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INTIMATE PARTNER VIOLENCE AND FAMILY PLANNING: OPPORTUNITIES FOR ACTION

1 in 3

The share of women worldwide who have experienced intimate partner violence.

Unintended pregnancy is more common among women who have experienced intimate partner violence compared to those who have not.

2X Higher

The difference in induced abortion rates between women who have experienced intimate partner violence and those who have not.

Intimate partner violence (IPV)—physical and/or sexual violence by a current or former partner—is an issue that women in all regions and all countries experience (see definition, Box 1).¹ Globally, approximately one in three women who have ever been in a relationship have experienced IPV.² Women face a greater risk of violence from an intimate partner than from anyone else.³

This brief presents data to help policymakers and others understand the nature and extent of the harm caused by IPV, especially as it relates to women’s reproductive health and autonomy, and highlights opportunities for action. Policymakers can combat IPV and its consequences by promoting integrated policies and dedicating financial resources to support systems, programs, and services to address the intersection of IPV, health, and women’s empowerment.

Intimate Partner Violence Is a Global Epidemic

The highest rates of IPV are found in Africa, the eastern Mediterranean, and Southeast Asia—approximately 37 percent of women in each of those regions, compared to 23 percent in high-income regions.⁴ Some women may be especially vulnerable to IPV and the associated negative consequences, including young women and women in crisis or conflict settings (see Figure 1; see Box 2).⁵ Other factors that increase a woman’s risk of IPV include early marriage, partner’s alcohol abuse, and witnessing domestic violence as a child.⁶

IPV imposes significant health and rights consequences on women, including poor physical, mental, and reproductive health, and on their infants and children, who are at greater risk for a variety of poor health and development outcomes. The negative effects of IPV extend to national development that is hampered by lost productivity and increased health and other social services costs.

BOX 1

Defining Intimate Partner Violence (IPV)

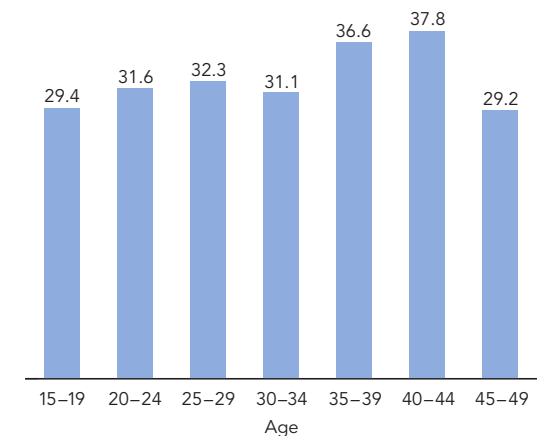
Intimate partner violence (IPV) refers to physical and/or sexual violence by a current or former partner. Physical and sexual violence often occur together, though not always, and can happen in the context of marriage or less formal relationships (including dating or unmarried sexual relationships). IPV can affect men and women alike, but most frequently women experience IPV at the hands of male partners.

Source: World Health Organization (WHO), *Global and Regional Estimates of Violence Against Women: Prevalence and Health Effects of Intimate Partner Violence and Non-Partner Sexual Violence* (Geneva: WHO, 2013); and WHO, *Preventing Intimate Partner and Sexual Violence Against Women: Taking Action and Generating Evidence* (Geneva: WHO, 2010).

FIGURE 1

IPV Occurs Among Women of All Ages

Percent of Ever-Partnered Women Who Have Experienced IPV



Sources: World Health Organization (WHO), *Global and Regional Estimates of Violence Against Women: Prevalence and Health Effects of Intimate Partner Violence and Non-Partner Sexual Violence* (Geneva: WHO, 2013).

BOX 2

IPV Among Adolescent Girls and Young Women

IPV is a common experience among adolescent girls and young women. Among those who have ever been in a relationship, 29 percent of 15-to-19-year-old girls and 32 percent of 20-to-24-year-old young women have experienced physical or sexual violence from a partner. These figures are especially alarming since early sexual and relationship experiences are a significant influence on a woman's future: The effects of violence during this formative period on a woman's long-term health and well-being may be magnified. Since women who experience one instance of partner violence are likely to experience more, violence at a young age may increase a woman's overall lifetime exposure.¹

Adolescent girls and young women may be at heightened risk for IPV because of their youth, relative inexperience, and gendered power dynamics, especially if the male partner is older.² Though IPV frequently occurs outside of marriage, early marriage is a particular risk factor.

