kNOwVAWdata

Prevalence Rates, Trends and Disparities in Intimate Partner Violence:

POWER OF DATA IN THE IPV GEOSPATIAL DASHBOARD

UNFPA

Cover photo: Haitian woman doing laundry at her home. © Maxence Bradley

Acknowledgements

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Introduction

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Intimate partner violence (IPV) is the most common form of violence that women and girls face globally. Given prevailing social norms that sanction male dominance over women, violence between intimate partners is often perceived as an ordinary or normal element of relationships, particularly in the context of marriage or other unions.

Prevalence data are required to measure the magnitude of the problem; understand the various forms of violence and their consequences; identify groups at high risk; explore the barriers to seeking help; and ensure that the appropriate responses are being provided. Such data is the starting point for informing laws, policies and developing effective responses and programmes. It also allows countries to monitor change over time and optimally target resources to maximize the effectiveness of interventions, especially in resource-constrained settings.

IPV includes any abuse perpetrated by a current or former partner within the context of marriage, cohabitation or any other formal or informal union. It is currently measured by the Sustainable Development Goals indicator 5.2.1, under Goal 5 and Target 5.2 (box 1).

The different forms of violence included in the indicator are defined as follows[1]:

1. **Physical violence** consists of acts aimed at physically hurting the victim and include, but are not limited to, acts like pushing, grabbing, twisting the arm, pulling hair, slapping, kicking, biting or hitting with a fist or object, trying to strangle or suffocate, burning or scalding on purpose, or threatening or attacking with some sort of weapon, gun or knife.
2. **Sexual violence** is defined as any sort of harmful or unwanted sexual behaviour that is imposed on someone, whether by use of force, intimidation or coercion. It includes acts of abusive sexual contact, forced engagement in sexual acts, attempted or completed sexual acts without consent, and non-contact acts such as being forced to watch or participate in pornography, etc. In intimate partner relationships, sexual violence is commonly defined as: being physically forced to have

BOX 1: SUSTAINABLE DEVELOPMENT GOALS AND IPV

GOAL 5: Achieve gender equality and empower all women and girls

Target 5.2: Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation

Indicator 5.2.1: Proportion of ever-partnered women and girls aged 15 years and older subjected to physical, sexual or psychological violence by a current or former intimate partner in the previous 12 months, by form of violence and by age *

* Due to constraints related to feasibility, global reporting on this indicator currently reflects the percentage of ever-partnered women and girls aged 15 to 49 who have experienced physical and/or sexual partner violence.

1 For a more detailed definition of physical, sexual and psychological violence against women see Guidelines for Producing Statistics on Violence against Women – Statistical Surveys (UN, 2014), the International Classification of Crime for Statistical Purposes ICCS (UNODC, 2015) and Violence Against Women Key Terminology - kNOwVAWdata (UNFPA 2016). https://asiapacific.unfpa.org/en/publications/violence-against-women-key-terminology-knowvawdata

sexual intercourse, having sexual intercourse out of fear for what the partner might do or through coercion, and/or being forced to so something sexual that the woman considers humiliating or degrading.

3. **Psychological violence** consists of any act intended to induce fear or emotional distress caused by a person's behaviour or act. It includes a range of behaviours that encompass acts of emotional abuse such as being frequently humiliated in public, intimidated or having things you care for destroyed, etc. These often coexist with acts of physical and sexual violence by intimate partners. In addition, surveys often measure controlling behaviours (e.g. being kept from seeing family or friends, or from seeking health care without permission).

Measurement of SDG indicator 5.2.1 relies on population-based household surveys that implements an internationally standardized methodology. The inclusion of a Domestic Violence Module in the Demographic and Health Surveys has provided a significant amount of data. Additional data comes from dedicated surveys on violence against women in countries that have implemented, for example, the World Health Organization's violence against women survey methodology. Where available, other national-specific dedicated surveys are included if the data are deemed comparable.

