Intimate partner violence

Intimate partner violence is one of the most common forms of violence against women and includes physical, sexual, and emotional abuse and controlling behaviours by an intimate partner.

Intimate partner violence[1] (IPV) occurs in all settings and among all socioeconomic, religious and cultural groups. The overwhelming global burden of IPV is borne by women.

Although women can be violent in relationships with men, often in self-defence, and violence sometimes occurs in same-sex partnerships, the most common perpetrators of violence against women are male intimate partners or ex-partners (*1*). By contrast, men are far more likely to experience violent acts by strangers or acquaintances than by someone close to them (*2*).

BOX 1. FORMS OF INTIMATE PARTNER VIOLENCE (*2*)

IPV refers to any behaviour within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship. Examples of types of behaviour are listed below.

Acts of physical violence, such as slapping, hitting, kicking and beating.

Sexual violence, including forced sexual intercourse and other forms of sexual coercion.

Emotional (psychological) abuse, such as insults, belittling, constant humiliation, intimidation (e.g. destroying things), threats of harm, threats to take away children.

Controlling behaviours, including isolating a person from family and friends; monitoring their movements; and restricting access to financial resources, employment, education or medical care.

[1] The term **'domestic violence'** is used in many countries to refer to partner violence but the term can also encompass child or elder abuse, or abuse by any member of a household. 'Battering' refers to a severe and escalating form of partner violence characterized by multiple forms of abuse, terrorization and threats, and increasingly possessive and controlling behaviour on the part of the abuser.

World Health Organization

Pan American Health Organization
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How common is intimate partner violence?

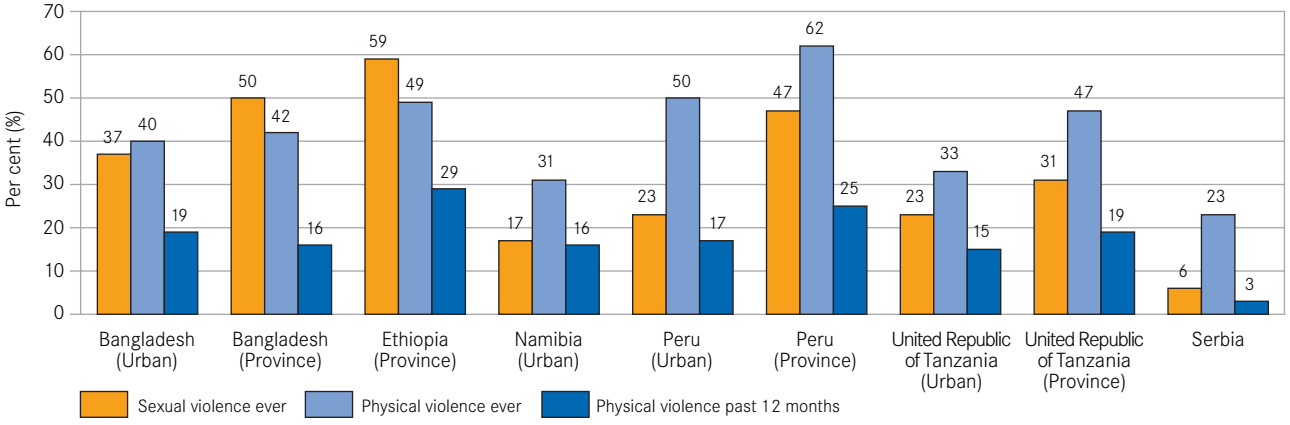
A growing number of population-based surveys have measured the prevalence of IPV, most notably the *WHO multi-country study on women's health and domestic violence against women*, which collected data on IPV from more than 24 000 women in 10 countries,[1] representing diverse cultural, geographical and urban/rural settings (3). The study confirmed that IPV is widespread in all countries studied (**Figure 1**). Among women who had ever been in an intimate partnership:

- 13–61% reported ever having experienced physical violence by a partner;
- 4–49% reported having experienced severe physical violence by a partner;
- 6–59% reported sexual violence by a partner at some point in their lives; and
- 20–75% reported experiencing one emotionally abusive act, or more, from a partner in their lifetime (3).