1 Heidi Stöckl et al., "Intimate Partner Violence Among Adolescents and Young Women: Prevalence and Associated Factors in Nine Countries, A Cross-Sectional Study," *BMC Public Health* 14, no. 751 (2014); Michelle Decker et al., "Gender-Based Violence Against Adolescent and Young Adult Women in Low- and Middle-Income Countries," *Journal of Adolescent Health* 56 (2015): 188-96; and World Health Organization (WHO), *Global and Regional Estimates of Violence Against Women: Prevalence and Health Effects of Intimate Partner Violence and Non-Partner Sexual Violence* (Geneva: WHO, 2013).

2 WHO, *Preventing Intimate Partner and Sexual Violence Against Women: Taking Action and Generating Evidence* (Geneva: WHO, 2010).

Some of the most severe consequences of IPV are related to women's reproductive health and empowerment. These outcomes include higher rates of unplanned pregnancy, abortion, and miscarriage, suggesting that IPV often interferes with women's ability to consistently use effective contraception.

Bringing IPV Into the Open

IPV is often treated as a private matter, ignored, or even seen as normal or acceptable. Frequently, women do not report abuse by an intimate partner out of fear of retaliation or stigma, the belief that violence from partners is expected, or the feeling that no one can or will help them.⁷ Violent behavior in general and violence towards a partner in particular are often seen as normal, acceptable masculine behaviors. These attitudes are learned early on, and boys and girls who witness household abuse often carry those behaviors into the next generation.⁸

Only within the past few decades has IPV (along with other types of violence against women) come to be seen as a crime

BOX 3

Addressing IPV Within a Rights-Based Approach to Reproductive Health

The growing emphasis on a rights-based approach to reproductive health care promotion and provision presents a key opportunity to address the negative impact of IPV. It is a violation of multiple human rights, including the right to life and security of the person, the right to equality, and the right to the highest attainable standard of health.¹ A rights-based approach to family planning and reproductive health accounts for the full range of barriers that may interfere with a woman's ability to make free, informed, and voluntary decisions about her reproductive health and behavior, including contraceptive use.² Seen through this lens, addressing IPV is a strategy for enabling otherwise disempowered women to gain some control over one aspect of their lives.

1 World Health Organization (WHO), *Responding to Intimate Partner Violence and Sexual Violence Against Women: WHO Clinical and Policy Guidelines* (Geneva: WHO, 2013).

2 Family Planning 2020, "Rights and Empowerment Principles for Family Planning," (2014), accessed at www.familyplanning2020.org/resources/4697 on May 20, 2015.

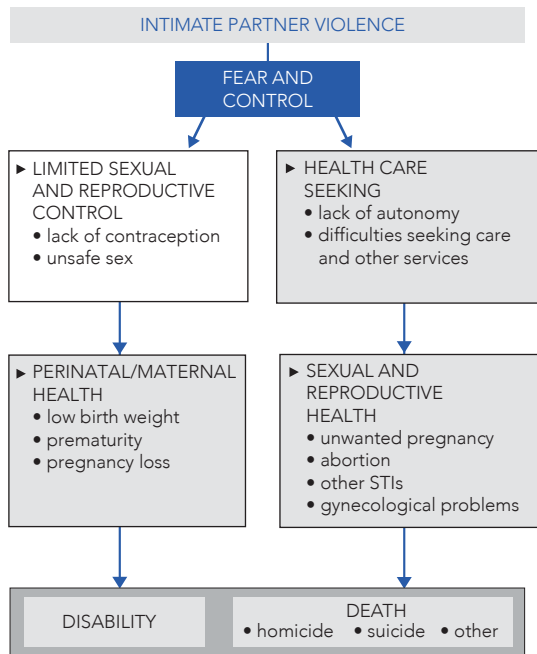
and a violation of human rights (see Box 3).⁹ Increasingly, IPV is also being recognized as a health issue, especially reproductive health.¹⁰ Awareness is still limited regarding the relationship between IPV and reproductive health and the appropriate role of policymakers and health care providers in identifying, responding to, and supporting women experiencing IPV.

