Socio-economic status	Domestic violence					
	Psychological abuse		Physical abuse		Sexual abuse	
	No	Yes	No	Yes	No	Yes
Husband/Partner						
Age						
≤15-25 year	18.9	81.1	55.6	44.4	58.9	41.4
26-35 year	31.1	68.9	50.5	49.5	50.5	49.5
≥36 year	30.0	70.0	43.8	56.3	56.3	43.8
	χ^2 = 4.757		χ^2 = 2.371		χ^2 = 1.950	
	p-value = 0.093		p-value = 0.306		p-value = 0.377	
Education						
Illiteracy/primary school	20.0	80.0	47.1	52.9	52.9	47.1
Secondary school	21.7	78.3	43.4	56.6	43.4	56.6
Vocational education/Diploma	35.8	64.2	56.7	43.3	59.7	40.3
Bachelor degree and higher	43.1	56.9	63.1	36.9	72.3	27.7
	χ^2 = 14.959		χ^2 = 8.463		χ^2= 16.200	
	p-value = 0.002		p-value = 0.037		p-value = 0.001	
	V = 0.204		V = 0.153		V = 0.212	
Occupation						
Unemployed/unskilled worker/ agricultural worker	19.2	80.8	51.2	48.8	54.4	45.6
Factory worker/private office employee	35.0	65.0	50.4	49.6	56.1	43.9
Civil servant/state enterprise employee	27.0	73.0	51.4	78.6	43.2	56.8
Commercial/trading/private business/others	30.7	69.3	48.0	52.0	54.7	45.3
	χ^2 = 8.069		χ^2 = 0.216		χ^2 = 1.960	
	p-value = 0.045		p-value = 0.975		p-value = 0.581	
	V = 0.150					

Table 13 Demographic background and socio-economic status of pregnant women and their husbands or partners and domestic violence (cont.)

Socio-economic status	Domestic violence					
	Psychological abuse		Physical abuse		Sexual abuse	
	No	Yes	No	Yes	No	Yes
Income						
0 – 5,000 Baht	9.5	90.5	45.2	54.8	59.5	40.5
5,001-10,000 Baht	27.4	72.6	50.0	50.0	48.9	51.1
10,001-20,000 Baht	28.0	72.0	48.8	51.2	61.0	39.0
≥ 20,001 Baht	45.7	54.3	58.7	41.3	56.5	43.5
	χ^2 = 14.320		χ^2= 1.810		χ^2 = 4.189	
	p-value = 0.002		p-value = 0.613		p-value = 0.242	
	V = 0.199					
Marital status						
Not registered	24.7	75.3	49.0	51.0	51.7	48.3
Registered	35.6	64.4	53.5	46.5	59.4	40.6
	χ^2 = 4.330		χ^2 = 0.571		χ^2 = 1.720	
	p-value = 0.037		p-value = 0.450		p-value = 0.190	
	Ø = -0.110					

Table 14 Domestic violence and risk of acquiring HIV/AIDS infection of pregnant women

Risk behavior of being infected with HIV/AIDS	Domestic violence					
	Psychological abuse		Physical abuse		Sexual abuse	
	No	Yes	No	Yes	No	Yes
<u>Alcohol consumption</u>						
No	97.0	83.8	92.8	82.1	92.3	81.9
Yes	3.0	16.2	7.2	17.9	7.7	18.1
Total	100.0	100.0	100.0	100.0	100.0	100.0
	χ^2 = 11.425		χ^2 = 9.411		χ^2= 8.745	
	p-value = 0.001		p-value = 0.002		p-value = 0.003	
	Ø = 0.178		Ø = 0.162		Ø = 0.156	
<u>Drug and substance abuse</u>						
No	98.0	94.2	98.9	91.6	97.9	92.2
Yes	2.0	5.8	1.1	8.4	2.1	7.8
Total	100.0	100.0	100.0	100.0	100.0	100.0
	χ^2= 2.281		χ^2 = 13.045		χ^2 = 6.618	
	p-value = 0.131		p-value = 0.011		p-value = 0.010	
			Ø = 0.190		Ø = 0.136	
<u>Partnership outside marriage</u>						
No	100.0	92.7	98.9	90.5	99.5	89.2
Yes	0.0	7.3	1.1	9.5	0.5	10.8
Total	100.0	100.0	100.0	100.0	100.0	100.0
	χ^2= 7.715		χ^2 = 12.679		χ^2 = 19.087	
	p-value = 0.005		p-value = 0.000		p-value = 0.000	
	Ø = 0.146		Ø = 0.188		Ø = 0.230	