In addition, a comparative analysis of Demographic and Health Survey (DHS) data from nine countries found that the percentage of ever-partnered women who reported ever experiencing any physical or sexual violence by their current or most recent husband or cohabiting partner ranged from 18% in Cambodia to 48% in Zambia for physical violence, and 4% to 17% for sexual violence (4). In a 10-country analysis of DHS data, physical or sexual IPV ever reported by currently married women ranged from 17% in the Dominican Republic to 75% in Bangladesh (5). Similar ranges have been reported from other multi-country studies (6).

FIGURE 1

Percentage of ever-partnered women reporting physical and/or sexual IPV by type and when the violence took place, *WHO multi-country study* (3)



Existing research suggests that different types of violence often coexist: physical IPV is often accompanied by sexual IPV, and is usually accompanied by emotional abuse. For example, in the *WHO multi-country study*, 23–56% of women who reported ever experiencing physical or sexual IPV had experienced both (3). A comparative analysis of DHS data from 12 Latin American and Caribbean countries found that the majority (61–93%) of women who reported physical IPV in the past 12 months also reported experiencing emotional abuse (6).

[1] Countries included: Bangladesh, Brazil, Ethiopia, Japan, Namibia, Peru, Samoa, Thailand, the former state union of Serbia and Montenegro, and the United Republic of Tanzania.

IPV affects adolescent girls as well as older adult women, within formal unions in settings where girls marry young, and within informal partnerships such as 'dating relationships'. Estimates of the prevalence of violence against women and girls within dating relationships vary widely, depending on how they are measured. The examples below illustrate selected findings:

- a South African study found that 42% of females aged 13–23 years reported ever experiencing physical dating violence (*7*);
- a survey of male college students in Ethiopia found that 16% reported physically abusing an intimate partner or non-partner, and 16.9% reported perpetrating acts of sexual violence (*8*).

Why don't women leave violent partners?

Evidence suggests that most abused women are not passive victims – they often adopt strategies to maximize their safety and that of their children. Heise and colleagues (1999) argue that what might be interpreted as a woman's inaction may in fact be the result of a calculated assessment about how to protect herself and her children (*1*). They go on to cite evidence of various reasons why women may stay in violent relationships, including:

- fear of retaliation;
- lack of alternative means of economic support;
- concern for their children;
- lack of support from family and friends;
- stigma or fear of losing custody of children associated with divorce; and
- love and the hope that the partner will change.

Despite these barriers, many abused women eventually do leave their partners, often after multiple attempts and years of violence. In the *WHO multi-country study*, 19–51% of women who had ever been physically abused by their partner had left home for at least one night, and 8–21% had left two to five times (*3*).

Factors associated with a woman leaving an abusive partner permanently appear to include an escalation in violence severity; a realization that her partner will not change; and the recognition that the violence is affecting her children (*3*).

What are the causes of and risk factors for intimate partner violence?

The most widely used model for understanding violence is the ecological model, which proposes that violence is a result of factors operating at four levels: individual, relationship, community and societal. Researchers have begun to examine evidence at these levels in different settings, to understand better the factors associated with variations in prevalence; however, there is still limited research on community and societal influences. Some risk factors are consistently identified across studies from many different countries, while others are context specific and vary among and within countries (e.g. between rural and urban settings). It is also important to note that, at the individual level, some factors are associated with perpetration, some with victimization, and some with both.

Individual factors

Some of the most consistent factors associated with a man's increased likelihood of committing violence against his partner(s) are (2,9):

- young age;
- low level of education;
- witnessing or experiencing violence as a child;
- harmful use of alcohol and drugs;
- personality disorders;
- acceptance of violence (e.g. feeling it is acceptable for a man to beat his partner) (10); and
- past history of abusing partners.

Factors consistently associated with a woman's increased likelihood of experiencing violence by her partner(s) across different settings include (2,9,11):

- low level of education;
- exposure to violence between parents;
- sexual abuse during childhood;
- acceptance of violence; and
- exposure to other forms of prior abuse.

Relationship factors

Factors associated with the risk of both victimization of women and perpetration by men include (2,9):

- conflict or dissatisfaction in the relationship;
- male dominance in the family;
- economic stress;
- man having multiple partners (9); and
- disparity in educational attainment, i.e. where a woman has a higher level of education than her male partner (3,12).

