Research Brief

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INTIMATE PARTNER VIOLENCE AND UNMET NEED FOR FAMILY PLANNING: FINDINGS AMONG WOMEN OF DIFFERENT AGES FROM SIX SUB-SAHARAN AFRICAN COUNTRIES

More than **40%** of married women experienced IPV in the last year in DRC, Kenya, and Tanzania.

IPV influences family planning decisions differently across the life course.

Services for IPV victims should evaluate their clients' family planning needs and help ensure they are met.

A range of social, cultural, and economic factors influence women's decisions regarding family planning. One factor that could play a significant role is intimate partner violence (IPV). A number of studies have investigated whether experiencing IPV is associated with contraceptive use, but results are mixed. Some studies reveal that women who experience IPV report lower contraceptive use compared to those who do not, some find the opposite, and others find no significant association between the two.[1] The nature of the association between IPV and contraceptive use is likely complex. Understanding the relationship is important, especially in sub-Saharan Africa where the rates of both IPV and unmet need for family planning are the highest in the world.

Faced with a variety of challenges and opportunities, women at different stages of their reproductive lives may be influenced differently by factors affecting contraceptive use. This analysis by the Population Reference Bureau (PRB)—using data from six countries across sub-Saharan Africa—extends previous research by examining whether the IPV-unmet need association differs by age of women. Women who experience IPV may be less likely to use contraception out of fear of additional violence from their partners, or because they are less able to negotiate with their partners compared to other women. Alternatively, women who experience IPV may be more motivated to use contraception to avoid bringing a child into abusive marriages or relationships. They may also want to protect themselves from sexually transmitted infections, including HIV/AIDS, if they perceive their abusive partners will place them at a greater risk of contracting these diseases. Because women may respond differently to IPV depending on where they are in their reproductive lives, it is important to examine age variation in the IPV-unmet need association.

IPV and Unmet Need in Sub-Saharan Africa

Women in sub-Saharan Africa have high rates of IPV compared to other regions around the world. Studies have shown that IPV is associated with a number of reproductive health outcomes, such as unintended pregnancies, induced abortions, and contraceptive use.[2]

To better understand the IPV-unmet need association, PRB examined whether experiencing IPV in the past year was associated with unmet need for any contraceptive methods and, if so, whether and how the association varied by age. Data for the analysis came from the most recent waves of the Demographic and Health Surveys (DHS) from selected countries with a DHS violence module and with sample sizes large enough to support the study analysis—Democratic Republic of the Congo (DRC), Kenya, Malawi, Nigeria, Tanzania, and Zimbabwe. Experience with IPV in this study was measured as any exposure to physical, sexual, or emotional IPV in the past 12 months.

According to DHS, more than 30 percent of ever-married women of reproductive age (ages 15 to 49) in all the study countries, except Nigeria, experienced physical, sexual, or emotional violence committed by their husband or partner in the 12 months preceding the survey. In three of these countries—DRC, Kenya, and Tanzania—the prevalence surpassed 40 percent. Even in Nigeria, with the lowest prevalence among the study countries, the rate was 19 percent.

After assessing the IPV-unmet need association and its age variation, the study further examined whether key characteristics of women (education, household wealth, household decisionmaking power, marital status (married versus living with her partner), parity (number of live births), urban-rural residence, and husband's age and education levels) explained why IPV and unmet need may be associated and why it may vary by age. The study also examined the use of modern contraceptive methods versus traditional methods among women using any family planning methods by IPV status across all age groups.

The study sample consists of women who were married or living with their partner (hereafter referred to as married women) at the time of the survey who responded to the violence module and who had demand for family planning. Demand is defined as those who are either currently using contraception or have unmet need for family planning. Women with unmet need are those who are fecund—capable of giving birth—and who want to either postpone their next birth for two years or more, or not have any more children, but are not using a family planning method. Pregnant women or postpartum amenorrheic women whose pregnancy or last birth was mistimed or unwanted are also considered to have unmet need for family planning. As defined for this study, unmet need is computed as a percentage of only the women with demand, rather than the larger population of women in their respective age cohorts (as is usually done), and thus, can be considered as the percent of total demand for family planning that is not satisfied among currently married women. Women in the sample were grouped into three age groups—young (ages 15 to 24), middle (ages 25 to 34), and older (ages 35 to 49). (More details on data and methods are available upon request.)