IPV: Wide-Ranging Consequences

Women who experience IPV are at greater risk of a range of poor health conditions and outcomes (see Figure 2, page 3). They are twice as likely to experience depression as women who have not experienced IPV, and up to one and a half times more likely to become HIV positive.¹¹ Other negative health outcomes include injury, gastrointestinal problems, chronic pain, depression, posttraumatic stress disorder, suicide, and alcohol use.¹²

IPV also has serious consequences for infants and children: Women in violent relationships are less likely to receive adequate prenatal care and more likely to have a preterm birth or low birth-weight baby. Children of women who experience IPV are less likely to receive immunizations and may be at increased risk of additional health, developmental, and behavioral problems later in life.¹³ Moreover, children who witness violence in their home are significantly more likely to perpetrate or experience violence themselves later in life.¹⁴

FIGURE 2
Pathways and Health Effects of Intimate Partner Violence



Source: Adapted from World Health Organization (WHO), *Global and Regional Estimates of Violence Against Women: Prevalence and Health Effects of Intimate Partner Violence and Non-Partner Sexual Violence* (Geneva: WHO, 2013).

The accumulated impact of IPV on individual women’s well-being translates into negative consequences for communities and nations. Direct costs in the form of increased health care and social service expenditures represent a significant burden to national budgets. For example, the annual estimated cost of expenses related to IPV is between US\$1.7 billion and US\$10 billion in the United States.¹⁵ Additional economic costs are accrued when women miss days of work or are prevented from working outside the home: Estimates from Brazil, Tanzania, Chile, and South Africa place lost productivity due to IPV at 1 percent to 2 percent of gross domestic product.¹⁶ Total annual costs of IPV are estimated at almost 23 billion pounds in the United Kingdom and the equivalent of 4.5 billion pounds in Australia.¹⁷ Though these are the most recent calculations, they are a number of years old and likely underestimate the actual costs.

IPV: A Reproductive Health Issue

Some of the most severe consequences of IPV are related to women’s reproductive health and autonomy. In a global review, the World Health Organization (WHO) notes that, “Women in violent relationships, or who live in fear of violence, may...have limited control over the timing or circumstances of sexual intercourse...” Women exposed to IPV may not be able to choose when to have sex, protect themselves from

HIV and other sexually transmitted infections (STIs), or insist on contraception.¹⁸ IPV is sometimes accompanied by reproductive coercion, in which a male partner directly interferes with a woman’s desires for her pregnancy (see Box 4).¹⁹ The controlling behavior that often characterizes violent relationships can constrain a woman’s access to health care, including family planning, and exacerbate health problems associated with IPV.²⁰

Women who experience IPV also experience higher rates of unintended pregnancy.²¹ A study in Colombia estimated that stopping IPV in that country would prevent over 32,000 unintended pregnancies every year.²²

Rates of induced (often unsafe) abortion are also higher—by some estimates, more than double—among women who experience IPV, reflecting the high rates of unintended pregnancies.²³ Women in violent relationships also experience higher rates of miscarriage and stillbirth.²⁴

IPV and Family Planning: A Complicated Picture

Given the high rates of unintended pregnancy and poor reproductive health outcomes among women exposed to IPV, it is important to consider the relationship between IPV and family planning. The impact of IPV on contraceptive use is complicated and varies across countries and settings. Longitudinal studies—that is, studies with data from more than a single point in time—can help explain the relationship between IPV and family planning and determine whether IPV makes it more or less likely that women will use contraception. One analysis of longitudinal studies in developed countries found evidence that women who experienced IPV within

BOX 4

Reproductive Coercion

Silverman and Raj define reproductive coercion as “...behaviors that directly interfere with contraception and pregnancy, reducing female reproductive autonomy. The two forms of reproductive coercion are pregnancy coercion and contraception sabotage.” Pregnancy coercion refers to efforts by a male partner to force a woman to become pregnant or carry a pregnancy to term when she does not wish to or, conversely, to end a pregnancy against her will. Contraception sabotage describes intentional interference by a male partner with a woman’s attempts to prevent pregnancy, for example hiding or destroying pills or breaking a condom.