Community and societal factors

The following factors have been found across studies (2,9):

- gender-inequitable social norms (especially those that link notions of manhood to dominance and aggression);
- poverty;
- low social and economic status of women;
- weak legal sanctions against IPV within marriage;
- lack of women's civil rights, including restrictive or inequitable divorce and marriage laws;
- weak community sanctions against IPV;
- broad social acceptance of violence as a way to resolve conflict; and
- armed conflict and high levels of general violence in society.

In many settings, widely held beliefs about gender roles and violence perpetuate partner violence (*1*,*7*,*9*) (**Box 2**).

BOX 2. EXAMPLES OF NORMS AND BELIEFS THAT SUPPORT VIOLENCE AGAINST WOMEN (*9*)

- A man has a right to assert power over a woman and is considered socially superior
- A man has a right to physically discipline a woman for 'incorrect' behaviour
- Physical violence is an acceptable way to resolve conflict in a relationship
- Sexual intercourse is a man's right in marriage
- A woman should tolerate violence in order to keep her family together
- There are times when a woman deserves to be beaten
- Sexual activity (including rape) is a marker of masculinity
- Girls are responsible for controlling a man's sexual urges

What are the consequences of intimate partner violence?

IPV affects women's physical and mental health through direct pathways, such as injury, and indirect pathways, such as chronic health problems that arise from prolonged stress. A history of experiencing violence is therefore a risk factor for many diseases and conditions (2).[1]

Current research suggests that the influence of abuse can persist long after the violence has stopped. The more severe the abuse, the greater its impact on a woman's physical and mental health, and the impact over time of different types and multiple episodes of abuse appears to be cumulative (2).

Injury and physical health

The physical damage resulting from IPV can include: bruises and welts; lacerations and abrasions; abdominal or thoracic injuries; fractures and broken bones or teeth; sight and hearing damage; head injury; attempted strangulation; and back and neck injury (2). However, in addition to injury, and possibly far more common, are ailments that often have no identifiable medical cause, or are difficult to diagnose. These are sometimes referred to as 'functional disorders' or 'stress-related conditions', and include irritable bowel syndrome/gastrointestinal symptoms, fibromyalgia, various chronic pain syndromes and exacerbation of asthma (2). In the *WHO multi-country study*, the prevalence of injury among women who had ever been physically abused by their partner ranged from 19% in Ethiopia to 55% in Peru. Abused women were also twice as likely as non-abused women to report poor health and physical and mental health problems, even if the violence occurred years before (3).

Mental health and suicide

Evidence suggests that women who are abused by their partners suffer higher levels of depression, anxiety and phobias than non-abused women (2). In the *WHO multi-country study*, reports of emotional distress, thoughts of suicide, and attempted suicide were significantly higher among women who had ever

[1] These are described in greater detail in the information sheet *Health consequences* in this series.

experienced physical or sexual violence than those who had not (3). In addition, IPV has also been linked with (2):

- alcohol and drug abuse;
- eating and sleep disorders;
- physical inactivity;
- poor self-esteem;
- post-traumatic stress disorder;
- smoking;
- self-harm; and
- unsafe sexual behaviour.

Sexual and reproductive health

IPV may lead to a host of negative sexual and reproductive health consequences for women, including unintended and unwanted pregnancy, abortion and unsafe abortion, sexually transmitted infections including HIV, pregnancy complications, pelvic inflammatory disease, urinary tract infections and sexual dysfunction (13–16). IPV can have a direct effect on women's sexual and reproductive health, such as sexually transmitted infections through forced sexual intercourse within marriage, or through indirect pathways, for example, by making it difficult for women to negotiate contraceptive or condom use with their partner (1,17,18).

Violence during pregnancy

Studies have found substantial levels of physical IPV during pregnancy in settings around the world. The *WHO multi-country study* found prevalences of physical IPV in pregnancy ranging from 1% in urban Japan to 28% in provincial Peru, with prevalences in most sites of 4–12% (3). Similarly, a review of studies from 19 countries found prevalences ranging from 2% in settings such as Australia, Denmark and Cambodia, to 13.5% in Uganda, with the majority ranging between 4% and 9% (19). A few facility-based studies in some settings have found even higher prevalences, including one from Egypt with an estimated prevalence of 32% (20) and a review of studies from Africa that found a prevalence as high as 40% in some settings (21).