Unmet Need and IPV Prevalence by Age

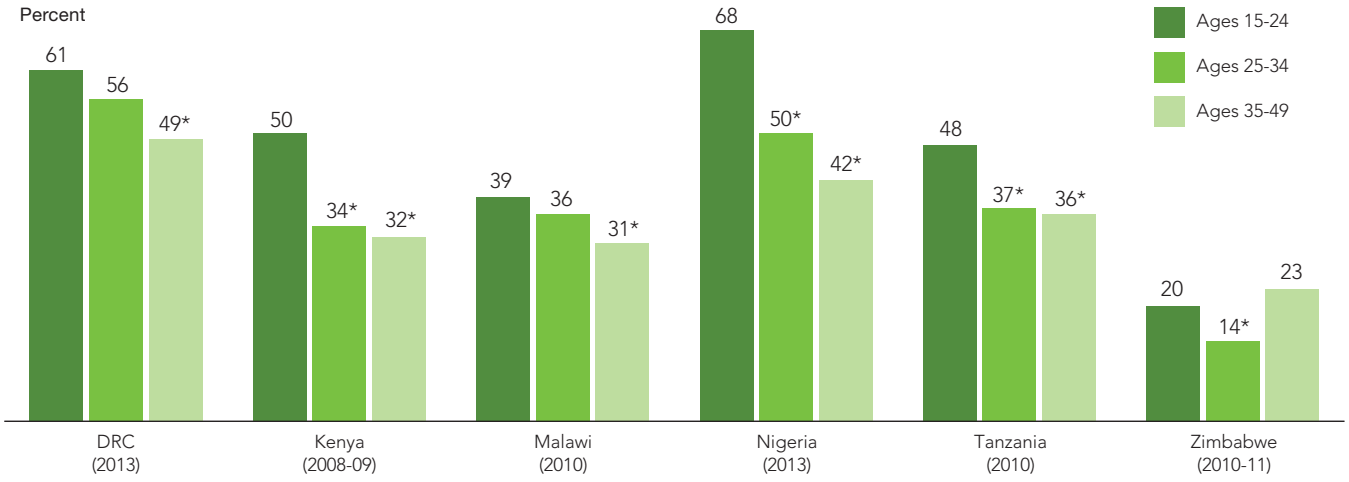
Figure 1 shows that unmet need is highest among the youngest age group and lowest among the oldest age group in each country sample, with the exception of Zimbabwe, where the oldest group ranks first and the youngest ranks second. For example, in Nigeria and DRC, the percentage of women with demand who have an unmet need are 68 percent and 61 percent, respectively, among young women, and 42 percent and 49 percent, respectively, among the oldest women. Across the three groups, DRC has the highest overall rate of unmet need and Zimbabwe has the lowest in the study sample.

Figure 2, page 3 shows the percent of married women with demand for family planning who experienced IPV in the past 12 months by age. In DRC, Tanzania, and Zimbabwe, young women are significantly more likely to experience IPV compared to the oldest women (and also compared to middle-age women in the case of Zimbabwe). In contrast, there is little difference in the percentage experiencing IPV by age in the other three countries that have lower overall rates of IPV: Kenya, Malawi, and Nigeria. DRC and Tanzania have the highest overall rates of IPV and Nigeria has the lowest among the study sample.

Women in the study sample (married women with demand for family planning) have a higher prevalence of IPV than the overall DHS sample of ever-married women in DRC, Malawi, and Tanzania. The higher IPV prevalence among the study sample may reflect the possibility that women experiencing IPV do not want to bring a child into an abusive marriage or relationship.

