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Evidence of socio cultural factors influencing intimate partner violence among young women in Sub-Saharan Africa: A systematic scoping review.

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ABSTRACT

Objective: This study carried out a systematic scoping review of research on intimate partner violence to determine the extent to which studies on socio cultural factors influencing intimate partner violence among young women (15-24 years) have been conducted, and how different geographic areas are represented. It also considered whether the methodologies used were sufficient to describe the risk factors, prevalence, and health outcomes associated with intimate partner violence among young women.

Study design: Systematic scoping review.

Methods: Online databases were used to identify studies published between 2008−2019. The Preferred Reporting Items for Systematic Review and Meta-Analysis guidelines by Arksey and O'Malley were used to select studies, and primary studies were assessed using the Mixed Method Appraisal Tool, version 2011. Thematic content analysis was used to summarize the findings of the scoping review.

Results: The majority of publications 8 (61.5%) reported cross-sectional studies, while 4 (31.5%) were qualitative studies. One of the studies (7%) collected measured data. Overall, 13 (100%) of the publications examined factors influencing intimate partner violence.

Using a customized quality assessment instrument, 12 (92.3%) of studies achieved a "high" quality ranking with a score of 100%, and (7.7%) of studies achieved an "average"quality ranking with a score of 75%.

Conclusions. While the quality of the studies is generally high, researches on socio cultural factors influencing intimate partner violence among young women would benefit from a careful selection of methods and reference standards, including direct measures of the violence affecting young women. Prospective cohort studies are required linking early exposure with individual, socio cultural and community factors and detailing the abuse experienced from childhood, adolescence and youth.

Keywords: "intimate partner violence", "factors influencing intimate partner violence", "socio cultural factors", "dating violence", "domestic violence", "prevalence of intimate partner violence", "young women".

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Strengths and limitations of this study

We conducted an exhaustive search for relevant studies from five search engines and after that the screening of abstracts and full articles was performed using a structured tool where in the degree of agreement calculations they revealed no significant difference, therefore the mixed method tool was applied to assess the risk of bias.

Limited findings to compare risk factors specific to younger women aged 15−24, as data on socio cultural factors influencing intimate partner violence were mostly derived from studies using existing studies in women of reproductive ages.

The use of cross-sectional design in the included studies and self-administered questionnaires in accessing the experiences of intimate partner violence, runs the risk of potential bias in the studies included, in respect of the study sample selection and the recall period and, in obtaining socially desirable responses.

The scarcity of research evidence regarding the socio cultural factors influencing intimate partner violence among young women aged 15−24 in the Sub-Saharan African settings.

INTRODUCTION

Intimate partner violence (IPV) is a widespread global public health concern[1]. According to UNESCO (2015), 85% of the violence against women is perpetrated by their male intimate partners[2, 3]. The World Health Organization (WHO) estimates that globally one in three women (30%), experience violence from their partners [4]. Worldwide, statistics show that IPV is highest in the WHO South-East Asian region (37.7%), and in the WHO Eastern Mediterranean region (37%) and WHO African regions (36.6%). However, the WHO America region (29.8%), WHO European region (25.45%) and WHO Western Pacific (24.6%) are less affected[4, 5].

The Sub Saharan Africa region (SSA), carries the most substantial burden of IPV, where Ethiopia (70.9%), Tanzania (55.9%) and Namibia (35.9%) have been reported as the most affected countries with high prevalences[6]. IPV in SSA has been reported to exist among younger women (YW) where it has been estimated as ranging from 37.6% to 65.7%[7].

The World Bank classify young people as individuals aged 10−24[8]. Therefore, YW in this study refers to those women aged 15 to 24 years.

Globally, the numbers of YW are increasing. Worldwide, there are about 880 million females aged 15−24 years, 12% of the world population[8]. Mostly they are living in developing countries, including countries from SSA region[9].

YW are also the population group that is mostly affected by numerous inequalities leading them to be potentially vulnerable to violence including IPV. It is estimated that 80% of YW aged 15−24 have not completed their secondary education in many settings of SSA[9]. Moreover, the high rate of unemployment affecting these group, decreases their autonomy in making important decisions about their lives[8]. For instance, around 80% of YW in SSA countries cannot decide about their own health, which limits their access to health services and therefore, to prevent IPV[9].

The problem of IPV among YW is worrying since this group of women is still developing, and the negative impact of IPV is likely to compromise their lives and future wellbeing[10]. IPV among YW deserves immediate attention, as delay in mitigating this problem may promote recurrence and continuation of the cycle of IPV[11].

The concern is that the factors that influence IPV among YW are well documented in developed countries mainly in the United States of America (USA) settings, and this includes economic, psychological, physical and cultural factors[4], but it is less evident in SSA settings. Therefore, where the research on IPV among YW has been documented in SSA, the factors of sexual coercion,

economic constraints and low level of education have been reported to increase their risk of IPV[7]. Young People in SSA are further affected by their high risk behaviours such as sexual and violent behaviours, and dating older partners which increases their vulnerability to IPV,[12]. IPV among YW is perpetrated more by older men than their younger male counter parts[13, 14]. Authors focusing on gender based violence research argue that YW who are dating older men are unable to take control of their relationships[15, 16]. These YW are not given the opportunity to negotiate or discuss issues. An example of this is that of YW who, if they want to use protective measures such as condoms and contraceptives must get approval from their older partner, who are not always willing to use such protective measures[17]. In addition to these risk behaviours affecting this group, various other specific and contextual risk factors such as parents' and peers' influences, and the use/abuse of alcool and drugs might influence their vulnerability to partner violence[12, 18].

The harmful social norms and the acceptance of the male's dominant role in our society also perpetuates gender inequality to the detriment of females[19, 20].

Although the Mozambican Constitution entrenches gender equality,[21] these negative harmful norms are upheld by society and place YW in a subservient role and at risk of IPV[22]. However, the main challenges to the prevention of IPV among this population are the following: Firstly, little is known about the socio cultural factors that contribute toward IPV in YW; instead, research is mainly focused on household surveys aimed at measuring the prevalence of domestic violence in adult and ever-married women; Secondly, due to the community acceptance of violence and social norms of male dominance, their perceived risk of violence is often not seen; Thirdly, the policies, law enforcement, reduction and prevention strategies are more focused and known for domestic violence in ever-married or cohabiting woman.

Understanding how these factors influence IPV in YW could better inform policy makers, health sectors and other relevant entities for tailor-made interventions for prevention and reduction of IPV among YW.

This study aimed to map existing evidence on socio cultural factors influencing IPV among YW aged 15−24 years, in SSA.

METHODS

Protocol and registration

The authors undertook a systematic scoping review of the socio cultural factors influencing IPV

among YW in SSA as part of a broader study aimed at investigating the socio cultutral factors influencing IPV among YW aged 15−24 years in Maputo city, Mozambique.

The scoping review protocol was developed and registered a priori, in the International Prospective Register for Systematic Reviews (PROSPERO), under the following registration number: CRD42018116463 and is accessible via the following link: *https://www.crd.york.ac.uk/prospero/6*. Further it was published in BMC systematic reviews and is available via the following link:*https://doi.org/10.1186/s13643-019-1234-y.*

The review was guided by the scoping review framework. It conformed to the Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA) extension for scoping review guidelines in presenting the results of this scoping review (Arksey and O'Malley)[23]. Briefly, the framework involves *(*i) identifying the research question, (ii) identifying relevant studies, (iii) study selection (iv) charting the data and (v) collating, summarizing and reporting the results. Quality assessment of the included studies recommended by Levac et al. was also performed[24].

We determined the eligibility of articles to answer our research question for a scoping review study using the Population, Intervention, Comparison and, Outcome nomenclature (PICO), presented in Table1.

Table 1. Framework for determining the eligibility of research questions (PICO)

Criteria	Determinants
Population	Women aged 15−24 years
Intervention	Intimate partner violence against women
Comparison	N/A
Outcomes	Socio cultural factors; Individual factors; Morbidity; Mortality; Prevalence; Socio-economic effects; Types of IPV;
Study Setting	Sub-Saharan Africa

Sources of Information and search strategy

A primary search of research articles published in peer-reviewed journals, review articles and grey literature was conducted from the following databases: PubMed, CINAHL with Full Text, MEDLINE with full text, Health Source: Nursing/Academic Edition**,** Google scholar (advanced search), and Academic search complete. Reference lists of the obtained studies were also searched

to identify studies that could be added to the review. The search was guided by the following keywords:"intimate partner violence", "factors influencing intimate partner violence", "socio cultural factors", "dating violence", "domestic violence", "prevalence of intimate partner violence", "young women". Boolean terms (AND and OR) were used to separate the keywords and the use of MeSH (Medical Subject Headings) terms were also included during the search.The search was limited to studies from SSA, that were published in any language, for the ten year period 2008– 2019.

Study selection

Studies were considered eligible if they met all the following inclusion criteria:

- Studies reporting evidence of the prevalence of IPV in adult women including YW aged 15−24;
- Studies reporting evidence on socio cultural factors influencing IPVagainst women;
- Evidence of types of IPV;
- Evidence of the impact of IPV;
- Study design: quantitative, qualitative, mixed methods, randomized controlled trial, cohort study, case-control study and cross-sectional study.

However, studies were deemed ineligible if:

- Studies do not report on the outcomes of the study;
- Studies were published before 2008;
- Studies evidenced intervention on IPV on partners of the same-sex;
- Studies reporting evidence on factors influencing IPV only in women above 24 years.
- Studies were not done in SSA;
- Review articles.

Following the previously outlined stages of the study selection and guided by our eligibility criteria, first, we conducted a title screening, whereby one reviewer (M.S.B.), screened the titles from the databases. Eligible titles for abstract screening were then exported to the End Note Library. All the studies that did not address the research questions were excluded together with all the duplicates. The reviewer sought and obtained assistance from the UKZN library services for articles that were difficult to find. The reviewer also contacted the authors to request full copies of the included articles that were not available via the databases and the UKZN library. The final End

Note database was shared among the review team for abstract screening. At this stage, two independent reviewers screened the abstracts (M.S.B. and N.P.), guided by the eligibility criteria. Discrepancies between the reviewers' responses at this stage were resolved by discussions until an agreement was reached. At the third stage, the two reviewers independently screened the full articles (M.S.B. and N.P.). Discrepancies between the reviewers' responses at the full-article screening stage were resolved by involving a third reviewer (N.F. T). The copies of the complete articles for the eligible studies were kept for data extraction by the two reviewers (M.S.B. and N.P.). Lastly, a Kappa statistics' calculation was performed to determine the degree of agreement between reviewers at the full-article screening by using STATA 13 software (Stata-Corp, College Station, Texas, USA).

A PRISMA flow diagram of the study selection (Figure 1: literature search and selection of studies) shows the process involved in obtaining the eligible studies.