Table 14 Domestic violence and risk of acquiring HIV/AIDS infection of pregnant women (cont.)

Risk behavior of being infected with HIV/AIDS	Domestic violence					
	Psychological abuse		Physical abuse		Sexual abuse	
	No	Yes	No	Yes	No	Yes
Negotiation of condom use						
No	35.0	28.1	28.7	31.3	32.0	27.7
Yes	65.0	71.9	71.3	68.7	68.0	72.3
Total	100.0	100.0	100.0	100.0	100.0	
100.0						
	$\chi^2 = 7.715$		$\chi^2 = 0.280$		$\chi^2 = 0.769$	
	p-value = 0.005		p-value = 0.597		p-value = 0.381	
	Ø = 0.146					
Refusal to use condom of husband/partner						
No	58.5	32.1	35.4	19.0	52.3	24.2
Yes	41.5	67.9	35.9	49.7	47.7	75.8
Total	100.0	100.0	100.0	100.0	100.0	100.0
	$\chi^2 = 14.120$		$\chi^2 = 13.061$		$\chi^2 = 20.893$	
	p-value = 0.000		p-value = 0.001		p-value = 0.000	
	Ø = 0.237		Ø = 0.190		Ø = 0.288	

Table 15 Domestic violence and risk of acquiring HIV/AIDS infection of husband or partner

Risk behavior of being infected with HIV/AIDS	Domestic violence					
	Psychological abuse		Physical abuse		Sexual abuse	
	No	Yes	No	Yes	No	Yes
Alcohol consumption						
No	37.5	62.5	54.7	45.3	63.3	36.7
Yes	22.4	77.6	47.8	52.2	48.7	51.3
	χ^2 = 9.358		χ^2 = 1.545		χ^2 = 7.051	
	p-value = 0.002		p-value = 0.214		p-value = 0.008	
	Ø = 0.161		Ø = 0.140		Ø = 0.140	
Drug and substance abuse						
No	30.8	69.2	52.0	48.0	57.6	42.4
Yes	24.1	75.9	48.1	51.9	49.4	50.6
	χ^2= 2.014		χ^2= 0.534		χ^2 = 2.407	
	p-value = 0.156		p-value = 0.465		p-value = 0.121	
Sexual intercourse with prostitute						
No	34.2	65.8	55.5	44.5	58.8	41.2
Yes	8.0	92.0	34.1	65.9	38.6	61.4
	χ^2= 22.814		χ^2 = 12.207		χ^2= 10.904	
	p-value =0.000		p-value = 0.000		p-value = 0.001	
	Ø = 0.252		Ø = 0.184		Ø = 0.174	
Sexual intercourse with other women						
No	35.1	64.9	57.0	43.0	61.8	38.2
Yes	11.0	89.0	34.9	65.1	35.8	64.2
	χ^2= 21.912		χ^2= 14.861		χ^2= 20.632	
	p-value = 0.000		p-value = 0.000		p-value = 0.000	
	Ø = 0.247		Ø = 0.203		Ø = 0.239	

Table 15 Domestic violence and risk of acquiring HIV/AIDS infection of husband or partner (cont.)