UNFPA launched its first geospatial IPV dashboard on intimate partner violence (IPV) in December 2020, As reliable, comparable data on violence against women is essential to prevention and response efforts. It features data on the proportion of ever-partnered women who experienced IPV in the past 12 months. It uses the latest SDG indicator 5.2.1 data that governments have reported to the United Nations for the Sustainable Development Goals. Data in the IPV dashboard follows the definition in box 1.

The dashboard features sub-national data and disaggregated data by age, urban-rural employment, women's highest level of education, and household wealth. This IPV dashboard offers the highest data coverage of any related source, including data for 119 countries covering all regions of the world (table 1). This is a powerful new tool to see where women are at greatest risk, and tailor programming accordingly.

The dashboard can be accessed at: https://pdp.unfpa.org/intimate-partner-violence/.

TABLE 1:
NUMBER OF COUNTRIES INCLUDED IN THE DASHBOARD WITH AVAILABLE IPV DATA

DATA	# COUNTRIES WITH AVAILABLE DATA
National IPV Rates	119
Residence	54
Age group*	68
Education	54
Employment	51
Wealth	51

**Only seven age groups were included in the current report, the IPV dashboard includes other age group categories for specific countries*

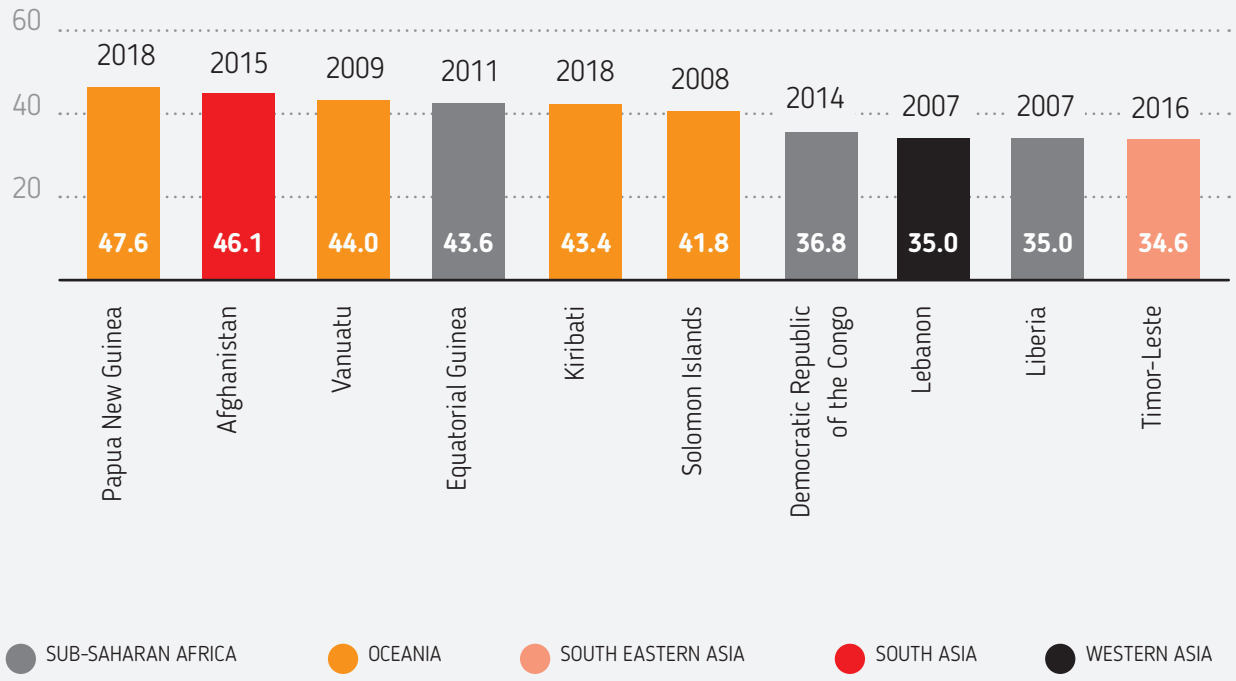
This report will demonstrate the power of the readily available, accessible, accurate data provided by the UNFPA IPV Dashboard. It will do so by telling the story of IPV in the top 10 countries with the highest IPV levels in the past 12 months; disparities at the sub-national level by place of residence, age, level of education, household wealth, women's employment status; and changes in IPV over time for countries in which more than two data points are available. It is based on data from the IPV dashboard. Counties are clustered by SDG region[2] in the analysis.