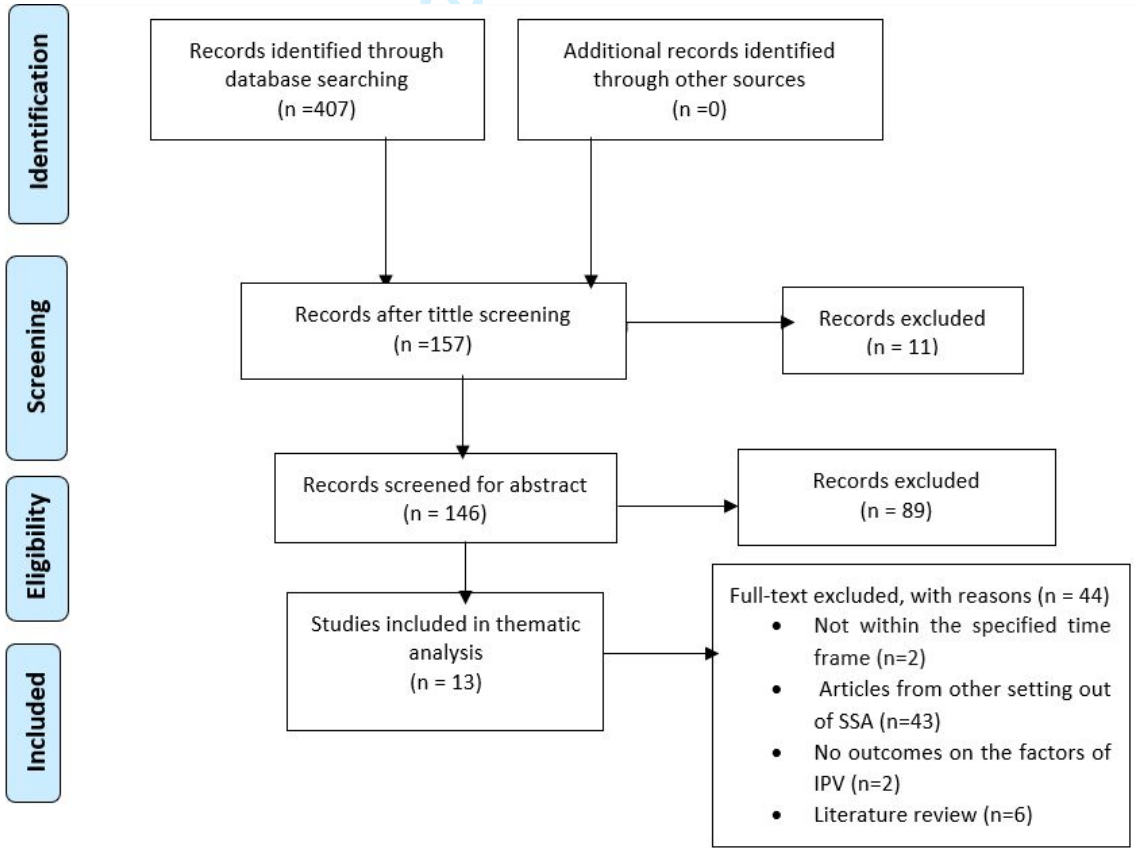

Figure1- PRISMA flow diagram of study selection.

Quality assessment

The Mixed Method Quality Appraisal Tool (MMAT), version 2011 was used to examine the quality of articles to determine the risk of bias[25]. The tool was used to investigate the relationship between the theme and the research questions. Two reviewers (M.S.B. and N.P.), assessed the quality of evidence of the included studies. The studies were evaluated in terms of the following domains: "clarity of the research questions, relevant resources to address the objectives, relevant process of data analysis, the relationship between the findings and the context and the relevance of the findings"[25]. An overall quality percentage score for each of the included studies was calculated. Scores were described as low quality (25%), fair quality (50%), average quality (75%) and good quality (100%). The quality scores in this study are reported in the results' section.

Data extraction

The information addressing the research questions was thoroughly extracted using a standardized data extraction sheet from the following domains: "author and year, study setting, population, gender, intervention, the aim of the study, study design, outcomes and key findings".

Collating and summarizing the findings

We performed a thematic analysis approach to identify evidence of the socio cultural factors influencing IPV in YW. NVivo version11 was used to extract the following relevant emergent themes: Being younger than partner, education level discrepancies between partners, being married, employment and economic status of women, alcohol use by male partner, previous history of violence in both partners, socio cultural norms, environment and legal systems.

RESULTS

Screening results

The screening results for this scoping review are presented in Figure 1 and here are explained in detail .

A total of 407 articles were retained from our initial search through the databases. Applying our exclusion criteria, a total of 250 studies were excluded as they did not meet the study's eligibility criteria, and the number of articles was reduced to 157. After the removal of duplicates, 146 articles remained for which the abstract screening was undertaken. Abstract screening resulted in 57 articles which were regarded as eligible for full-article screening. Following the full-article

screening, 44 records were excluded, and a total of 13 records were deemed eligible for data extraction and analysis. In respect of the full article screening, there was 96.49% agreement versus 64.73% expected by chance between screeners, which constitutes a satisfactory agreement (Kappa statistic = - 0. 90 and p-value <0.05). In addition, the McNemar's chi-square statistic indicates that there is no statistically significant difference in the proportions of yes/no answers by reviewers. (p-value >0.05).

The 44 excluded articles after full-article screening were excluded for the following reasons: Two studies had no outcomes of the factors influencing IPV against women [26, 27], six studies were not primary investigations but literature reviews[28-33], and two articles were published before the stipulated time frame [28, 29]. Forty-three out of the 44 full-text articles were not carried out in SSA[18, 26, 28-69].

Characteristics of included studies

Thirteen out of the 57 reviewed articles were eligible for data extraction. All the included studies were carried in SSA and published between 2008 and 2019[15, 70-81]. The studies are distributed as follows amongst SSA countries: Two in South Africa[72, 73], three in Kenya [75, 78, 80], two in Nigeria[70, 71], two in Tanzania [79, 81], one in Mali[74], one in Botswana[15], one in Rwanda[76] and one in Togo[77]. Regarding the settings of the studies, four out of the included studies were conducted in urban settings[15, 73, 78, 79], three were carried out in rural settings[70, 75, 80] and six were conducted in both rural and urban settings[71, 72, 74, 76, 77, 81]. The study settings included colleges[81], healthcare centres[70, 73, 75, 80], households[71, 72, 74, 76-79], and services support centres[15]. Data collection was done through questionnaires[70, 71, 73-75, 77-79, 81] and interviews[15, 72, 76, 80]. Regarding the study designs, 8 out of the 13 included studies were cross-sectional studies[15, 71, 74, 75, 77, 79, 81, 82], four were qualitative studies[70, 72, 76, 80] and one was a longitudinal study design[73] (Figure 2 indicates the studies' design).

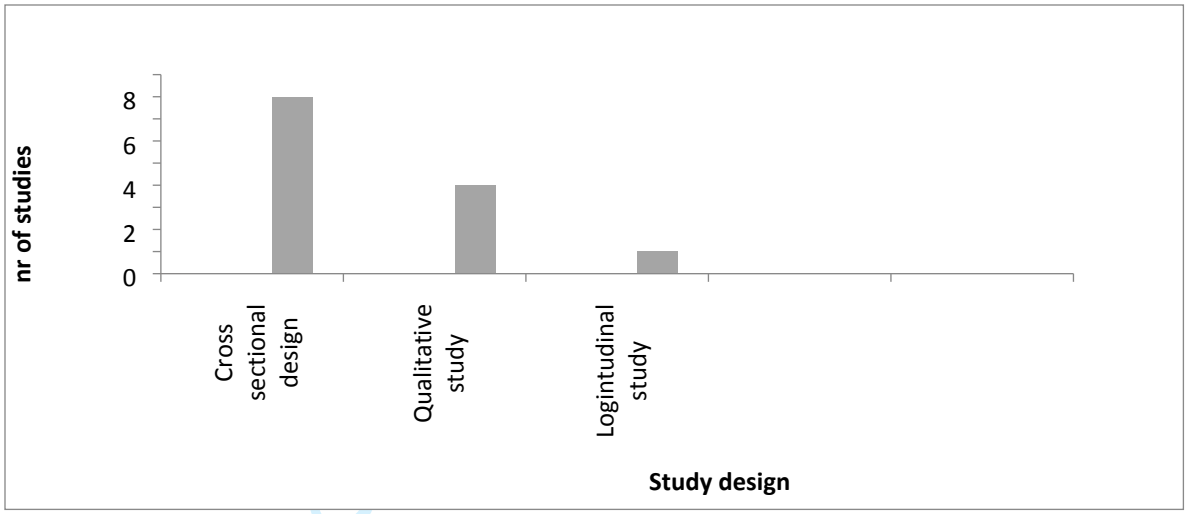

Figure 2. Distribution of the included study designs (N=13)

The total sample size was of 13,334 participants, ranging from studies with 8 to 4,906 participants, with the ages ranging from 14 to 56 years. Ten of the included studies had exclusively female participants, and in three studies, there were both females and males. The females comprised 12, 322 participants, corresponding to 92.4 % of the total sample size.

All the 13 included studies investigated IPV. Within the included studies, eight investigated the prevalence and factors predicting IPV, including the socio cultural factors[70, 71, 73-75, 78, 79, 81], four narrated the meanings and factors associated with IPV among women who have ever experienced IPV[15, 72, 76, 80] and two assessed also the health consequences of IPV among women subjected to IPV[72, 80]. All included studies assessed experiences of IPV against women including older and YW. Two studies focused only on YW with the ages between 15 and 36 years. It was demonstrated that all the participants in the studies had experienced at least one form of IPV in their lifetime. It is also important to mention that the lifetime prevalence reported in the studies that examined the prevalence of IPV in YW aged 15−24 ranged between 28.77 % to 67%[71, 74].

Risk of bias within studies

All 13 included studies underwent a methodological quality assessment using the MMAT version 2011[25]. 12 out of the 13 included studies were scored as high-quality with a score of 100% [15, 70, 71, 73-81]. The remaining study had an average score of 75% [72]. None of the included studies was scored as low quality (25%). The overall evidence was considered to have a minimal risk of bias.

Summary of the findings

Evidence on socio cultural factors influencing IPV among young women in SSA was found in 13 studies. The summaries of findings were presented under the following themes: Being younger than partner, education level discrepancies between partners, being married, employment and economic status of women, alcohol use by male partner, previous history of violence in both partners, socio cultural norms, environment and legal systems.

Being younger than partner

Five studies reported that age discrepancies between women and their partners were a factor that influences IPV. The findings of the studies suggested that being young is predictive of women experiencing IPV[1, 75, 76, 79, 83]. The age discrepancy between partners were found to be associated with IPV both in a study conducted in South Africa among pregnant and postpartum women,[73] and in a study conducted in a general population of women from rural and urban communities in Nigeria [71]. In a Tanzanian study which aimed at describing and comparing the baseline prevalence of IPV among men and women, being young was associated with being both a perpetrator and a victim of violence[79]. The age differences between partners were a reported predictor for IPV in a qualitative study from Botswana[15]. If a young woman is married to, or in a relationship with a partner older than herself, she may struggle to air her opinions about their relationship, and further the older partner may expose the younger female partner to violence.

Education level discrepancies between partners

Findings are divergent regarding the educational level and its association with IPV across countries. For example, in a study from Togo, educated and young female partners were more likely to experience IPV. The findings suggested that the women with grade seven to ten education were 1.5 fold more likely to experience IPV compared to their counterparts with no education [77]. Studies from Kenya, Tanzania and Botswana similarly suggested that a high level of education placed women at increased risk for psychological abuse[77, 81, 83]. In a study from Botswana, the unequal standard of knowledge between partners put YW at risk of violence, as the male partner might feel inferior and inflict violence to demonstrate that he is still superior even with a low level or without any education. In contrast, one study conducted in an urban region of Kenya aimed at

evaluating the association between acceptance of IPV and IPV victimization, suggested that YW with a high level of education were less likely to accept IPV[78].

The women's status of married

Our review reported that marital status influenced IPV among YW. In one study, being married and having children rather than having no children influenced the YW's decision to remain in a marriage with violence[75]. Two studies reported the status of being married as a risk factor for IPV[76, 81]. In one of these studies, being married was linked to the risk of IPV [76]. While the other study that reported agreement between the idea that it is the women's duty to sustain the duration of the relationship, found that this was significantly associated with acceptance of IPV[81]. Studies have reported that being in a formal marriage influenced YW to remain in a relationship with violence[15]. The wedding vows taken on a legal marriage are binding for them and for them marriage is forever.

Employment and economic status of women

Three studies reported the status of employment and low economic situation as a factor associated with IPV in YW; however, the type of violence varied according to employment status [15, 79, 81]. For example, in a study from Tanzania aiming at describing and compare the baseline prevalence, overlap and risk factors of psychological, physical, and sexual IPV, the study findings suggested that YW who were not employed reported more IPV[79]. While in a study from a rural area of Botswana which aimed at evaluating the association between acceptance of IPV and reported IPV victimization, the study findings suggested that employed and educated YW were more likely to report psychological rather than physical abuse[15]. However, even when YW earn more money than their male partner, the latter still controls the finances and women need to depend on him. Whereas in a study conducted in South Africa and Tanzania, reports of economic deprivation, individual level of poverty, inability to meet daily needs and living in nations with lower Gross National Income (GNIs), were predictive factors for IPV[81]. Thus, the study's findings suggest that YW who were conomically dependent or lacked sources of survival and were not owning a place to live were more likely to remain in a relationship with violence, since their partners were their main financial and subsistence source[81]. Furthermore, a study conducted in a rural setting of

Kenya, reported that poverty and dependence were factors that hindered YW from leaving or prosecuting a violent husband, who provided the food for the family[78].