Risk behavior of being infected with HIV/AIDS	Domestic violence					
	Psychological abuse		Physical abuse		Sexual abuse	
	No	Yes	No	Yes	No	Yes
Multiple partnership						
No	33.0	67.0	55.4	44.6	59.4	40.6
Yes	19.1	80.9	41.9	58.1	44.9	55.1
	$\chi^2 = 8.171$		$\chi^2 = 6.119$		$\chi^2 = 7.182$	
	p-value = 0.004		p-value = 0.013		p-value = 0.007	
	Ø = 0.151		Ø = 0.130		Ø = 0.141	

Table 16 Risky sexual behavior of pregnant women before marriage and domestic violence

Risky sexual behavior before marriage	Domestic violence					
	Psychological abuse		Physical abuse		Sexual abuse	
	No	Yes	No	Yes	No	Yes
Multiple partnership						
No	33.0	67.0	55.4	44.6	59.4	40.6
Yes	19.1	80.9	41.9	58.1	44.9	55.1
	$\chi^2 = 8.171$		$\chi^2 = 6.119$		$\chi^2 = 7.182$	
	p-value = 0.004		p-value = 0.013		p-value = 0.007	
	Ø = 0.151		Ø = 0.130		Ø = 0.141	

Form to ask consent from the pregnant women to be questioned and getting permission to use the information for the study

Title : Asking for your kind cooperation and the willingness to answer the questionnaire

To : Study participants: Pregnant women

I am Miss Pintippa Sangwal, a Master Degree student in Medical and Health Social Science of the Faculty of Humanity and Social Science, Mahidol University. The objective of my study is to investigate the influence of pregnant women's behaviour, ability to determine sexual relationships and domestic violence and the risk to be infected with HIV/AIDS**.** The information derives from the study will be useful information for health personnel to plan preventive measures against HIV/AIDS infection and reduce domestic violence against women.

The information obtained from the questionnaire will be kept confidential and will be used for academic purpose only, without the participants' name and address. The participants are absolutely free to answer the questionnaire, if some questions dealing with a sensitive issue and the participants feel uncomfortable to answer it; she can omit that question. The willingness to answer the questionnaire will be very much appreciated and the information derived from the questionnaire will be used to help women preventing themselves from HIV/AIDS infection as well as domestic violence.

Thank you very much for your kind cooperation and the willingness to answer the questionnaire.

(Miss Pintippa Sangwan)
Researcher

I have read the consent form and clearly understand the information given; I am willing to answer the questionnaire.

…… (Participant)

Form No……

Questionnaire

Date of interview: Date ( ) Month ( ) Year ( )

Part 1. Demographic background and socio-economic status of pregnant women and husband/partner

Explanation: Please fill in the blank space or mark / in a space ( ) to answer each question

1.Age of pregnant woman ……year (full year)

Age of husband/partner……..year (full year)

2. Education of pregnant women and husband/partner

Pregnant women	Husband/partner
( ) 1. Illiteracy	( ) 1. Illiteracy
( ) 2. Primary school	( ) 2. Primary school
( ) 3. Secondary school	( ) 3. Secondary school
( ) 4. Vocational education	( ) 4. Vocational education
( ) 5. Diploma	( ) 5. Diploma
( ) 6. Bachelor degree	( ) 6. Bachelor degree
( ) 7. Master degree and higher	( ) 7. Master degree and higher

3. Occupation

Pregnant women	Husband/partner
( ) 1. Unemployed	( ) 1. Unemployed
( ) 2. Unskilled worker	( ) 2. Unskilled worker
( ) 3. Agricultural worker (plant crops, orchard gardening, paddy farming)	( ) 3. Agricultural worker (plant crops, orchard gardening, paddy farming)

Pregnant women	Husband/partner
( ) 4. Industrial/factory worker	( ) 4. Industrial/factory worker
( ) 5. Private office employee	( ) 5. Private office employee
( ) 6. Civil servant/state enterprise employee	( ) 6. Civil servant/state enterprise employee
( ) 7. Commercial/trading/private business	( ) 7. Commercial/trading/private business
( ) 8. Others……(specify)	( ) 8. Others……(specify)

4. Income……..Baht/month

   Income of the husband/partner…….Baht/month

5. Marital status

   ( ) 1. Not registered ( ) 2. Registered

Part 2. Alcohol consumption, drug and substance abuse and partnership outside marriage of husband/partner

Explanation: Please mark / in a ( ) according to the fact related to the respondent