2 For more information, see https://unstats.un.org/sdgs/indicators/regional-groups.

1 Top 10 countries with highest 12-month IPV rates

Christina Rizk© UNFPA

FIGURE 1:
TEN COUNTRIES WITH THE HIGHEST PROPORTIONS OF WOMEN EXPERIENCING PHYSICAL AND/OR SEXUAL VIOLENCE IN THE LAST 12 MONTHS



The above graph used data collected for women aged 15 to 49 from Demographic and Health Surveys (DHS) and other national surveys. IPV in this report is measured as the proportion of ever-partnered women who experienced physical and/or sexual violence in the 12 months prior to the survey interview.

The proportion of women experiencing physical and/or sexual violence in the last 12 months for the 10 countries ranged from 34.6 per cent in Timor-Leste to a high of 47.6 per cent in Papua New Guinea..

The 10 countries with the **highest 12-month prevalence rates** for IPV were geographically spread, with most coming from two subregions:

- Three countries from sub-Saharan Africa (Equatorial Guinea, Democratic Republic of the Congo and Liberia) have IPV prevalence rates ranging from 35.0 to 43.6 per cent (showing grey in figure 1);
- Four countries from Oceania (Kiribati, Papua New Guinea, Vanuatu, Solomon Islands) have an IPV range from 41.8 to 47.6 per cent (showing orange in figure 1).

2 IPV sub-national **disparities**

Georgina Goodwin© UNFPA

A prominent feature of the UNFPA IPV dashboard is that it provides sub-national data. This data maps in-country variation and cross-border patterns in the prevalence of physical and/or sexual violence against ever-partnered women (aged 15-49) by a current or former intimate partner in the previous 12 months.

2.1. Why we need sub-national data

With the emphasis of the Sustainable Development Goals on leaving no one behind there is increasing demand for disaggregated data.[3] The challenge, however, is the availability of integrated and quality data sets related to sub-national entities.

Often national-level data do not shed light on sub-national social dynamics. This information that is important for policymakers, for advocacy purposes and for development stakeholders to design and implement effective and contextually-relevant interventions at the local level. Such information can then feed into the national and global agenda. Also, being able to compare data among neighbouring provinces and across borders can be extremely helpful to understanding where efforts must be concentrated, accelerated and scaled up.

2.2.What does the IPV dashboard sub-national data tell us?

The IPV dashboard provides disaggregation of IPV prevalence at sub-national administrative level 1 for 58 of the 119 countries included, as of the first official release on 3 December 2020.[4] Subnational data sources are mainly the DHS, as well as a small number of other national violence against women prevalence surveys such as the National Study on Women's Health and Life Experiences 2017 in Bhutan, and the National Study on Violence against Women in Viet Nam 2019.[5]

The dashboard reveals that national aggregates often mask significant sub-national variations. In most countries with available disaggregated data, IPV prevalence among women and girls aged 15-49 differs significantly across administrative areas.

In Afghanistan, where national 12-month IPV prevalence was 46.1 per cent according to the 2015 Afghanistan DHS, rates vary widely across the country. They range from 4.5 per cent in Helmand Province to 90.3 per cent in Ghor (figure 2).