Alcohol use by male partner

Three studies reported alcohol use to be associated with the risk of IPV [15, 74, 77]. Alcohol use by a male partner was related to attitudes of controlling behaviour and with increased risk of IPV in YW in a study conducted in an urban area of Nigeria [71]. Similarly, findings from a study by Hayes (2017), linked alcohol abuse by a male partner to the risk of sexual and physical violence [74]. The risk of IPV among those who have ever consumed alcohol was due to the negative impact of alcohol consumption, since alcohol abuse is deemed to reduce responsibility. Therefore men use alcohol to exert power over women. In support of this, a study conducted in an urban area of Tanzania by Mulowa (2018), revealed that among men, having ever consumed alcohol was significantly associated with the risk of perpetrating IPV[79].

Previous history of violence in both partners

Six studies reported on previous exposure by the women to violence and IPV victimization. The findings of these studies suggested that women who have ever been exposed to any type of violence or who have ever witnessed violence in their life, were more likely to report IPV in their current relationships. One study, also, revealed that having a partner who has ever been involved in previous physical fights with other men was the risk factor for IPV victimizationin YW[74]. Another study suggested that YW who have been involved in violence in past relationships were more likely to report IPV in their current relationships[76]. One study indicated that YW who have ever perpetrated violence in a previous relationship were at higher risk to commit and to experience IPV in their current relationship[77]. Three studies reported on a childhood history of violence, in that either witnessing a parent's violence or being a victim was associated with the increased risk for IPV victimization[15, 78, 79].

Socio cultural factors

Most of the studies in this review (eight out of thirteen) reported on social norms which emphasize male dominance as a risk factor for IPV. Studies linked cultural practices and social norms with increasing risk of IPV in YW[72-78, 80]. Whereas attitudes to YW as subordinate and male dominance

within relationship were reported in three studies[72, 76, 78]; attitudes of YW's acceptance and their justifying violence as a husband's right were also noted in three studies[76, 78, 80]; and attitudes of men's controlling behaviour to YW were reported in one study[74]. Acceptance of cultural practices such as polygamy was reported in one study[75]; practices of bride price or lobola; changing one's name and relocating to men's residence were reported in one study[15], and attitudes regarding religion commitment were reported in one study[77]. All these factors emerged as socio cultural factors that contributed to IPV in YW. The cultural context and the existing harmful social norms in SSA affect also YW and may help to explain the burden and recurrence of IPV in this setting[1, 19].

Environment and legal systems

Three studies reported on violence in the community and the political systems and the women's responses to IPV. For example, a study from Togo revealed an increasing risk of IPV in YW in communities where violence is not condemned [77]. In another study aiming at investigating the lived experience of women in Botswana who had experienced emotional abuse from a partner, the findings suggested that YW who were from a specific ethnic group reported more IPV. In those communities, emotional abuse was not considered abuse as it falls under the dictates of local culture[15]. While a study from Rwanda among women who have ever experienced IPV, reported on the weakness of governmental laws regarding IPV, as factors that influenced the YW's decision whether to prosecute the perpetrator or to remain in a violent relationship [76].

DISCUSSION

This study sought to map evidence of the socio cultural factors influencing IPV among YW in SSA and to identify the research gaps. The search was restricted to studies published from January 2008 to May 2019. IPV occurs globally despite the actions that have been taken to prevent it in most countries. Therefore, the findings of this study have helped to underscore better the existing evidence on the socio cultural factors influencing IPV among YW in SSA.

Bearing in mind the reported high prevalence and the emerged individual, socio cultural and community factors influencing the practices of IPV among YW in SSA, these findings pose a global health concern regarding the need for countries to achieve the Sustainable Development Goals 5[84].

Regarding this global concern, the WHO emphasizes the need for research and evidence-based information to support education programs and strategies empowering girls in skills to challenge social norms in the context of SSA where the prevalence of IPV is alarming[19]. Moreover, a recent review aimed at evaluating what works, concerning interventions to prevent violence against girls and YW in Low- and Middle-Income Countries, (which includes most of the countries in the SSA region), revealed the need for multilevel interventions to address young people[12]. Responses should be based on community engagement to enhance their social network resources, and promote women's agency and encourage role models. The review has contributed to the required evidence-based information to provide the scientific basis needed to address socio cultural factors influencing IPV against YW in SSA.

To the best of our knowledge, our study is the first systematic review of the socio cultural factors influencing IPV among YW aged 15−24 in these settings. It is noted that the prevalence of IPV as reported in this study differs from that from the studies from some high-resource regions, such as the USA where the overall reported prevalence of IPV in YW was not as high and, was estimated at 8%−51.2% [35, 61, 85]. The prevalence of IPV reported in our review was much higher ranging from 28.77% to 67%, and was similar to the one reported in a study conducted among YW aged 15−24 years in SSA and elsewhere, where the prevalence ranged between 19%−66% [7].

These results show that IPV among YW is common in many countries in the world but varies according to countries and regions. However, it is much higher in the SSA region, where governments are struggling to find the resources to provide effective preventive programs to reduce IPV among YW[1]. These differences in the prevalence of IPV, reported in our study, could be due to the differences in methods, differences in the effectiveness of the health services responses, differences in the health education strategies, as well as differences in the compliance with regulations and laws on violence against women and even the cultural differences within countries.

Our review reported childhood exposure to violence, previous experience of IPV, and witnessing parents' violence as risk factors for IPV. Findings from our review regarding these life course factors are also consistent with those reported in studies conducted in USA[18, 53, 55, 58, 68, 85]. Further in a study by Al Modalal, (2016), which examined the risk of partner physical violence victimization as a function of childhood maltreatment among college women in Jordan, the findings revealed that the risk of severe physical partner violence was three-times greater among

women who had experienced childhood physical violence and five-times greater among those who had witnessed father-to-mother violence[35]. In another study, conducted by Herrennkohe et al., (2016), in Pennsylvania, which examined data from a longitudinal study with a sample of 457 preschool-aged children who were reassessed as adults, the findings revealed that having experienced dating violence victimisation and reporting peer approval of dating violence in adolescence, were predictors of IPV victimisation in their current relationships[49]. The review confirms the theoretical model which hypothesizes about the relationship between the children's exposure to violence and the risk for IPV [6]. The likelihood of experiencing IPV among YW who have ever been exposed to violence in childhood, might be through the mechanism of their lacking in coping skills. This may lead them to engage in violent methods when resolving conflicts, rather than non-violent conflict resolution methods. Another reason may be through the influence of their parents or their parents' modelling behaviour. Children may learn violent behaviour from their parents and might then imitate or replicate the behaviour from adulthood and across their lives. We highlighted similar findings from two studies carried out in South Africa among grade 8 learners, where the factors associated with girls' experience of IPV included childhood experiences of violence such as corporal punishment at home, school or community, witnessing parents' violence and growing up in a violent community[13, 86]. These findings, therefore, highlight the importance of starting prevention efforts early in childhood, by adding in prevention strategies' programmes that may build their skills and abilities to negotiate and engage in safe relationships.

In this review, findings revealed the use of alcohol by the partner and the young age of female partner, as factors that are associated with IPV. Consistent with a study by Brown, (2009), among a clinical sample of young people aged 15−24 years, the findings revealed that physical dating violence against women was associated with poorer psycho social functioning and the substance dependence of the partner [39]. Another study by Collibe,(2018), reported on alcohol use as a factor associated with the increase in dating aggression among young people[42]. Kelly's (2009) study, which assessed the attitudes, self-efficacy and occurrence of dating violence, revealed a significant association between such violence and risk factors. These comprised the early initiation of sexual experience, drug abuse, unwillingness to engage in the initial sexual experience and inability or low self-efficacy to prevent abuse with IPV victimization[55]. Alcohol use is suggested to have an influence in reducing one's sense of responsibility and thus people engage in risky behaviours, including IPV and other forms of violence. This is in concordance with the findings from a study

among adolescents' grade 8 learners in South Africa, which reports an increased risk of IPV among those adolescents using alcohol[13, 86]. It is hypothesised that the use of alcohol among men may lead them to use negative styles to resolve conflict through their limited ability to use non-violent conflict resolution methods. Moreover, men might persuade YW to engage in alcohol drinking with an expectation that YW will then welcome sex and then use force if they do not agree to engage in sexual activity[86]. Widespread alcohol consumption and its connection with violence among young people has been in the spotlight of research in many countries in SSA[87]. It is thus crucial to tackle alcohol use and its association with violent attitudes when implementing IPV programmes among young people and thus to teach YW to recognise and to avoid engaging in such violent relationships.

Although cultural differences exist between settings, IPV is a broad phenomenon that prevails worldwide. Our review findings reported on gender inequalities, cultural practices and the community and legal systems associated with increased risk of IPV[15, 74, 77]. In support of our findings are the studies from the USA settings[39, 42, 52, 55, 66, 68]. For example, Straus (2014), in a study which analysed 13,877 university students who were in dating relationships, reported that attitudes of coercive control of women by men are associated with increased risk of IPV [66]. Similarly, the prevailing patriarchal norms of male dominance influence the relationship dynamics amongst the Maori women and also shape their decision of remaining in a violent relationship [50]. Recent studies from Bangladesh and Vietnam higligthted persistent social norms of male dominance that still prevailing in those societies[14, 16].

The findings from our review emphasize that IPV remains a burden across countries and continents, especially in SSA. It appears that cultural differences between settings, may explain the differences in rates, types and responses rather than the occurrence of IPV. For example, the study among grade 8 learners in South Africa, reported a reduced risk of emotional violence among women who disagreed with the ideologies of male dominance[13]; However, disagreeing with partners or arguing, might increase the risk of physical violence among those partners who use violence to resolve conflict or those dating partners with strong ideologies of male dominance[86]. Prevention programs would need to challenge these ideologies in a safe environment and to raise awareness about non-violent ways of resolving conflicts between young partners. Moreover, a longitudinal research is needed to determine whether protective factors work in mixed or separated gender groups. Thus, the effective interventions will need to tackle empowering girls with skills

to challenge negative social norms and, to tackle policies and law enforcement that condone all forms of violence against women from childhood across their lifespan.

The findings from this review have confirmed the contribution of factors at the individual, socio cultural and community levels that influence IPV among YW in SSA. This review has also provided additional evidence on the contextual socio cultural factors that may increase YW's vulnerability to IPV in the setting of SSA. The particular findings reported on cultural practices of polygamy, payment of lobola for marriage, involvement with older men, changing the name of the woman who relocates to the man's residence, and childhood experience of violence including attitudes to child punishment, increase the current information by providing a unique context of the socio cultural factors placing YW at increased risk of IPV in SSA. These traditional practices still prevail in most countries in SSA and contribute to IPV behaviours. In contrast, socio cultural factors are less common in developed countries outside SSA such as the USA setting where the researches on IPV among YW are often conducted, and the typical findings are related to whether the YW have witnessed or experienced IPV during childhood, their having multiple partners and the use of drugs and alcohol among young people.

Given that the contextual factors which have emerged often constrain the existing strategies aimed at reducing IPV among YW in SSA, new approaches for addressing YW in SSA should be added to the current interventions. Therefore, additional efforts are necessary to increase YW's ability to challenge harmful social and cultural norms and to build their skills to avoid their engagement with older partners and in violent relationships. There is also an urgent need for those in such relationships to enhance their ability to decide whether to remain and manage such violent relationships or to have the option to leave.

Although the research on socio cultural factors influencing IPV among YW is reportedless in the SSA setting, our review is noteworthy of several contributions. This review has firstly contributed to the body of literature by examining, comparing and, synthesizing the studies' findings on the evidence of the factors influencing IPV against YW across multiple forms of IPV in SSA countries. Secondly, our review provided quantitative and qualitative data, regarding factors influencing IPV among YW in SSA and this has been underlined by the rigorous standards, criteria and methodology used in this review process. This has helped to examine the emerged individual, socio cultural and community factors that show promise to guide the design of contextual and effective preventive interventions addressing YW in SSA. Finally, the review emphasizes the socio

cultural factors placing YW at increased vulnerability of IPV in SSA. In this setting, the majority of communities are dictated to by the social norms which give privilege to men's dominance over women, leading to gender inequalities and promoting IPV, which needs to be targeted.