FIGURE 1

Unmet Need for Family Planning by Age Among Married Women With Demand for Family Planning



Note: Asterisk (*) after the data value indicates that unmet need level for that age group significantly differs from the level for the 15-to-24 age group (the reference age group).
Source: Population Reference Bureau (PRB) analysis of Demographic and Health Survey data.

Age Variation in the IPV-Unmet Need Association: What the Evidence Tells Us

The analysis of the IPV-unmet need association shows that IPV is significantly associated with unmet need (see Figure 3, page 4), but the association varies by age in all the study countries except Zimbabwe. In DRC, Kenya, and Tanzania, the association is only statistically significant among older women (and also among middle-age women in Tanzania); these women with IPV have significantly higher unmet need compared to their counterparts without IPV. In contrast, in Malawi and Nigeria, the association between IPV and unmet need is statistically significant only among young women; these young women with IPV have significantly lower unmet need compared to their counterparts without IPV. Even in other countries where the association is not statistically significant, young women with IPV generally have similar levels of unmet need—or lower—compared to their peers without IPV. One possible explanation for the findings among young women is that they may have greater sense of control over their family lives than older women due to changing social norms. If so, young women with IPV may be less accepting of having more children than older women with IPV. The findings may be also a reflection of the sample chosen for the analysis. Because young women are both less likely to be currently married and more likely to want a child within two years compared to older women, young women are the least likely to be represented in the sample.

Unlike the other countries, in Zimbabwe, levels of unmet need for women with IPV and those without IPV did not significantly differ in any age groups. The lack of a significant IPV-unmet need association in Zimbabwe may reflect its high overall rates of contraceptive use—Zimbabwe has the second highest contraceptive prevalence rate across sub-Saharan Africa.

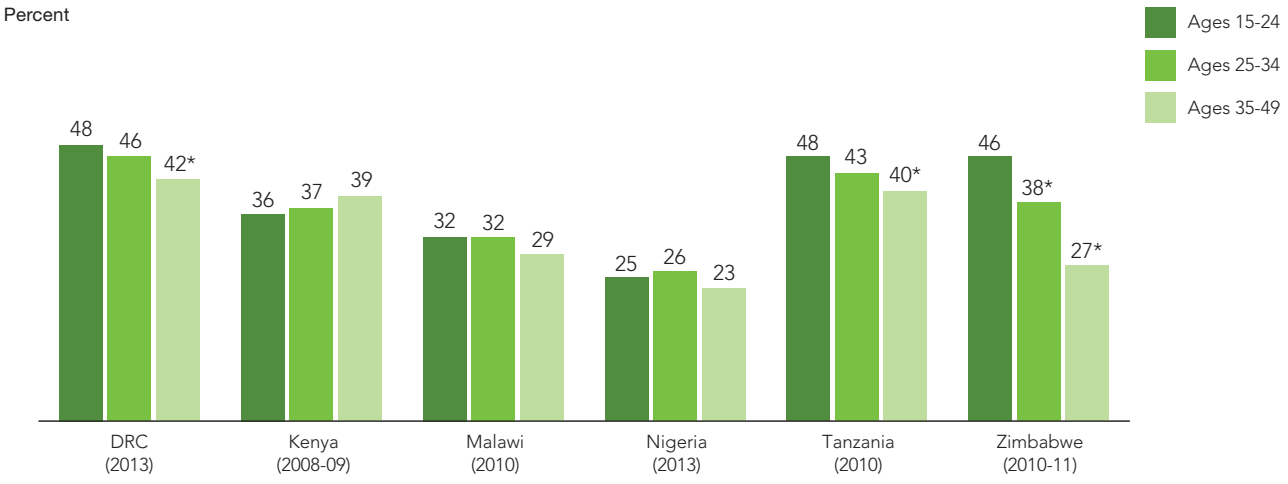
Additional analyses (not presented here) examine the types of contraceptive methods used—traditional or modern—among women who are using a family planning method by IPV status. Among family planning users in the sample, women with IPV use modern methods at similar rates compared to the women without IPV across all age groups in all study countries with the exception of young women in DRC. Young women with IPV in DRC are significantly less likely to use modern methods compared to young women without IPV (29 percent versus 45 percent), even though they have higher overall contraceptive use than those without IPV due to their higher reliance on traditional methods.