1. Alcohol consumption

   ( ) 1. No, don't drink

   ( ) 2. Yes, drink (specify the frequency)

      ( ) >4 times/week

      ( ) 3-4 times/week

      ( ) <1-2 times/week

2. Drug and substance abuse

( ) 1. No,

( ) 2. Yes, (specify the type of drug and substance)

3. Sexual intercourse with the prostitute

( ) 1. No ( ) 2. Yes

4. Sexual intercourse with other women

( ) 1. No ( ) 2. Yes (answer no. 5)

5. Women whom the husband/partner have sexual intercourse with

( ) 1. Causal sex partner

( ) 2. Minor wife

( ) 3. Others……(specify)

Part 3. Risky behavior of pregnant women related to HIV infection

Explanation: Please mark / in a ( ) according to the information associated with the respondent

3.1 Alcohol consumption, drug and substance abuse

1. Do you drink alcohol?

( ) 1. No

( ) 2. Yes (specify the frequency)

( ) >4 times/week

( ) 3-4 times/week

( ) <1-2 times/week

2. Do you use drug and substance?

( ) 1. No

( ) 2. Yes (specify the type of drug and substance)

3.2 Risky sexual behavior

3. Have you ever had a partnership before getting married (can give more than one answer)

( ) 1. No (go to answer no. 5)

( ) 2. Yes……Boy friend……..persons

( ) 3. Lover/partner……persons

( ) 4. Others……..(specify)

4. Did your partner use condom?

( )1. No ( ) 2. Inconsistently use ( ) 3. Consistently use

5. Do you have a partnership outside marriage?

( ) 1. No

( ) 2. Yes

3.3 Negotiation of condom use

6. Have you ever asked husband/partner to use condom in order to prevent sexually transmitted diseases?

( ) 1. No (go to answer the question of part 4)

( ) 2. Yes

7. Did your husband/partner refuse to use condom?

( ) 1. No, he did not refuse (go to answer the question of part 4)

( ) 2. Yes, he did refuse

8. The reaction of husbands/partners after the refusal to use condoms (can give more than one answer)

( ) 1. Being told he never used condom

( ) 2. Shouting/angry

( ) 3. Act as to hurt/hit

( ) 4. Threatening to leave participant or evict participant from the home

( ) 5. Hurt/batter

( ) 6. Seize/damage the condom

( ) 7. Accusing of disloyalty

( ) 8. Laugh as it was a nonsense matter

( ) 9. Thought it was unnecessary to use condom

( ) 10. Others…….(specify)

Part 4. The factors related to power

4.1 The sexual relationship power, the questionnaire was divided into two parts

Explanation: Please mark / in the ( ) according to information concerning the respondent

1) Relationship control

Subject	Absolutely agree	Agree	Disagree	Absolute disagree
1. If I ask my partner to use a condom, he would get violent.				
2. If I ask my partner to use a condom, he would get angry.				
3. Most of the time, we do what my partner wants to do.				
4. My partner won't let me wear certain things.				
5. When my partner and I are together, I'm pretty quiet.				
6. My partner has more to say than I do about important decision that affect us.				
7. My partner tells me with whom I can spend time with.				
8. If I asked my partner to use a condom, he would think I'm having sex with other people.				
9. I feel trapped or stuck in our relationship.				
10. My partner does what he wants, even if I do not want him to.				

Subject	Absolutely agree	Agree	Disagree	Absolute disagree
11. I am more committed to our relationship than my partner is.				
12. When my partner and I disagree, he gets his way most of the time.				
13. My partner gets more out of our relationship than I do.				
14. My partner always wants to know where I am.				
15.My partner might be having sex with someone else.				

2) Decision-Making Dominance

Topic	Husband/partner	Respondent and husband/partner	Respondent
1. Who usually has more to say about friends to go out with?			
2. Who usually has more to say about whether you have sex?			
3. Who usually has more to say about what you do together?			
4. Who usually has more to say about how often you see one another?			
5. Who usually has more to argue about when you talk about serious things?			
6. In general, who do you think has more power in your relationship			

Topic	Husband/partner	Respondent and husband/partner	Respondent
7. Who usually has more to say about whether your partner use a condom?			
8. Who usually has more to say about what types of sexual acts you do?			