This synthesis is important, given the focus of the research on YW, a group that is most affected by gender inequalities resulting in higher risk for IPV. Due to the harmful social norms that still prevail in SSA and the limited research on factors influencing IPV among YW, there is still a need to provide additional research on other socio cultural factors affecting YW such as peer pressure, parental influences, socio-economic and educational background of parents, in order to adequately contribute to effective intervention programs to reduce IPV among YW in SSA. Such programs to reduce IPV among this vulnerable population group should be initiated early, using contextual and multi-level approaches to safeguard the physical, sexual and emotional wellbeing of YW's.

Strengths and limitations

This study is a unique systematic scoping review to map evidence on socio cultural factors influencing IPV among YW in SSA and to provide evidence-based recommendations, a topic for which few review studies exist outside America.

The scoping review methodology employed herein was detailed. We conducted an exhaustive search for relevant studies from five search engines. The screening of abstracts and full articles was performed using a structured tool. Then the degree of agreement calculations after full-article screening revealed no significant difference between the screeners' responses. The MMAT was applied to assess the risk of bias. However, despite the above mentioned strengths, limitations regarding the study design of the included studies were encountered. Most studies were cross-sectional in design. There was also potential for bias in the studies included in respect of their selection of the study sample and the recall period.

Moreover, the evidence of IPV experiences was mainly assessed in most of the studies using self-administered questionnaires. This method runs the risk of potential recall bias and obtaining socially desirable responses[88]. Few studies were focused specifically on YW aged 15−24. Data on socio cultural factors influencing IPV among YW aged 15−24 were mostly derived from existing studies researching IPV in women of reproductive ages, which included YW. This may have limited the findings to compare risk factors specific to YW. Thus, this highlights the need for more primary research focused on socio cultural factors influencing IPV among YW in SSA to

contribute evidence-based prevention programs to reduce IPV among this vulnerable population group.

Conclusion

Although unevenly distributed among SSA countries, the studies revealed considerable research evidence of the factors associated with IPV in some of these settings. Many of the studies that provided evidence about IPV among YW were carried out in the USA settings, whereas few studies were from SSA. The findings point to the scarcity of research evidence regarding the socio cultural factors influencing IPV among YW in SSA. Nevertheless, IPV is a common phenomenon in SSA. It is mainly influenced by the factors interacting at the individual, socio cultural and community levels such as young age of YW, discrepancies in the education level between partners, YW's marital status, low economic/unemployment status of YW, alcohol use by YW's partner, previous history of violence including childhood violence experienced by both partners, social norms of male dominance and, environmental and legal systems. Understanding about the socio cultural risk factors for IPV among specific groups of YW in SSA will help to design contextual preventive programs that contribute to the reduction of their vulnerability and the trajectories of victimization from childhood and across the life course. Thus effective prevention programs should incorporate actions empowering YW economically and with education to enhance their awareness and autonomy, and develop their ability to challenge harmfull social norms, allowing YW to pursue their relationships' lives with integrity and free from violence.

Implications for practice

Risk factors such as young age of YW, discrepancies in the education level between partners,YW's marital status, low economic/unemployment status of YW, alcohol use by YW's partner, previous history of violence including childhood violence experienced by both partners, social norms of male dominance and, environmental and legal systems are associated with IPV among YW and therefore constitute a public health concern. We recommend that health promoters and providers at health system facilities and including at community and political levels continue monitoring and providing health assistance and political and legal support for the victims. Action is also needed to empower YW concerning their awareness about IPV in a community-based approach.

Implications for research

This scoping review shows a gap in research focusing on socio cultural factors influencing IPV among YW in SSA. The existing few studies conducted in SSA, and most of the studies undertaken in SSA setting are cross-sectional studies. The implementation of qualitative and longitudinal studies focusing on YW would be beneficial in providing more understanding of the factors underpinning the IPV and guide proper preventive interventions.

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Authors' contributions

M.S.M. conceptualized and prepared the draft proposal of the study under the supervision of M.T. and N.K. M.T. and N.K. assisted with the manuscript redaction. M.S.M. prepared the manuscript, and M.T. and N.K. reviewed it. P.N. contributed to abstract and full-article screening. N.F.T. contributed to resolving discrepancies between two reviewers during full-article screening. Respectively M.S.M.; M.T. and N.K. contributed to the reviewed draft version of the manuscript and approved the final version.

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Competing interests

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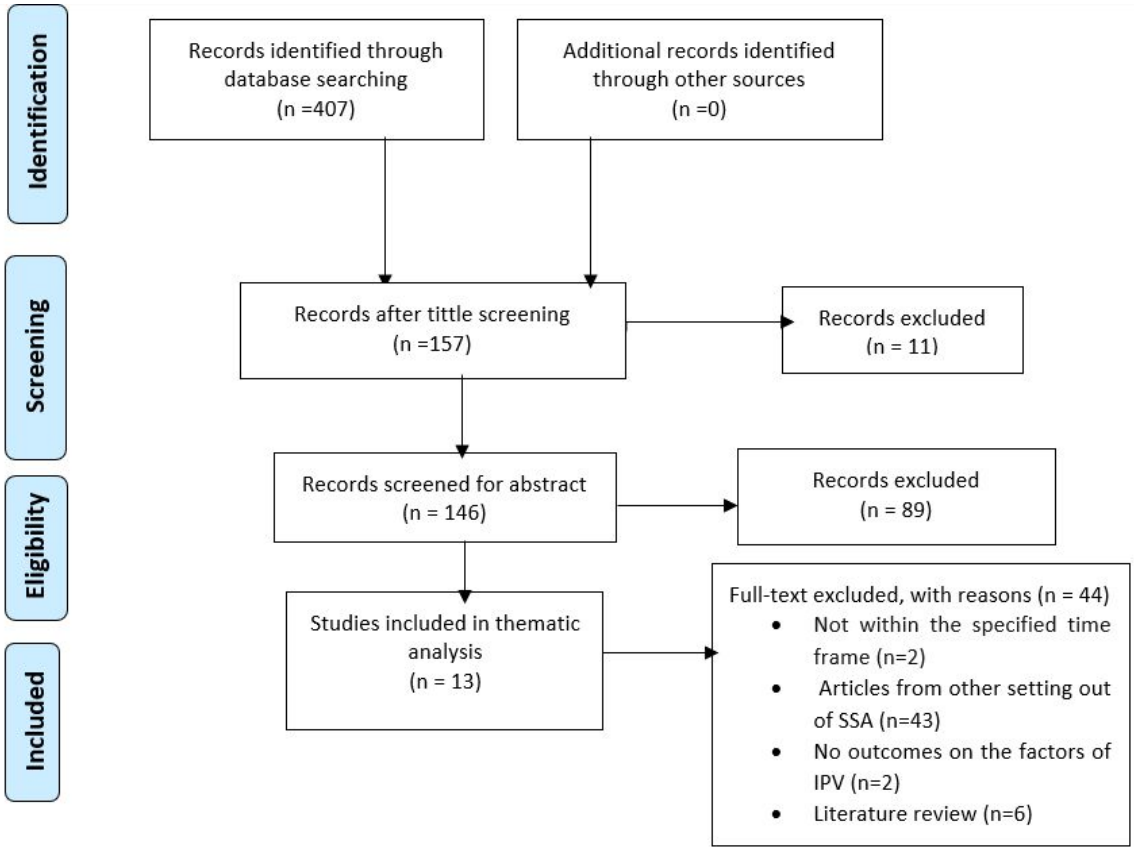
Figure 1- PRISMA flow diagram of study selection.



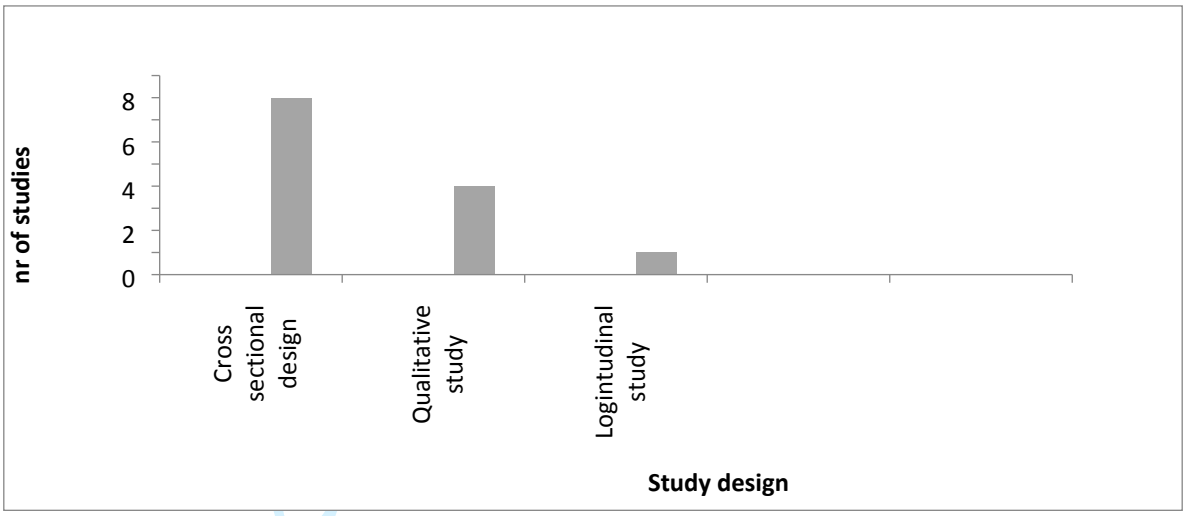


Figure.2 Study design

Full article screening results

Stata output

```
          Expected
Agreement      Kappa   Std. Err.       Z     Prob>Z
-------------------------------------------------------------
 96.49%     64.73%    0.9005    0.1318      6.83     0.0000


. mcc Reviewer1 Reviewer2

             | Controls            |
Cases        |  Exposed   Unexposed |     Total
-------------+----------------------+-----------
      Exposed |       12         2 |        14
    Unexposed |        0        43 |        43
-------------+----------------------+-----------
        Total |       12        45 |        57

McNemar's chi2(1) =      2.00    Prob > chi2 = 0.1573
Exact McNemar significance probability      = 0.5000

Proportion with factor
      Cases       .245614
      Controls    .2105263  [95% Conf. Interval]
              ---------     --------------------
      difference .0350877     -.0302236    .100399
      ratio      1.166667     .9420481   1.444842
      rel. diff.  .0444444     -.0157669   .1046558

      odds ratio     .     .1878091     .   (exact)
```

Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) Checklist

SECTION	ITEM	PRISMA-ScR CHECKLIST ITEM	REPORTED ON PAGE #
TITLE			
Title	1	Identify the report as a scoping review.	Yes- 1
ABSTRACT			
Structured summary	2	Provide a structured summary that includes (as applicable): background, objectives, eligibility criteria, sources of evidence, charting methods, results, and conclusions that relate to the review questions and objectives.	Yes- 2
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of what is already known. Explain why the review questions/objectives lend themselves to a scoping review approach.	Yes- 4
Objectives	4	Provide an explicit statement of the questions and objectives being addressed with reference to their key elements (e.g., population or participants, concepts, and context) or other relevant key elements used to conceptualize the review questions and/or objectives.	Yes-5
METHODS			
Protocol and registration	5	Indicate whether a review protocol exists; state if and where it can be accessed (e.g., a Web address); and if available, provide registration information, including the registration number.	Yes-6
Eligibility criteria	6	Specify characteristics of the sources of evidence used as eligibility criteria (e.g., years considered, language, and publication status), and provide a rationale.	Yes-8
Information sources*	7	Describe all information sources in the search (e.g., databases with dates of coverage and contact with authors to identify additional sources), as well as the date the most recent search was executed.	Yes-7
Search	8	Present the full electronic search strategy for at least 1 database, including any limits used, such that it could be repeated.	Yes-7
Selection of sources of evidence†	9	State the process for selecting sources of evidence (i.e., screening and eligibility) included in the scoping review.	Yes-7
Data charting process‡	10	Describe the methods of charting data from the included sources of evidence (e.g., calibrated forms or forms that have been tested by the team before their use, and whether data charting was done independently or in duplicate) and any processes for obtaining and confirming data from investigators.	Yes-8
Data items	11	List and define all variables for which data were sought and any assumptions and simplifications made.	Yes-8
Critical appraisal of individual sources of evidence§	12	If done, provide a rationale for conducting a critical appraisal of included sources of evidence; describe the methods used and how this information was used in any data synthesis (if appropriate).	Yes-9