Role of Socioeconomic Characteristics in the IPV-Unmet Need Association

Further analysis to control for various explanatory factors reveals that women's education, household wealth, and urban-rural residence—all used to measure their socioeconomic status (SES)—are among the key reasons underlying the significant age differences in the IPV-unmet need association in DRC, Kenya, Nigeria, and Tanzania. When adjusting for the SES of women, differences in unmet need levels between women with IPV and those without are substantially reduced, especially among older women, and the differences in the IPV-unmet need association between young and older women become statistically insignificant.

FIGURE 2

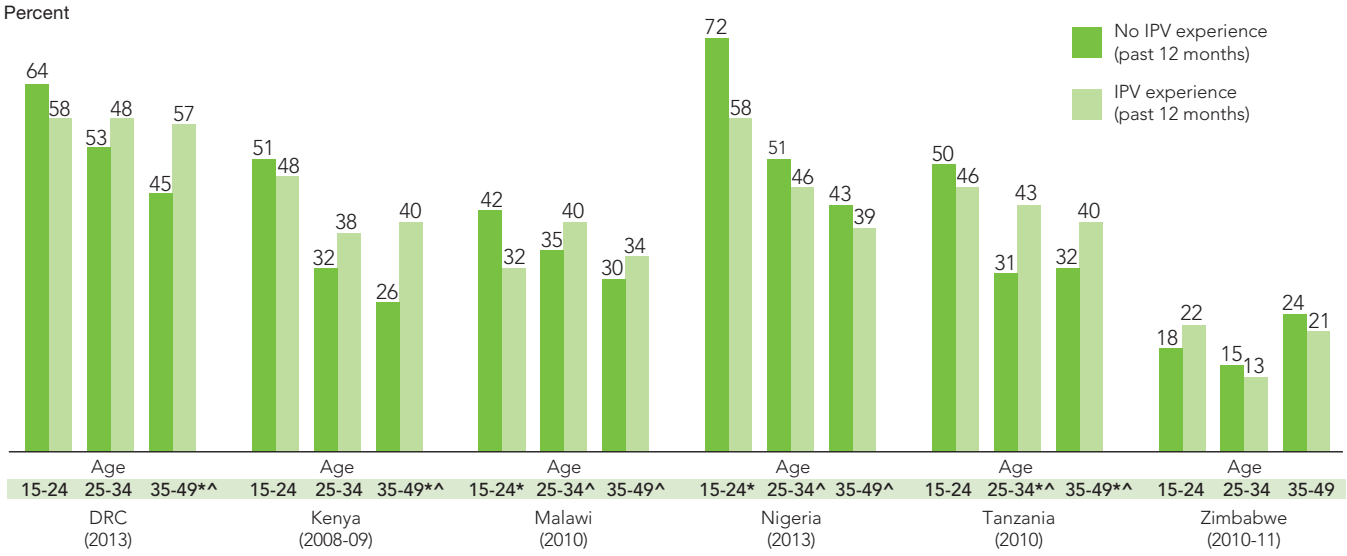
Recent IPV Experience by Age Among Married Women With Demand for Family Planning



Note: Asterisk (*) after the data value indicates that IPV level for that age group significantly differs from the level for the 15-to-24 age group (the reference age group).
Source: Population Reference Bureau (PRB) analysis of Demographic and Health Survey data.