4.2 Decision-making within the family

Explanation: Please mark / in the space behind the question according to the person who make the decision.

Issue	Husband/partner	Respondent and husband/partner	Respondent
1. Family expenses			
2. Buying things for the family such as TV, refrigerator, washing machine, computer			
3. Buying a car			
4. Moving to a new apartment			
5. Business investment or new career			
6. Attend a wedding party, ordination ceremony			

Issue	Husband/partner	Respondent and husband/partner	Respondent
7. Who decides about what to do in case of sickness of a family member			
8. The number of children you want to have			
9. School and education planning for the children			
10. Punishment and advice given to the children			

Part 5. Domestic violence

Explanation: Please mark / in the space behind the question according to the experience of respondent related to domestic violence

Domestic violence	(a) The experience of domestic violence		(b) In the past 12 months		(c) The frequency of the domestic violence in the past 12 months				(d) The frequency of the domestic violence previous 12 months	
	Yes (go to answer (b))	No	Yes (go to answer (c))	No (go to answer (d))	1 time	2-5 times	> 5 times	1 time	2-5 times	> 5 times
Psychological abuse										
1. Being insulted or made to feel bad about oneself										
2. Being humiliated or belittled in front of others 3. Being intimidated or scared on purpose for example by a partner yelling and smashing things										

Domestic violence	(a) The experience of domestic violence			(b) In the past 12 months			(c) The frequency of the domestic violence in the past 12 months		(d) The frequency of the domestic violence previous 12 months	
	Yes (go to answer (b))	No	Yes (go to answer (c))	No (go to answer (d))	1 time	2-5 times	> 5 times	1 time	2-5 times	> 5 times
4. Being threatened with harm directly or indirectly in the form of a threat to hurt someone you cared about										
Physical abuse										
5.Being slapped or thrown something at that could hurt you										
6. Being pushed or shoved										

Domestic violence	(a) The experience of domestic violence			(b) In the past 12 months			(c) The frequency of the domestic violence in the past 12 months		(d) The frequency of the domestic violence previous 12 months	
	Yes (go to answer (b))	No	Yes (go to answer (c))	No (go to answer (d))	1 time	2-5 times	> 5 times	1 time	2-5 times	> 5 times
7. Being hit by a fist or something else that could hurt you										
8. Being kicked, dragged or beaten										
9. Being choked or burnt on purpose										
10. Being threatened with a gun, knife or other weapon										

Domestic violence	(a) The experience of domestic violence			(b) In the past 12 months			(c) The frequency of the domestic violence in the past 12 months		(d) The frequency of the domestic violence previous 12 months	
	Yes (go to answer (b))	No	Yes (go to answer (c))	No (go to answer (d))	1 time	2-5 times	> 5 times	1 time	2-5 times	> 5 times
Sexual abuse										
11. Being physically forced to have sexual intercourse										
12. Having sexual intercourse because of the fear that husband/partner might do something unpleasant										
13. Being forced to do something in your sexual relationship you found degrading or humiliating										

BIOGRAPHY

NAME	Miss Pintippa Sangwan
DATE OF BIRTH	20 May 1981
PLACE OF BIRTH	King Chulalongkorn Memorial Hospital Bangkok, Thailand
INSTITUTIONS ATTENDED	Rajabhat Institute Bansomdejchaopraya, 2000–2003 Bachelor of Science In Healthy Science (Child Health Promotion) Mahidol University, 2004–2007 Master of Arts (Medical and Health Social Sciences)
OFFICE ADDRESS	Darunsikkhalai School for Innovative Learning, King Mongkut's University of Technology Thonburi, 126 Pracha-uthit Road, Bangmod, Thungkru, Bangkok 10140 Thailand Tel. 0-2470-8315 Fax. 0-2470-8319 E-mail : pintippa.san@kmutt.ac.th
POSITION	Teacher
HOME ADDRESS	73/408 Thungmahamek, Sathorn, Bangkok 10120, Thailand