SECTION	ITEM	PRISMA-ScR CHECKLIST ITEM	REPORTED ON PAGE #
Synthesis of results	13	Describe the methods of handling and summarizing the data that were charted.	Yes-9
RESULTS			
Selection of sources of evidence	14	Give numbers of sources of evidence screened, assessed for eligibility, and included in the review, with reasons for exclusions at each stage, ideally using a flow diagram.	Yes-10
Characteristics of sources of evidence	15	For each source of evidence, present characteristics for which data were charted and provide the citations.	Yes-11
Critical appraisal within sources of evidence	16	If done, present data on critical appraisal of included sources of evidence (see item 12).	Yes-12
Results of individual sources of evidence	17	For each included source of evidence, present the relevant data that were charted that relate to the review questions and objectives.	Yes-11
Synthesis of results	18	Summarize and/or present the charting results as they relate to the review questions and objectives.	Yes-12
DISCUSSION			
Summary of evidence	19	Summarize the main results (including an overview of concepts, themes, and types of evidence available), link to the review questions and objectives, and consider the relevance to key groups.	Yes-16
Limitations	20	Discuss the limitations of the scoping review process.	Yes-21
Conclusions	21	Provide a general interpretation of the results with respect to the review questions and objectives, as well as potential implications and/or next steps.	Yes-21
FUNDING			
Funding	22	Describe sources of funding for the included sources of evidence, as well as sources of funding for the scoping review. Describe the role of the funders of the scoping review.	Yes-23

JBI = Joanna Briggs Institute; PRISMA-ScR = Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews.

* Where *sources of evidence* (see second footnote) are compiled from, such as bibliographic databases, social media platforms, and Web sites.

† A more inclusive/heterogeneous term used to account for the different types of evidence or data sources (e.g., quantitative and/or qualitative research, expert opinion, and policy documents) that may be eligible in a scoping review as opposed to only studies. This is not to be confused with *information sources* (see first footnote).

‡ The frameworks by Arksey and O'Malley (6) and Levac and colleagues (7) and the JBI guidance (4, 5) refer to the process of data extraction in a scoping review as data charting.

§ The process of systematically examining research evidence to assess its validity, results, and relevance before using it to inform a decision. This term is used for items 12 and 19 instead of "risk of bias" (which is more applicable to systematic reviews of interventions) to include and acknowledge the various sources of evidence that may be used in a scoping review (e.g., quantitative and/or qualitative research, expert opinion, and policy document).

From: Tricco AC, Lillie E, Zarin W, O'Brien KK, Colquhoun H, Levac D, et al. PRISMA Extension for Scoping Reviews (PRISMAScR): Checklist and Explanation. Ann Intern Med. 2018;169:467–473. doi: 10.7326/M18-0850.

BMJ Open

Evidence of socio cultural factors influencing intimate partner violence among young women in Sub- Saharan Africa: A scoping review.

Journal:	*BMJ Open*
Manuscript ID	bmjopen-2020-040641.R1
Article Type:	Original research
Date Submitted by the Author:	15-Oct-2020
Complete List of Authors:	Maguele, Maria Suzana; Instituto Superior de Ciencias de Saude, Departamento de Investigacao; University of KwaZulu-Natal College of Health Sciences, Public Health Taylor, Myra; University of KwaZulu-Natal College of Health Sciences, Public Health Khuzwayo, Nelisiwe; University of KwaZulu-Natal, School of Nursing and Public Health
Primary Subject Heading:	Public health
Secondary Subject Heading:	Sexual health, Public health, Global health
Keywords:	SEXUAL MEDICINE, REPRODUCTIVE MEDICINE, PUBLIC HEALTH, Community child health < PAEDIATRICS, Sexual and gender disorders < PSYCHIATRY

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Evidence of socio cultural factors influencing intimate partner violence among young women in Sub-Saharan Africa: A scoping review.

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ABSTRACT

Objective: This study carried out a scoping review of research on intimate partner violence to determine the extent to which studies on socio cultural factors influencing intimate partner violence among young women (15-24 years) have been conducted, and how different geographic areas are represented. It also considered whether the methodologies used were sufficient to describe the risk factors, prevalence, and health outcomes associated with intimate partner violence among young women.

Study design: Scoping review.

Methods: Online databases were used to identify studies published between 2008−2019. The Preferred Reporting Items for Systematic Review and Meta-Analysis guidelines by Arksey and O'Malley were used to select studies, and primary studies were assessed using the Mixed Method Appraisal Tool, version 2011. Thematic content analysis was used to summarize the findings of the scoping review.

Results: The majority of publications 8 (61.5%) reported cross-sectional studies, while 4 (31.5%) were qualitative studies. One of the studies (7%) collected measured data. Overall, 13 (100%) of the publications examined factors influencing intimate partner violence. Using a customized quality assessment instrument, 12 (92.3%) of studies achieved a "high" quality ranking with a score of 100%, and (7.7%) of studies achieved an "average" quality ranking with a score of 75%.

Conclusions. While the quality of the studies is generally high, researches on socio cultural factors influencing intimate partner violence among young women would benefit from a careful selection of methods and reference standards, including direct measures of the violence affecting young women. Prospective cohort studies are required linking early exposure with individual, socio cultural and community factors and detailing the abuse experienced from childhood, adolescence and youth.

Keywords: "intimate partner violence", "factors influencing intimate partner violence", "socio cultural factors", "dating violence", "domestic violence", "prevalence of intimate partner violence", "young women".

Prospero Registration Number: CRD42018116463

Scoping protocol publication: https://doi.org/10.1186/s13643-019-1234-

Strengths and limitations of this study

- We conducted an exhaustive search for relevant studies from five search engines and after that the screening of abstracts and full articles was performed using a structured tool. The degree of agreement calculations revealed no significant difference, and the mixed method tool was applied to assess the risk of bias.
- The review limited the findings to compare risk factors specific to younger women aged 15−24, as data on socio cultural factors influencing intimate partner violence were mostly derived from studies using existing studies in women of reproductive age.
- The use of a cross-sectional design in the included studies and use of self-administered questionnaires in accessing the experiences of intimate partner violence, runs the risk of potential bias in the studies included, in respect of the study sample selection, the recall period and in obtaining socially desirable responses.
- There was a scarcity of research evidence regarding the socio cultural factors influencing intimate partner violence among young women aged 15−24 in the Sub-Saharan African settings.

INTRODUCTION

Intimate partner violence (IPV) is a widespread global public health concern.[1] According to UNESCO (2015), 85% of the violence against women is perpetrated by their male intimate partners.[2] The World Health Organization (WHO) estimates that globally one in three women (30%), experience violence from their partners.[1] The prevalence in young women aged 15-24 years is high, ranging from 29.4% to 31.6%, while the prevalence in older women above 24 years ranges from 15.1% to 37.8%.[1, 3] In the Sub-Saharan Africa (SSA) region which carries the most substantial burden of IPV, (36.6% of the global estimates), the prevalence among young women aged 15 to 24 years, ranges from 19% to 66%.[3] Although the data are scarce in Low-and Middle-Income Countries, (including SSA countries) regarding the IPV in young people, where the data are available the evidence points to increased vulnerability to IPV among the younger groups of women compared to those older. For example, a recent study conducted in Low and Middle-Income Countries including SSA found that female adolescents and younger adults of 15−19 years were at higher risk of IPV when compared to older groups of women[4]. This pattern was mostly observed in Namibia, Senegal, Zimbabwe, Cameroon, Sierra Leone, Congo, Zambia and Rwanda. However, different patterns regarding the higher risk of IPV in older rather than younger women, were found particularly in countries outside SSA such as in Europe and Central Asia.[4]

Globally, the numbers of young women are increasing. Worldwide, there are about 880 million females aged 15−24 years, who constitute 12% of the world population.[5] Mostly they are living in developing countries, including countries from the SSA region.[5]

It is young women in this age group who are the population group that is most affected by social and economic inequalities leading them to be potentially vulnerable to violence including IPV.[6] For example, the high rate of unemployment affecting this group, decreases their autonomy in making important decisions about their lives.[7] Around 80% of young women in SSA countries cannot decide about their own health, which limits their access to health services and therefore, to prevent IPV.[6]

In SSA many young women although they may be living in their parents' households and not in co-habiting relationships, initiate sexual relationships at an early age.[3, 8, 9] The harmful social norms and the acceptance of the dominant role of males in society also perpetuate

gender inequality to the detriment of females.[4, 10] Young women in SSA are further affected by high risk behaviours including risky sexual behaviour and violence, including IPV and their dating older partners increases their vulnerability to IPV.[11, 12] Authors focusing on gender-based violence research argue that young women who are dating older men are unable to take control of their relationships.[11, 13] An example of this is that of young women who, if they want to use protective measures such as condoms and contraceptives must get approval from their older partner, who are not always willing to use such protective measures.[11] In addition to these risk behaviours affecting this group, various other specific and contextual risk factors including parents' and peers' influences, and the use/abuse of alcohol and drugs might influence their vulnerability to partner violence.[3, 14]

The problem of IPV among young women is thus of concern and deserves immediate attention in order to mitigate such violence, since this group of women is still developing, and the negative impact of IPV is likely to compromise their lives and future wellbeing.[15, 16] The factors that influence IPV among young women are well documented in developed countries, particularly in the United States of America (USA) settings, and this includes economic, psychological, physical and cultural factors, but there is less evidence available from SSA settings.[17-19] The main challenges to the prevention of IPV among this population are therefore: firstly, little is known about the socio cultural factors that contribute toward IPV in young women who although still living at home, may be in violent relationships.[20, 21] Instead, research is mainly focused on household surveys aimed at measuring the prevalence of domestic violence in adult and ever-married women.[1, 4] Secondly, due to the community acceptance of violence and social norms of male dominance, the young women's risk of violence is often not addressed.[4, 10] Thirdly, the policies, law enforcement, reduction and prevention strategies are more focused on domestic violence in ever-married or cohabiting woman, with little attention to the circumstances of young women experiencing violent relationships.[22] Understanding how these factors influence IPV in young women are necessary to better inform policy makers, health sector programmers and other relevant sectors for tailor-made interventions for prevention and reduction of IPV among young women.

This study thus, aimed to map existing evidence on socio cultural factors influencing IPV among ever partnered young women aged 15−24 years, in SSA.

IPV for young women is defined in this study as an act of physical, sexual and/or psychological/emotional threats or such harm by a current or former spouse/husband, a dating partner, an ongoing sexual partner, whether or not cohabiting, against the female partner.[23]

METHODS

Patient and Public Involvement

No patient involved

Protocol and registration

The authors undertook a scoping review of the socio cultural factors influencing IPV among young women in SSA as part of a broader study aimed at investigating the socio cultural factors influencing IPV among young women aged 15−24 years in Maputo city, Mozambique.

A scoping review is a method undertaken to determine the value and scope of a full systematic review, and is useful to summarize and disseminate research findings, to identify research gaps and for determining the need and recommendations for future research. "Scoping reviews are therefore of particular use when a body of literature has not yet been comprehensively reviewed.[24]

To capture a more complete range of relationships we considered not only cohabiting young women but also ever partnered young women (young women who have ever had an intimate partner, and ever experienced partner violence). An intimate partner was defined as any male partner with whom the young woman has or ever had a romantic relationship since the age of 15, which included having sexual activities, whether spouse/husband, boyfriend/dating partner, or ongoing sexual partner/occasional partne.[23]

The scoping review protocol was developed and published in BMC systematic reviews and is available via the following link: *https://doi.org/10.1186/s13643-019-1234-y.*

The review was guided by the scoping review framework. It conformed to the Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA) extension for scoping review guidelines in presenting the results of this scoping review (Arksey and O'Malley).[25] Briefly, the framework involves *(*i) identifying the research question, (ii) identifying relevant studies, (iii) selection of studies (iv) charting the data and (v) collating,

summarizing and reporting the results. Quality assessment of the included studies as recommended by Levac et al. was also performed.[26]

We determined the eligibility of articles to answer our research question for a scoping review study using the Population, Concept, Context nomenclature (PCC), presented in Table1.