Source: Jay G. Silverman and Anita Raj, “Intimate Partner Violence and Reproductive Coercion: Global Barriers to Women’s Reproductive Control,” *PLOS Medicine* 11, no. 9 (2014): e1001723.

the past 6 months to 12 months were less likely to use contraception, particularly condoms.²⁵ Unfortunately, few longitudinal studies have been done in developing countries.

Available data for developing countries paint a complicated and context-dependent picture: Some studies have found that women who experience IPV are less likely to use modern methods of contraception, while other studies have found similar or higher rates of contraceptive use among women reporting IPV, as compared to those who do not report.²⁶ Other studies have found that women subject to abuse are more likely to have used contraception at some point, but are also more likely to stop using contraception and are less likely to use their preferred method, suggesting that IPV interferes with women's ability to consistently use their preferred method over time.²⁷

More research is needed to explain the reasons for these variations, but a few factors seem to influence whether a woman experiencing IPV is motivated and able to use family planning. Those include:

- **Gender norms.** Where gender norms are more rigid and male authority or dominance is strongly enforced, women have less autonomy overall. In this context, women in violent relationships may be even less able to use contraception.²⁸
- **Community acceptance of contraceptive use.** Where modern contraception is widely used, it may be more acceptable and easier for women experiencing IPV to use family planning.²⁹ If contraception is not widely used in the woman's community, however, a woman may be afraid that using contraception will be seen as a transgression of accepted behavior, putting her at risk of violent retaliation from her partner. The type of methods that are most commonly used in a community may also influence use. For example, the most common methods in India are condoms and female sterilization, but condoms require a partner's cooperation, which may not be possible for women in violent relationships, and sterilization is permanent, which may not meet the needs of all women.³⁰
- **Availability of contraception.** When contraception is more widely available, affordable, and accessible—for example, through strong government family planning programs or community-based distribution—it may be easier for women to use, even when their autonomy is limited by partner violence.³¹
- **Type of IPV.** A few recent studies have shown that women experiencing sexual violence from a partner are more likely to use contraception, and more likely to use a female-controlled method, than women experiencing physical partner violence or women not experiencing partner violence at all.³²

Given that unintended pregnancy and induced abortion are more common among women experiencing IPV across nearly

all settings, even when reported contraceptive use is high, it is reasonable to assume that IPV interferes with women's ability to effectively and consistently use contraception.³³ It also indicates that current family planning resources and services are not meeting the needs of women in violent relationships.

A Window of Opportunity

The vast majority of women—including those who experience IPV—will use reproductive health care services at some point in their lives. Studies have shown that women are willing to disclose and receive support from health care providers. Universal screening—assessing all women for IPV during a health care visit, regardless of whether she presents any indications she has experienced or is at risk of experiencing IPV—may not be feasible or appropriate in settings where women cannot be offered or referred to comprehensive support services.³⁴ However, even when active screening is not implemented, providers are often the first to recognize or be told about abuse. Recognizing this, WHO recommends that regardless of screening protocol, all providers be trained to offer compassionate, woman-centered care (see Box 5, page 5).³⁵

Recognizing the realities of women in violent relationships is essential to providing them with appropriate care that meets their particular needs. This care includes helping a woman choose a contraceptive method that she can use easily, safely, and effectively; offering other essential reproductive health services, like STI and HIV screening and treatment, antenatal care, and maternal health services; and connecting women to other resources where available, such as psychosocial counseling, social services, and legal counsel.³⁶

The health care system needs to be equipped to offer compassionate support and tailored care for women experiencing IPV, with providers trained in woman-centered care, adequate staffing levels, supportive supervision, standardized protocols, and linkages to broader systems of support for women exposed to violence. Putting all these pieces in place requires political action and financial commitment.

Policymakers Are Critical Partners for Meeting the Needs of Women Experiencing IPV

Policymakers can establish the policy framework and financial commitments to enable family planning and reproductive health programs to reach women experiencing IPV with appropriate services and supportive tailored care. Policies and dedicated funding to support integrated and effective approaches to IPV response and family planning provision should include the development of comprehensive health system guidelines, training for providers, adequate staffing, strong supply chains to ensure the full range of contraceptive methods is available, and strong

referral networks and support services for women in violent relationships.