Violence during pregnancy has been associated with (1,19–21):

- miscarriage;
- late entry into prenatal care;
- stillbirth;
- premature labour and birth;
- fetal injury; and
- low-birth-weight or small-for-gestational-age infants.

IPV may also account for a proportion of maternal mortality, although this association is often unrecognized by policy-makers.

Homicide and other mortality

Studies from a range of countries have found that 40–70% of female murder victims were killed by their husband or boyfriend, often in the context of an abusive relationship (2).[1] In addition, evidence suggests that IPV increases the risk of a woman committing suicide (22), and may also increase the risk of contracting HIV, and thus of AIDS-related death (16,18).

Effects on children

Many studies have found an association between IPV against women and negative social and health consequences for children, including anxiety, depression, poor school performance and negative health outcomes (2). A large body of evidence indicates that exposure to IPV against the mother is one of the most common factors associated with male perpetration and female experience of IPV later in life (4,11). A number of studies have found an association between IPV and child abuse within the same household (23).[2] In addition, studies from some low-income countries, including Nicaragua and Bangladesh have found that children whose mothers were abused (24,25):

- are less likely to be immunized;
- have higher rates of diarrhoeal disease; and/or
- are at greater risk of dying before the age of five.

What are the best approaches to preventing and responding to IPV?

In recent years, a number of international reviews have synthesized evidence on effective, or at least promising, approaches to preventing and responding to violence against women, including IPV (9,26–28). These reviews suggest a need for comprehensive, multi-sectoral, long-term collaboration between governments and civil society at all levels of the ecological framework. Unfortunately, while individual-level interventions are relatively easy to assess, evaluation of comprehensive, multi-level, multi-component programmes and institution-wide reforms is more challenging, and therefore, while these approaches are almost certainly the key to long-term prevention, they are also the most under-researched (27). However, these reviews have identified a set of specific strategies that have demonstrated promise or effectiveness, including:

- reform civil and criminal legal frameworks;
- organize media and advocacy campaigns to raise awareness about existing legislation;
- strengthen women's civil rights related to divorce, property, child support and custody;
- build coalitions of government and civil society institutions;
- build the evidence base for advocacy and awareness;
- use behaviour change communication to achieve social change;
- transform whole institutions in every sector, using a gender perspective; in particular, integrate attention to violence against women into sexual and reproductive health services;

[1] Aspects of murder of women are described in greater detail in the information sheet *Femicide* in this series.

[2] This is described in greater detail in the information sheet *When violence against women and children occurs in the same household* in this series.

- promote social and economic empowerment of women and girls;
- build comprehensive service responses to IPV survivors in communities;
- design life-skills and school-based programmes;
- engage men and boys to promote nonviolence and gender equality; and
- provide early-intervention services to at-risk families.

Life-skills and school-based programmes

Many initiatives have aimed to influence knowledge, attitudes and behaviours of young people through life-skills programmes in low-income countries (29) or classroom-based dating violence prevention programmes in the USA, such as Safe Dates, which demonstrated effectiveness in reducing perpetration (30).

Early intervention services for at-risk families

There is growing evidence that programmes aimed at parents, including home visits and education, can reduce or prevent child abuse and maltreatment (15) and thus help reduce child conduct problems and later violent behaviour, which has been associated with IPV perpetrated by men (31). Efforts to include an IPV component in these programmes are currently being tested.

Increase access to comprehensive service response to survivors and their children

As described by Heise and colleagues (1999), women who experience IPV have complex needs and may need services from many different sectors, including health care, social services, legal entities and law enforcement, and therefore, multi-sectoral collaboration is essential for ensuring survivors' access to comprehensive services (1). Evidence from many sectors indicates that the best way to improve the service response to survivors is to implement institution-wide reforms rather than narrow policy reforms or training – a strategy sometimes referred to as a 'systems approach' (1,26,32). A systems approach may include, for example:

- policies and infrastructure that protect the privacy and confidentiality of women;
- ongoing training and support for staff to ensure effective service provision;
- written protocols and referral systems to help survivors access services from other sectors;