Table 1. Framework for determining the eligibility of research questions (PCC)

Criteria	Description
Population	Women aged 15−24 years
Concept	Socio cultural factors associated with IPV. (physical and/or sexual and/or emotional/psychological violence) and/or domestic violence.
Context	Sub Saharan Africa

Sources of Information and search strategy

A primary search of research articles published in peer-reviewed journals, review articles and grey literature was conducted from the following databases: PubMed, CINAHL with Full Text, MEDLINE with full text, Health Source: Nursing/Academic Edition**,** Google scholar (advanced search), and Academic search complete. Reference lists of the obtained studies were also searched to identify studies that could be added to the review. The search was guided by the following keywords: "intimate partner violence", "factors influencing intimate partner violence", "socio cultural factors", "dating violence", "domestic violence", "prevalence of intimate partner violence", "young women". Boolean terms (AND and OR) were used to separate the keywords and the use of MeSH (Medical Subject Headings) terms were also included during the search. The search was limited to studies from SSA, that were published in any language, for the ten-year period 2008– 2019.

Study selection

- Studies could include older women, but to meet inclusion criteria they needed to include some women aged 15 – 24 years. Therefore, studies were considered eligible if they met all the following inclusion criteria:

- Studies reporting evidence of the prevalence of IPV in adult women which included women aged 15-24 years;
- Studies reporting evidence on socio cultural factors influencing IPV against women;
- To be included the studies needed to have evidence of at least one type of IPV. There should be an evidence of physical, or sexual or psychological violence or co-occurrence of two or all forms of IPV.
- Study design: quantitative, qualitative, mixed methods, randomized controlled trial, cohort study, case-control study and cross-sectional study.

However, studies were deemed ineligible if:

- Studies do not report on the outcomes of the study;
- Studies were published before 2008;
- Studies examining IPV among same-sex partners;
- Studies reporting evidence on factors influencing IPV only in women above 24 years.
- Studies were not done in SSA;
- Review articles.

Following the previously outlined stages of the study selection and guided by our eligibility criteria, first, we conducted a title screening, whereby one reviewer (M.S.M.), screened the titles from the databases. Eligible titles for abstract screening were then exported to the End Note Library. All the studies that did not address the research questions were excluded together with all the duplicates. The reviewer sought and obtained assistance from the UKZN library services for articles that were difficult to find. The reviewer also contacted the authors to request full copies of the included articles that were not available via the databases and the UKZN library. The final End Note database was shared among the review team for abstract screening. At this stage, two independent reviewers screened the abstracts (M.S.M. and N.P.), guided by the eligibility criteria. Discrepancies between the reviewers' responses at this stage were resolved by discussions until an agreement was reached. At the third stage, the two reviewers independently screened the full articles (M.S.M. and N.P.). Discrepancies between the reviewers' responses at the full-article screening stage were resolved by involving a third reviewer (N.F. T). The copies of the complete articles for the eligible studies were kept for data extraction by the two reviewers (M.S.M. and N.P.). Lastly, a Kappa statistics' calculation was performed to determine the degree of agreement between reviewers at the

full-article screening by using STATA 13 software (Stata-Corp, College Station, Texas, USA).

A flow diagram of the study selection **Figure 1**: (The Preferred Reporting Items for Systematic Reviews and Meta-Analyses 2009 flow diagram to update screening, updated from Moher et al., 2009)[27] shows the process involved in obtaining the eligible studies.

Quality assessment

The Mixed Method Quality Appraisal Tool (MMAT), version 2011 was used to examine the quality of articles to determine the risk of bias.[28] The tool was used to investigate the relationship between the theme and the research questions. Two reviewers (M.S.M. and N.P.), assessed the quality of evidence of the included studies. The studies were evaluated in terms of the following domains: "clarity of the research questions, relevant resources to address the objectives, relevant process of data analysis, the relationship between the findings and the context and the relevance of the findings".[28] An overall quality percentage score for each of the included studies was calculated. Scores were described as low quality (25%), fair quality (50%), average quality (75%) and good quality (100%). The quality scores in this study are reported in the results' section.

Data extraction

The information addressing the research questions was thoroughly extracted using a standardized data extraction sheet from the following domains: "author and year, study setting, population, gender, intervention, the aim of the study, study design, outcomes and key findings".

Collating and summarizing the findings

In this study, thematic analysis was found suitable for the purpose of identifying socio cultural factors influencing IPV among young women from the included studies.[29] NVivo version11 was used to extract the following relevant emergent themes: Being younger than partner, education level discrepancies between partners, being married, employment and economic status of women, alcohol use by male partner, previous history of violence in both partners, socio cultural norms, environment and legal systems.

RESULTS

Screening results

The screening results for this scoping review are presented in Figure 1. A total of 13 records were deemed eligible for data extraction and analysis. Degree of agreement was calculated after full-text screening. In respect of the full article screening, there was 96.49% agreement versus 64.73% expected by chance between screeners, which constitutes a satisfactory agreement (Kappa statistic = - 0. 90 and p-value <0.05). In addition, the McNemar's chi-square statistic indicates that there is no statistically significant difference in the proportions of yes/no answers by reviewers (p-value >0.05).

Characteristics of included studies

Thirteen out of the 57 reviewed articles were eligible for data extraction. The total sample size was of 13,334 participants, ranging from studies with 8 to 4,906 participants, with the ages ranging from 14 to 56 years. Ten of the included studies had exclusively female participants, and in three studies, there were both females and males. The females comprised 12, 322 participants, corresponding to 92.4 % of the total sample size. The characteristics of the included studies are presented in table 2 bellow:

Table 2. Summary characteristics of included articles (n=13)

Table 2 Summary characteristics of included articles (n=13)	
	Number (% of total studies)
Publication year	
2008-2011	4 (30.8)
2012-2015	6 (46.2)
2016-2019	3 (23)
Location	
South Africa	2 (15.4)
Kenya	3 (23)
Nigeria	2 (15.4)
Tanzania	2 (15.4)
Mali	1 (7.7)
Botswana	1 (7.7)
Rwanda	1 (7.7)
Togo	1 (7.7)
Setting: Urban versus rural	
Urban settings	4 (30.8)

Rural settings	3 (23)
Both urban and rural settings	6 (46.2)
Setting-Sector	
Colleges	1 (7.7)
Healthcare centre	4 (30.8)
Households	7 (53.8)
Services support centre	1 (7.7)
Design	
Cross-sectional studies	8 (61.5)
Qualitative studies	4 (30.8)
Longitudinal	1 (7.7)
Collection of data (methods)	
Questionnaires	9 (69.3)
Interviews	3 (23)
Focus group discussion	1 (7.7)
Topics investigated	
Prevalence and factors predicting IPV	7 (53.8)
Meanings and factors influencing IPV	4 (30.8)
Health consequences of IPV	2 (15.4)

Risk of bias within studies

All 13 included studies underwent a methodological quality assessment using the MMAT version 2011.[28] 12 out of the 13 included studies were scored as high-quality with a score of 100%.[13, 17, 19, 30-38] The remaining study had an average score of 75%.[39] None of the included studies was scored as low quality (25%). The overall evidence was considered to have a minimal risk of bias

Summary of the findings

Evidence on socio cultural factors influencing IPV among young women in SSA was found in 13 studies and are presented under the following themes: Being younger than partner, education level discrepancies between partners, being married, employment and economic status of women, alcohol use by male partner, previous history of violence in both partners, socio cultural norms, environment and legal systems.

Being younger than partner

Four studies reported that age discrepancies between women and their partners were a factor that influences IPV. The age discrepancy between partners were found to be associated with IPV both in a study conducted in South Africa among pregnant and postpartum women[32] and

in a study conducted in a general population of women from rural and urban communities in Nigeria.[30] In a Tanzanian study which aimed at describing and comparing the baseline prevalence of IPV among men and women, being young was associated with being both a perpetrator and a victim of violence.[37] The age differences between partners were a reported predictor for IPV in a qualitative study from Botswana.[13] If a young woman is married to, or in a relationship with a partner older than herself, she may struggle to air her opinions about their relationship, and further the older partner may expose the younger female partner to violence.

Education level discrepancies between partners

Findings are divergent regarding the educational level and its association with IPV across countries. For example, in a study from Togo, educated and young female partners were more likely to experience IPV. The findings suggested that the women with grade seven to ten education were 1.5 fold more likely to experience IPV compared to their counterparts with no education.[35] Studies from Kenya, Tanzania and Botswana similarly suggested that a high level of education placed women at increased risk for psychological abuse.[17, 36] In a study from Botswana, the unequal standard of knowledge between partners put young women at risk of violence, as the male partner might feel inferior and inflict violence to demonstrate that he is still superior even with a low level or without any education. In contrast, one study conducted in an urban region of Kenya aimed at evaluating the association between acceptance of IPV and IPV victimization, suggested that young women with a high level of education were less likely to accept IPV.

The women's married status

Four studies reported marital status as a risk factor for IPV among young women. In one study, being married and having children rather than having no children influenced the young women's decision to remain in a marriage with violence.[34] In one of these studies, being married was linked to the risk of IPV.[19] While the other study that reported agreement between the idea that it is the women's duty to sustain the duration of the relationship, found that this was significantly associated with acceptance of IPV.[17] One study has reported that being in a formal marriage influenced young women to remain in a relationship with

violence. The wedding vows taken on a legal marriage are binding for them and for them marriage is forever.[13]

Employment and economic status of women

Three studies reported the status of employment and low economic situation as a factor associated with IPV in young women; however, the type of violence varied according to employment status.[13, 17, 37] In a study from Tanzania aiming at describing and compare the baseline prevalence, overlap and risk factors of psychological, physical, and sexual IPV, the study findings suggested that young women who were not employed reported more IPV.[37] While in a study from a rural area of Botswana which aimed at evaluating the association between acceptance of IPV and reported IPV victimization, the study findings suggested that employed and educated young women were more likely to report psychological rather than physical abuse.[13] Whereas in a study conducted in South Africa and Tanzania, reports of economic deprivation, individual level of poverty, inability to meet daily needs and living in nations with lower Gross National Income (GNIs), were predictive factors for IPV. Thus, the study's findings suggest that young women who were economically dependent or lacked sources of survival and were not owning a place to live were more likely to remain in a relationship with violence, since their partners were their main financial and subsistence source.[17] A study conducted in a rural setting of Kenya, reported that poverty and dependence were factors that hindered young women from leaving or prosecuting a violent husband, who provided the food for the family.[36] There is limited research aimed at investigating economic status of young women as a risk factor for IPV in SSA setting.