At the same time, policymakers can complement and strengthen the work of the health sector by introducing and supporting critical strategies to prevent and reduce IPV broadly. Since IPV is strongly linked to inequitable gender attitudes and harmful beliefs about men's and women's roles, this support includes implementing initiatives across sectors that promote gender equality and transform negative gender norms—in schools and youth sports programs, through mass media campaigns, or in economic development programs.³⁷ Policymakers can foster linkages across the health care system, social services, the police and judiciary, the education system, and other sectors to promote a coordinated response to IPV.

Promising Approaches

Given the tremendous toll on women, families, and countries, are there promising approaches for preventing IPV? Encouragingly, yes, and as Michau and colleagues write in the *Lancet*, “Evidence shows that changes in attitudes and behaviors do not need a generation, but can be achieved within shorter timeframes...”³⁸

CHARM: WORKING WITH MEN TO DECREASE IPV AND SUPPORT WOMEN'S USE OF CONTRACEPTION

CHARM (Counseling Husbands to Achieve Reproductive health and Marital equity) supports contraceptive use and gender equity among young married couples by working with husbands in rural India. Specially-trained, local male village health providers (VHPs) meet with young husbands in the program for two sessions to provide counseling and education on family planning and gender equity, such as shared responsibility for family planning, respectful joint decisionmaking with wives, and equal valuation of girl and boy children. VHPs emphasize the importance of valuing and respecting women and girls generally, rather than talking about gender-based violence (GBV) directly. At an additional session, VHPs counsel couples on family planning and joint decisionmaking and provide family planning services.

A recent rigorous randomized control trial of the intervention showed promising results. CHARM participants, as compared to those who did not receive the intervention, showed:

- Improvements in both modern contraceptive use and marital communication around contraceptive use. The greatest increase was seen for condom use, likely because of the intervention's focus on men.
- Significantly lower incidence of sexual IPV, making this the first study to document a significant positive impact on sexual IPV.

BOX 5

Training Health Care Providers in IPV Response and Woman-Centered Care

Ideally, providers will receive training throughout their careers, from preservice to regular in-service training. Basic training for IPV response and support should include sensitizing providers and improving their understanding of the causes of IPV, improving knowledge of the connection between IPV and health so providers can tailor their care to the specific needs of women, and connecting providers to other available resources for women experiencing IPV.¹

This basic training is foundational for woman-centered care, defined by WHO as:

- Being nonjudgmental and supportive.
- Providing practical care and support that responds to the woman's concern.
- Asking about her history of violence, listening carefully, but not pressuring her to talk.
- Helping her access information about resources.
- Assisting her to increase safety for herself and her children, where needed.
- Providing or mobilizing social support.
- Ensuring privacy and confidentiality.

1 Julia Kim and Mmatshilo Motsei, “Women Enjoy Punishment”: Attitudes and Experiences of Gender-Based Violence Among PHC Nurses in Rural South Africa,” *Social Science and Medicine*, 54 (2002): 1243–54.

- Less likelihood to agree that physical IPV is sometimes justified or to endorse sexual IPV.

Based on these encouraging results, the researchers are hoping to expand and scale up the program in different settings.³⁹

SASA! MOBILIZING CHANGE IN COMMUNITIES

SASA! was developed primarily as an HIV prevention intervention in Uganda, but the program's holistic approach to promoting gender equality and reducing violence resulted in significant impacts on a wide range of indicators, including IPV. SASA! sought to shift community attitudes, norms, and behaviors related to gender equality and health behaviors by engaging a broad range of community stakeholders in

mobilization and advocacy activities. A rigorous evaluation—one of the first for an intervention of this kind—found that in SASA! communities:

- Women were less likely to report physical IPV in the past year.
- Men were less likely to report concurrent partners in the past year.
- Both men and women were more likely to have progressive attitudes (reduced acceptance of men’s use of violence against a partner and increased acceptance of a woman’s right to refuse sex).