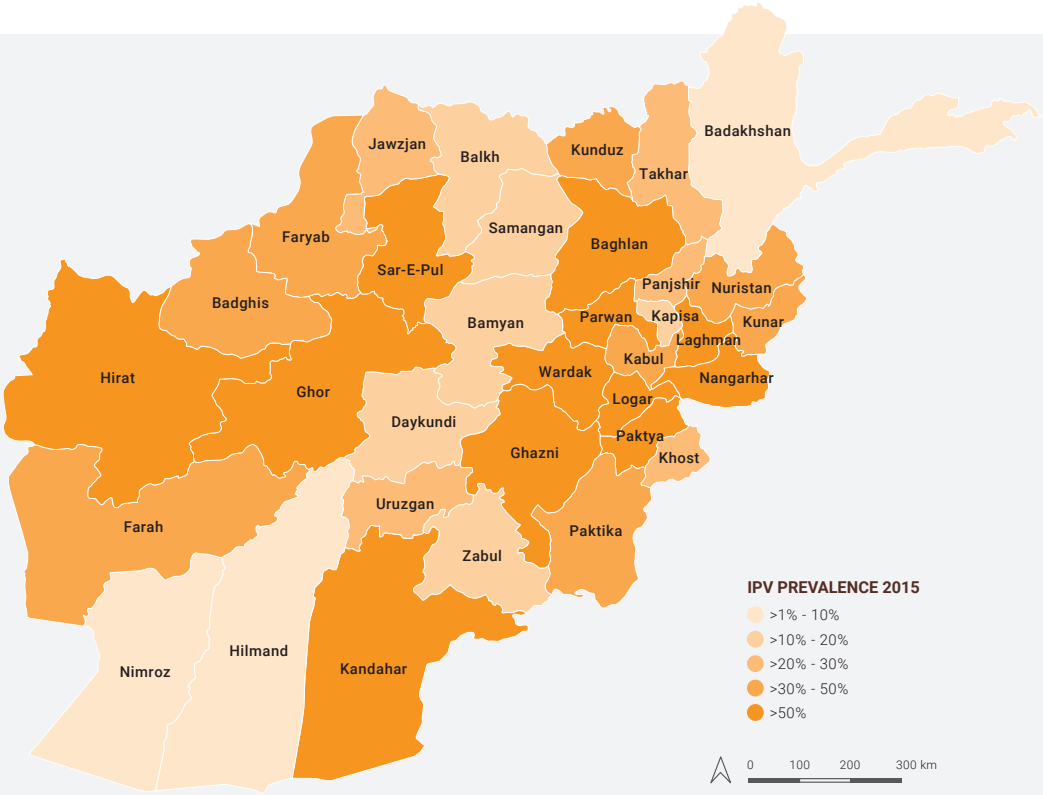
Similarly, the 2015-2016 Tanzania Demographic Health Survey estimated that prevalence of intimate partner violence varied from 4.6 per cent in Pemba South to 56.8 per cent in Mara province (figure 3) while the national estimate was 29.6 per cent.

3 Sustainable Development Goal indicator 17.18 states: "By 2020, enhance capacity building support to developing countries, including for LDCs and SIDS, to increase significantly the availability of high-quality, timely and reliable data disaggregated by income, gender, age, race, ethnicity, migratory status, disability, geographic location and other characteristics relevant in national contexts."

4 Administrative level 1 first-level administrative division of a country is the standard neutral reference for the largest administrative division or officially-delineated geographical area within a particular country (such as the states in the United States or Germany).