FIGURE 3

Unmet Need for Family Planning and Recent IPV Experience by Age Among Married Women With Demand for Family Planning



Note: Asterisk (*) after the age group indicates statistically significant difference in unmet need levels by experience of IPV; Caret (^) after the age group indicates that the IPV-unmet need association in that age group significantly differs from the association in the 15-to-24 age group (the reference age group); in other words, the caret indicates significant age variation in the IPV-unmet need association.
Source: Population Reference Bureau (PRB) analysis of Demographic and Health Survey data.

This finding reflects the general pattern that women with lower SES are more likely to experience both IPV and unmet need compared to higher-SES-women, and that this association appears to be stronger among older women in the sample.

Other characteristics account for some of the IPV-unmet need association and its age variation, but none as consistently across countries as SES. These additional explanatory factors include parity (in Kenya, Nigeria, and Tanzania), marital status and household decisionmaking power (in Nigeria and Tanzania), and husbands' age and education (in Tanzania). Having more children, living with a partner (compared to being married), having less household decisionmaking power, and having older husbands and husbands with lower education are all characteristics that are associated with both higher IPV and higher unmet need. Each of these characteristics, therefore, contributes to the association between IPV and unmet need, especially among older women, in the countries listed above.

Implications of the Research

This study contributes to the research on women's sexual and reproductive health in several important ways. The study:

- Confirms the significant association between women's IPV experience and unmet need for family planning among our sample of married women with demand for family planning.
- Uncovers a unique finding in the age variation in the IPV-unmet need association. This finding suggests that experiencing IPV may influence family planning decisions in different ways across the life course—underscoring the importance of understanding the characteristics of women with IPV at different life stages as well as other possible barriers to contraceptive use.
- Suggests the importance of women's socioeconomic characteristics in explaining the age-variation in the IPV-unmet need association in most study countries, which can help identify women at high risk of experiencing both IPV and unmet need, such as older women with low SES.
- Points to the stark differences in the IPV-unmet need association and the factors explaining the association and its age variation across countries, suggesting the importance of understanding the nature of the association in each setting to plan and implement successful interventions.

One major limitation of the study is its reliance on cross-sectional data (data collected at a single point in time) that does not allow for a causal interpretation: It is not possible to ascertain if contraceptive use preceded IPV or if it was a consequence. Longitudinal data, or data collected about the same individuals at multiple points in time, could shed light on the causal direction in the future. Despite this limitation, identifying the significant association between IPV experience and unmet need provides

important implications for future policy and practice to improve reproductive health outcomes of women experiencing IPV.

Policy and program implications of the study include:

- Among currently married women with demand for family planning, older women with IPV in three of the six countries examined are a particularly high-risk group in need of contraception. They represent a group that is often overlooked in family planning services in general. Family planning services should screen for IPV among women of all ages, but particularly older women with low SES, to ensure that their contraceptive needs are being met.

- While experiencing IPV is not associated with an increased level of unmet need among young women, they still have the highest unmet need among women—both with and without IPV—across all ages in most countries examined. Family planning services should place a high priority on reaching young women, especially those experiencing IPV, with counseling and services to meet their high levels of unmet demand and make modern methods easily accessible.

- Among women with IPV experience and unmet need, large majorities of them across countries have had at least one child, which highlights the importance of incorporating family planning counseling, services, and follow-up into postpartum programs as well as other services that provide opportunities to reach women, such as postabortion care, child survival, community health, and HIV interventions.

- Regardless of age, providers of family planning services should incorporate screening for IPV as a part of routine service provision, especially given that women with IPV are likely overrepresented among women who have demand for family planning. If IPV is detected, it is important to identify the appropriate method to ensure that the woman's contraceptive needs are being met, and to refer them to appropriate IPV support centers.

- Recognizing the association between IPV and unmet need, particularly in young and older age groups, also points to IPV services as an important potential entry point into the health system, including family planning facilities. Providers of programs for women suffering from IPV should routinely evaluate whether their clients' family planning needs are being addressed, and refer them to family planning counseling and services.

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