Other results indicate that the program had a positive impact on the occurrence of sexual IPV and on men’s attitudes about their right to demand sex from their partner. Most encouragingly, these results were seen across the community, not just among individuals intensely involved with the program, which holds great promise for achieving broad societal change in a relatively short time frame.⁴⁰

EMPOWER PROJECT: LAYING THE POLICY FOUNDATION FOR IPV RESPONSE IN BENIN

From 2007 to 2012, under the EMPOWER project, CARE Benin worked to improve the anti-GBV policy and legal framework in Benin. The EMPOWER project convened a network of stakeholders from civil society, ministries, communities, and the media to raise awareness of GBV and push for the passage of the nation’s first anti-GBV law. One key to the successful passage of the new law was the simultaneous mobilization and sensitization of communities, which created a groundswell of grassroots support for action against GBV.

By convening partners at the community and national level, CARE was able to build a strong platform for intensive advocacy and social mobilization, and Benin’s anti-GBV law was enacted in 2012. In his speech welcoming the bill, the former vice president of the National Assembly cited the EMPOWER project and implicitly recognized that there would be more work to do to realize the promise of the new law, saying, “EMPOWER planted a tree to be watered for the well-being of the people.”⁴¹

An Integrated Policy Strategy for Improving the Response of Public Health Systems

Spain offers an example of carefully crafted policies that promote an integrated response to violence against women. The country has a robust policy and legal framework, including an anti-GBV law that requires the provision of GBV services in the Regional Health Service, and a national GBV awareness and prevention plan that specifies the role and responsibilities of multiple sectors, including judicial, social services, education,

and the media. This plan has been translated into a strong framework for implementation through the health care system:

- The National Health System portfolio includes care for women affected by violence, with technical support, coordination, and accountability provided by a special commission.
- A standardized protocol to guide the health system response to GBV was produced that can be adapted to specific regional contexts and includes information on local resources.
- Training is offered for providers throughout the health system, including continuous workplace-based training, and funded by the Regional Health Services and Ministry of Health.

The coordination of activities across sectors and institutions is a major strength of the Spanish strategy, but structural conditions in the health care system still need improvement, such as reducing caseloads to ensure that providers have sufficient time to spend with each patient, and guaranteeing sufficient ongoing financing for training, supervision, and other support resources.

Compelling Actions

The consequences of IPV are not limited to the home and the response cannot be either. Policymakers in all sectors—education, finance, health, judicial, and others—can take steps to address IPV, especially in family planning/reproductive health programs and services.

MULTISECTORAL POLICY ACTIONS

- **Improve and enforce legal protections and support for women.** In countries where they are nonexistent or weak, legal protections and recourse for women experiencing IPV must be introduced. In countries where laws are already on the books, they must be consistently and rigorously enforced.
- **Develop policies that take an integrated approach to IPV and health, including family planning.** Ensure that IPV is specifically addressed in national health care policies and programs, including those related to family planning, and that family planning and health care are explicitly incorporated into violence prevention and response policies and plans. Back up policy commitments with budgetary and resource allocations across all relevant sectors.
- **Provide political and financial backing for initiatives that promote gender equality broadly.** Support the integration of gender equality initiatives into programs and policies across sectors through political commitments and concrete budget allocations. This support includes funding to incorporate gender equality into school health and life skills curricula, women’s economic empowerment programs, and community mobilization activities.

HEALTH-SECTOR SPECIFIC ACTIONS

- **Ensure that health care services are accessible and appropriate for women experiencing IPV.** Eliminate legal and logistical barriers that may be especially burdensome for women experiencing IPV, such as partner consent requirements and cost. Ensure the availability of a full range of methods, especially female-controlled and long-acting methods that can be used by a woman without the cooperation of her partner.
- **Allocate funds for adequate and continuous training and key resources for health care providers to care for women experiencing IPV.** Training for providers is critical to reduce harmful attitudes about IPV, increase sensitivity to individuals experiencing abuse, improve awareness of the relationship between IPV and health, and build skills to offer tailored, woman-centered care. Additional resources should be allocated to ensure that staffing levels and supervisory support are sufficient to enable healthcare providers to implement training in their day-to-day practice, and that providers can refer women to other relevant IPV services as available.

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