Alcohol use by male partner

Three studies reported alcohol use to be associated with the risk of IPV. Alcohol use by a male partner was related to attitudes of controlling behaviour and with increased risk of IPV in young women in a study conducted in an urban area of Nigeria.[30] Similarly, findings from study by Hayes (2017), linked alcohol abuse by a male partner to the risk of sexual and physical violence.[33] The risk of IPV among those who have ever consumed alcohol was due to the negative impact of alcohol consumption, since alcohol abuse is deemed to reduce responsibility. Therefore, men use alcohol to exert power over women. In support of this, a

study conducted in an urban area of Tanzania by Mulawa (2018), revealed that among men, having ever consumed alcohol was significantly associated with the risk of perpetrating IPV.[37]

Previous history of violence in both partners

Six studies reported on previous exposure by the women to violence and IPV victimization. The findings of these studies suggested that women who have ever been exposed to any type of violence or who have ever witnessed violence in their life, were more likely to report IPV in their current relationships. One study, also, revealed that having a partner who has ever been involved in previous physical fights with other men was the risk factor for IPV victimization in young women.[33] Another study suggested that young women who have been involved in violence in past relationships were more likely to report IPV in their current relationships.[19] One study indicated that young women who have ever perpetrated violence in a previous relationship were at higher risk to commit and to experience IPV in their current relationship.[35] Three studies reported on a childhood history of violence, in that either witnessing a parent's violence or being a victim was associated with the increased risk for IPV victimization.[13, 36, 37]

Social norms

Most of the studies in this review (eight out of thirteen) reported on social norms which emphasize male dominance as a risk factor for IPV. Studies linked cultural practices and social norms with increasing risk of IPV in young women.[19, 32-36, 38, 39] Whereas attitudes to young women as subordinate and male dominance within relationship were reported in three studies.[19, 36, 39] attitudes of young women's acceptance and their justifying violence as a husband's right were also noted in three studies.[19, 36, 38] and attitudes of men's controlling behaviour to young women were reported in one study.[33] Acceptance of cultural practices such as polygamy was reported in one study.[34] practices of bride price or lobola; changing one's name and relocating to men's residence were reported in one study[13] and attitudes regarding religion commitment were reported in one study.[35] The cultural context and the existing harmful social norms in SSA affect also young women and may help to explain the

burden and recurrence of IPV in this setting. There is limited research aimed at investigating social norms as a risk factor for IPV among young women in SSA.

Environment and legal systems

Three studies reported on violence in the community and the political systems and the women's responses to IPV. For example, a study from Togo revealed an increasing risk of IPV in young women in communities where violence is not condemned.[35] In another study aiming at investigating the lived experience of women in Botswana who had experienced emotional abuse from a partner, the findings suggested that young women who were from a specific ethnic group reported more IPV. In those communities, emotional abuse was not considered abuse as it falls under the dictates of local culture.[13] While studies from Tanzania and Rwanda among women who have ever experienced IPV, reported on the weakness of governmental laws regarding IPV, as factors that influenced the young women's decision whether to prosecute the perpetrator or to remain in a violent relationship.[19, 37]

DISCUSSION

Main findings

This study sought to map evidence of the socio cultural factors influencing IPV among young women in SSA and to identify the research gaps. The search was restricted to studies published from January 2008 to May 2019. We included in our review all papers accessing physical, sexual or psychological violence, perpetrated by an intimate male partner against the female partner. The studies could include older women as well but to meet the inclusion criteria they needed to also include and provide data on women aged 15 – 24. Knowing that studies concerning women experiencing partner violence often use different methods and definitions to address IPV, we included in the definition of IPV the designations for women aged 15−24 years attributed by others, such as domestic violence/husband abuse/partner abuse or dating violence. Thus, the included studies used different methods, definitions, different timing/ frequency and measures of IPV. For example, some studies considered women at risk of IPV to include only ever married/cohabiting women[13, 33, 37, 38], other studies considered currently partnered women[19, 32, 39] and ever partnered women.[17, 30, 31, 35, 37]

Therefore, this discussion applied not only to cohabiting women but includes ever partnered woman who has ever had an intimate partner, and ever experienced partner violence.

IPV occurs globally despite the actions that have been taken to prevent it in most countries. Therefore, the findings of this study have helped to underscore better the existing evidence on the socio cultural factors influencing IPV among young women in SSA. Bearing in mind the reported high prevalence and the, socio cultural factors influencing the practices of IPV among young women in SSA that emerged from this review, these findings pose a global health concern regarding the need for countries to achieve the Sustainable Development Goals 5.[40] Regarding this global concern, the WHO emphasizes the need for research and evidence-based information to support education programs and strategies empowering girls in skills to challenge social norms in the context of SSA where the prevalence of IPV is alarming.[41, 42] Moreover, a recent review aimed at evaluating what works, concerning interventions to prevent violence against girls and young women in Low and Middle-Income Countries, (which includes most of the countries in the SSA region), revealed the need for multilevel interventions to address young women.[20] Responses should be based on community engagement to enhance their social network resources and promote women's agency and encourage role models. The review has contributed to the required evidence-based information to provide the scientific basis needed to address socio cultural factors influencing IPV against young women in SSA. To the best of our knowledge, our study is the first scoping review of the socio cultural factors influencing IPV among young women aged 15−24 in these settings.

It is noted that the prevalence of IPV as reported in this study differs from that from the studies from some high-resource regions, such as the USA where the overall reported prevalence of IPV in young women was not as high and, was estimated at 8%−51.2%.[43-45] The prevalence of IPV reported in our review was much higher ranging from 28.77% to 67%, and was similar to the one reported in a study conducted among young women aged 15−24 years in SSA and elsewhere, where the prevalence ranged between 19%−66%.[3] These results show that IPV among young women is common in many countries in the world but varies according to countries and regions. However, it is much higher in the SSA region, where governments are struggling to find the resources to provide effective preventive programs to reduce IPV among young women.[18] These differences in the prevalence of IPV, reported in

our study, could be due to the differences in methods, differences in the effectiveness of the health services responses, differences in the health education strategies, as well as differences in the compliance with regulations and laws on violence against women and even the cultural differences within countries.

Our review reported that childhood exposure to violence, previous experience of IPV, either witnessing parents' violence or experiencing childhood violence, are risk factors for IPV. Findings from our review regarding these life course factors are also consistent with those reported in studies conducted in USA.[43, 46] Further in a study by Al Modalal, (2016), which examined the risk of partner physical violence victimization as a function of childhood maltreatment among college women in Jordan, the findings revealed that the risk of severe physical partner violence was three-times greater among women who had experienced childhood physical violence and five-times greater among those who had witnessed father-to-mother violence.[45] The review confirms the theoretical model which hypothesizes about the relationship between the children's exposure to violence and the risk for IPV. The likelihood of experiencing IPV among women who have ever been exposed to violence in childhood, might be through the mechanism of their lacking in coping skills. This may lead them to engage in violent methods when resolving conflicts, rather than non-violent conflict resolution methods. Another reason may be through the influence of their parents or their parents' modelling behaviour. Children may learn violent behaviour from their parents and might then imitate or replicate the behaviour from adulthood and across their lives. We highlighted similar findings from two studies carried out in South Africa among grade 8 learners, where the factors associated with girls' experience of IPV included childhood experiences of violence such as corporal punishment at home, school or community and witnessing parents' violence.[9, 47] These findings, therefore, highlight the importance of starting prevention efforts early in childhood, by adding in prevention strategies' programmes that may build their skills and abilities to negotiate and engage in safe relationships.

In this review, findings revealed the use of alcohol by the partner and the young age of female partner, as factors that are associated with IPV. Consistent with a study by Brown, (2009), among a clinical sample of young people aged 15−24 years, the findings revealed that physical dating violence against women was associated with poorer psycho social

functioning and the substance dependence of the partner.[48] Another study by Collibe,(2018), reported on alcohol use as a factor associated with the increase in dating aggression among young people.[49] Kelly's (2009) study, which assessed the attitudes, self-efficacy and occurrence of dating violence, revealed a significant association between such violence and risk factors. These comprised the early initiation of sexual experience, drug abuse, unwillingness to engage in the initial sexual experience and inability or low self-efficacy to prevent abuse with IPV victimization.[50] Alcohol use is suggested to have an influence in reducing one's sense of responsibility and thus people engage in risky behaviours, including IPV and other forms of violence. This is in concordance with the findings from a study among adolescents' grade 8 learners in South Africa, which reports an increased risk of IPV among those adolescents using alcohol.[9, 51] It is hypothesised that the use of alcohol among men may lead them to use negative styles to resolve conflict through their limited ability to use non-violent conflict resolution methods. Moreover, men might persuade young women to engage in alcohol drinking with an expectation that young women will then welcome sex and then use force if they do not agree to engage in sexual activity.[47] Widespread alcohol consumption and its connection with violence among young people has been in the spotlight of research in SSA and USA settings. It is thus crucial to tackle alcohol use and its association with violent attitudes when implementing IPV programmes among young people and thus to teach young women to recognise and to avoid engaging in such violent relationships.

Although cultural differences exist between settings, IPV is a broad phenomenon that prevails worldwide. Our review findings reported on gender inequalities, cultural practices and the community and legal systems associated with increased risk of IPV.[13, 33, 36] In support of our findings are the studies from the USA settings[46, 50, 52]. For example, Straus (2014), in a study which analysed 13,877 university students who were in dating relationships, reported that attitudes of coercive control of women by men are associated with increased risk of IPV.[52] Similarly, the prevailing patriarchal norms of male dominance influence the relationship dynamics amongst the Maori women and also shape their decision of remaining in a violent relationship.[53] Recent studies from Bangladesh and Vietnam highlighted persistent social norms of male dominance that still prevailing in those societies.[54, 55]

The findings from our review emphasize that IPV remains a burden across countries and continents, especially in SSA. It appears that cultural differences between settings, may

explain the differences in rates, types and responses rather than the occurrence of IPV. For example, the study among grade 8 learners in South Africa, reported a reduced risk of emotional violence among women who disagreed with the ideologies of male dominance.[47] However, disagreeing with partners or arguing, might increase the risk of physical violence among those partners who use violence to resolve conflict or those dating partners with strong ideologies of male dominance.[9] Prevention programs would need to challenge these ideologies in a safe environment and to raise awareness about non-violent ways of resolving conflicts between young partners. Moreover, a longitudinal research is needed to determine whether protective factors work in mixed or separated gender groups. Thus, the effective interventions will need to tackle empowering girls with skills to challenge negative social norms and, to tackle policies and law enforcement that condone all forms of violence against women from childhood across their lifespan.

The findings from this review have confirmed the contribution of factors at the individual, socio cultural and community levels that influence IPV among young women in SSA. This review has also provided additional evidence on the contextual socio cultural factors that may increase young women's vulnerability to IPV in the setting of SSA. The particular findings reported on cultural practices of polygamy, payment of lobola for marriage, involvement with older men, changing the name of the woman who relocates to the man's residence, and childhood experience of violence including attitudes to child punishment, increase the current information by providing a unique context of the socio cultural factors placing young women at increased risk of IPV in SSA. These traditional practices still prevail in most countries in SSA and contribute to IPV behaviours. In contrast, socio cultural factors are less common in developed countries outside SSA such as the USA setting where the researches on IPV among young women are often conducted, and the typical findings are related to whether the young women have witnessed or experienced IPV during childhood, their having multiple partners and the use of drugs and alcohol among young people.

Given that the contextual factors which have emerged often constrain the existing strategies aimed at reducing IPV among young women in SSA, new approaches for addressing young women in SSA should be added to the current interventions. Therefore, additional efforts are necessary to increase young women's ability to challenge harmful social and cultural norms and to build their skills to avoid their engagement with older partners and in violent

relationships. There is also an urgent need for those in such relationships to enhance their ability to decide whether to remain and manage such violent relationships or to have the option to leave.

Although the research on socio cultural factors influencing IPV among young women is reportedless in the SSA setting, our review is noteworthy of several contributions. This review has firstly contributed to the body of literature by examining, comparing and, synthesizing the studies' findings on the evidence of the factors influencing IPV against young women across multiple forms of IPV in SSA countries. Secondly, our review provided quantitative and qualitative data, regarding factors influencing IPV among young women in SSA and this has been underlined by the rigorous standards, criteria and methodology used in this review process. This has helped to examine the emerged individual, socio cultural and community factors that show promise to guide the design of contextual and effective preventive interventions addressing young women in SSA. Finally, the review emphasizes the socio cultural factors placing young women at increased vulnerability of IPV in SSA. In this setting, the majority of communities are dictated to by the social norms which give privilege to men's dominance over women, leading to gender inequalities and promoting IPV, which needs to be targeted. This synthesis is important, given the focus of the research on young women, a group that is most affected by gender inequalities resulting in higher risk for IPV. Due to the harmful social norms that still prevail in SSA and the limited research on factors influencing IPV among young women, there is still a need to provide additional research on other socio cultural factors affecting young women such as peer pressure, parental influences, socio-economic and educational background of parents, in order to adequately contribute to effective intervention programs to reduce IPV among young women in SSA. Such programs to reduce IPV among this vulnerable population group should be initiated early, using contextual and multi-level approaches to safeguard the physical, sexual and emotional wellbeing of young women.

Strengths and limitations

This study is a unique scoping review to map evidence on socio cultural factors influencing IPV among young women in SSA and to provide evidence-based recommendations, a topic for which few review studies exist outside America.

The scoping review methodology employed herein was detailed. We conducted an exhaustive search for relevant studies from five search engines. The screening of abstracts and full articles was performed using a structured tool. Then the degree of agreement calculations after full-article screening revealed no significant difference between the screeners' responses. The MMAT was applied to assess the risk of bias. However, despite the above-mentioned strengths, limitations regarding the study design of the included studies were encountered. Most studies were cross-sectional in design. There was also potential for bias in the studies included in respect of their selection of the study sample and the recall period. Moreover, the evidence of IPV experiences was mainly assessed in most of the studies using self-administered questionnaires. This method runs the risk of potential recall bias and obtaining socially desirable responses.[56] Few studies were focused specifically on young women aged 15−24. Data on socio cultural factors influencing IPV among young women aged 15−24 were mostly derived from existing studies researching IPV in women of reproductive ages, which included young women. This may have limited the findings to compare risk factors specific to young women. Thus, this highlights the need for more primary research focused on socio cultural factors influencing IPV among young women in SSA to contribute evidence-based prevention programs to reduce IPV among this vulnerable population group.

Conclusion

Although unevenly distributed among SSA countries, the studies revealed considerable research evidence of the factors associated with IPV in some of these settings. Many of the studies that provided evidence about IPV among young women were carried out in the USA settings, whereas few studies were from SSA. The findings point to the scarcity of research evidence regarding the socio cultural factors influencing IPV among young women in SSA. Nevertheless, IPV is a common phenomenon in SSA. It is mainly influenced by the factors interacting at the individual, community and societal levels such as young age of women, discrepancies in the education level between partners, young women's marital status, low economic/unemployment status of women, alcohol use by women's partner, previous history of violence including childhood violence experienced by both partners, social norms of male dominance and, environmental and legal systems. Understanding about the socio cultural risk factors for IPV among specific groups of young women in SSA will help to design contextual

preventive programs that contribute to the reduction of their vulnerability and the trajectories of victimization from childhood and across the life course. Thus, effective prevention programs should incorporate actions empowering young women economically and with education to enhance their awareness and autonomy, and develop their ability to challenge harmful social norms, allowing young women to pursue their relationships' lives with integrity and free from violence.

Implications for practice

Risk factors such as young age of young women, discrepancies in the education level between partners, young women's marital status, low economic/unemployment status of young women, alcohol use by young women's partner, previous history of violence including childhood violence experienced by both partners, social norms of male dominance and, environmental and legal systems are associated with IPV among young women and therefore constitute a public health concern. We recommend that health promoters and providers at health system facilities and including at community and political levels continue monitoring and providing health assistance and political and legal support for the victims. Action is also needed to empower young women concerning their awareness about IPV in a community-based approach.

Implications for research

This scoping review shows a gap in research focusing on socio cultural factors influencing IPV among young women in SSA. The existing few studies conducted in SSA, and most of the studies undertaken in SSA setting are cross-sectional studies. The implementation of qualitative and longitudinal studies focusing on young women would be beneficial in providing more understanding of the factors underpinning the IPV and guide proper preventive interventions.

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Authors' contributions

M.S.M. conceptualized and prepared the draft proposal of the study under the supervision of M.T. and N.K. M.T. and N.K. assisted with the manuscript redaction. M.S.M. prepared the manuscript, and M.T. and N.K. reviewed it. Respectively M.S.M.; M.T. and N.K. contributed to the reviewed draft version of the manuscript and approved the final version.

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Competing interests

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Supporting information/ Figure legends

Figure 1. The Preferred Reporting Items for Systematic Reviews and Meta-Analyses 2009 flow diagram to update screening. Source: (Moher et al., 2009).

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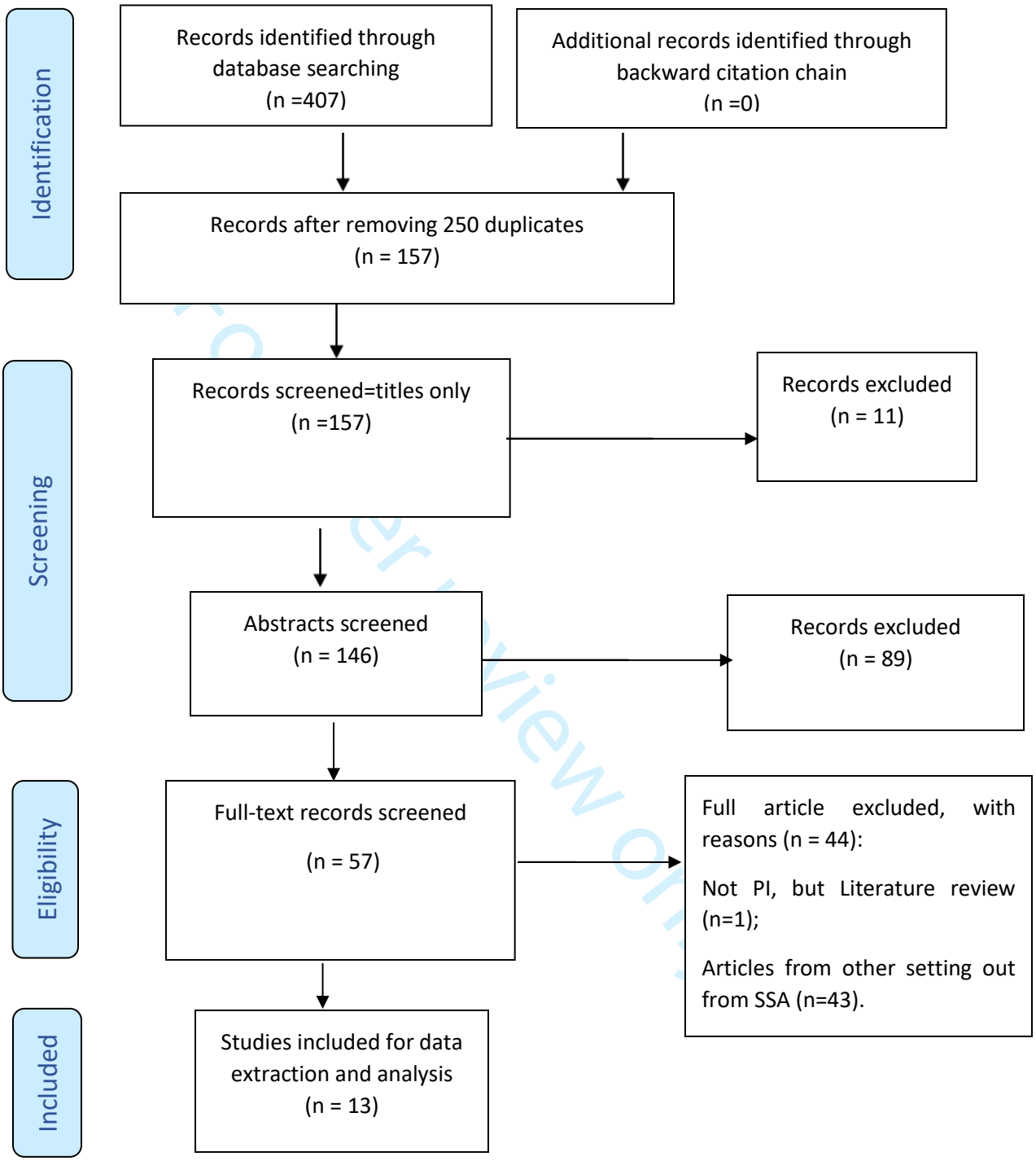

Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) Checklist

SECTION	ITEM	PRISMA-ScR CHECKLIST ITEM	REPORTED ON PAGE #
TITLE			
Title	1	Identify the report as a scoping review.	Yes- 1
ABSTRACT			
Structured summary	2	Provide a structured summary that includes (as applicable): background, objectives, eligibility criteria, sources of evidence, charting methods, results, and conclusions that relate to the review questions and objectives.	Yes- 2
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of what is already known. Explain why the review questions/objectives lend themselves to a scoping review approach.	Yes- 4
Objectives	4	Provide an explicit statement of the questions and objectives being addressed with reference to their key elements (e.g., population or participants, concepts, and context) or other relevant key elements used to conceptualize the review questions and/or objectives.	Yes-5
METHODS			
Protocol and registration	5	Indicate whether a review protocol exists; state if and where it can be accessed (e.g., a Web address); and if available, provide registration information, including the registration number.	Yes-6
Eligibility criteria	6	Specify characteristics of the sources of evidence used as eligibility criteria (e.g., years considered, language, and publication status), and provide a rationale.	Yes-8
Information sources*	7	Describe all information sources in the search (e.g., databases with dates of coverage and contact with authors to identify additional sources), as well as the date the most recent search was executed.	Yes-7
Search	8	Present the full electronic search strategy for at least 1 database, including any limits used, such that it could be repeated.	Yes-7
Selection of sources of evidence†	9	State the process for selecting sources of evidence (i.e., screening and eligibility) included in the scoping review.	Yes-7
Data charting process‡	10	Describe the methods of charting data from the included sources of evidence (e.g., calibrated forms or forms that have been tested by the team before their use, and whether data charting was done independently or in duplicate) and any processes for obtaining and confirming data from investigators.	Yes-8
Data items	11	List and define all variables for which data were sought and any assumptions and simplifications made.	Yes-8
Critical appraisal of individual sources of evidence§	12	If done, provide a rationale for conducting a critical appraisal of included sources of evidence; describe the methods used and how this information was used in any data synthesis (if appropriate).	Yes-9

SECTION	ITEM	PRISMA-ScR CHECKLIST ITEM	REPORTED ON PAGE #
Synthesis of results	13	Describe the methods of handling and summarizing the data that were charted.	Yes-9
RESULTS			
Selection of sources of evidence	14	Give numbers of sources of evidence screened, assessed for eligibility, and included in the review, with reasons for exclusions at each stage, ideally using a flow diagram.	Yes-10
Characteristics of sources of evidence	15	For each source of evidence, present characteristics for which data were charted and provide the citations.	Yes-11
Critical appraisal within sources of evidence	16	If done, present data on critical appraisal of included sources of evidence (see item 12).	Yes-12
Results of individual sources of evidence	17	For each included source of evidence, present the relevant data that were charted that relate to the review questions and objectives.	Yes-11
Synthesis of results	18	Summarize and/or present the charting results as they relate to the review questions and objectives.	Yes-12
DISCUSSION			
Summary of evidence	19	Summarize the main results (including an overview of concepts, themes, and types of evidence available), link to the review questions and objectives, and consider the relevance to key groups.	Yes-16
Limitations	20	Discuss the limitations of the scoping review process.	Yes-21
Conclusions	21	Provide a general interpretation of the results with respect to the review questions and objectives, as well as potential implications and/or next steps.	Yes-21
FUNDING			
Funding	22	Describe sources of funding for the included sources of evidence, as well as sources of funding for the scoping review. Describe the role of the funders of the scoping review.	Yes-23

JBI = Joanna Briggs Institute; PRISMA-ScR = Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews.
* Where *sources of evidence* (see second footnote) are compiled from, such as bibliographic databases, social media platforms, and Web sites.
† A more inclusive/heterogeneous term used to account for the different types of evidence or data sources (e.g., quantitative and/or qualitative research, expert opinion, and policy documents) that may be eligible in a scoping review as opposed to only studies. This is not to be confused with *information sources* (see first footnote).
‡ The frameworks by Arksey and O'Malley (6) and Levac and colleagues (7) and the JBI guidance (4, 5) refer to the process of data extraction in a scoping review as data charting.
§ The process of systematically examining research evidence to assess its validity, results, and relevance before using it to inform a decision. This term is used for items 12 and 19 instead of "risk of bias" (which is more applicable to systematic reviews of interventions) to include and acknowledge the various sources of evidence that may be used in a scoping review (e.g., quantitative and/or qualitative research, expert opinion, and policy document).

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