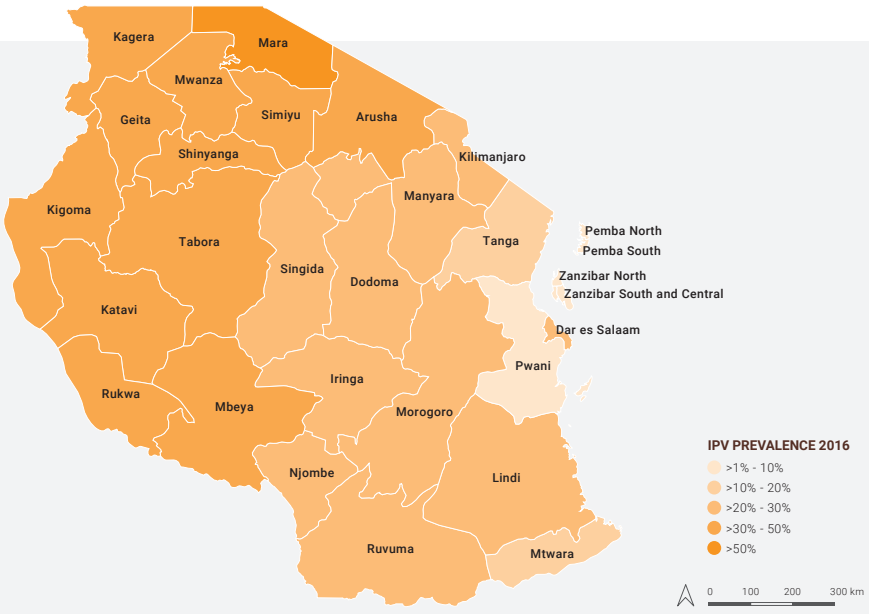
5 These surveys collect IPV data in a comparable way, using questions on behavioural acts.

FIGURE 2:
IPV PREVALENCE AT SUB-NATIONAL LEVEL IN AFGHANISTAN (DHS 2015).



Data Source: Afghanistan DHS 2015

FIGURE 3:
IPV PREVALENCE AT SUB-NATIONAL LEVEL IN TANZANIA (DHS 2015-2016).

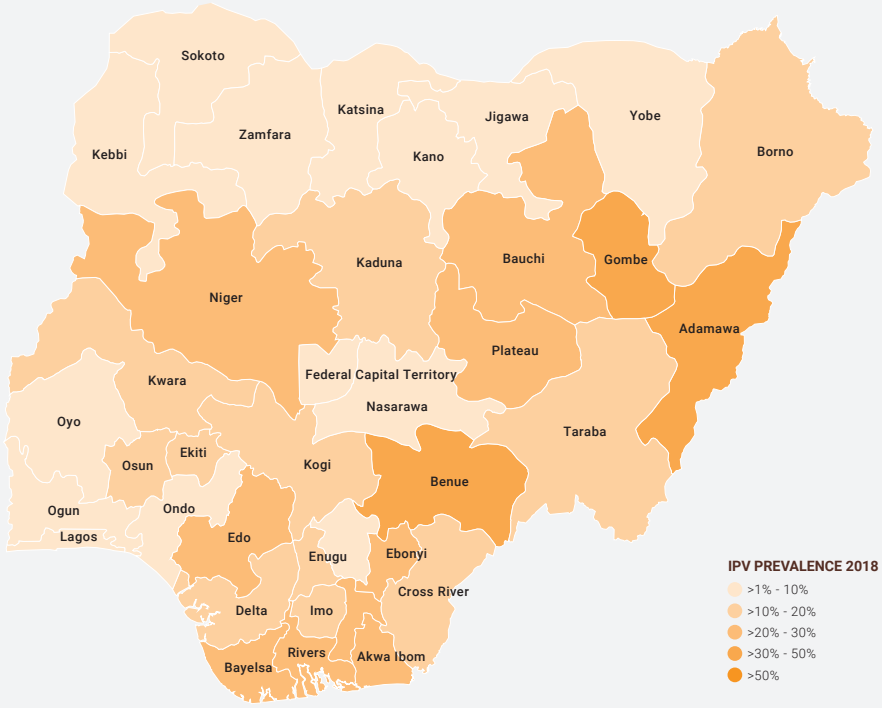


Data Source: Tanzania DHS 2015-2016

According to the 2018 Nigeria DHS, the national 12-month IPV prevalence rate measured 13.8 per cent and ranged from 2.6 per cent in Sokoto State to 35.6 per cent in Gombe State (figure 4).

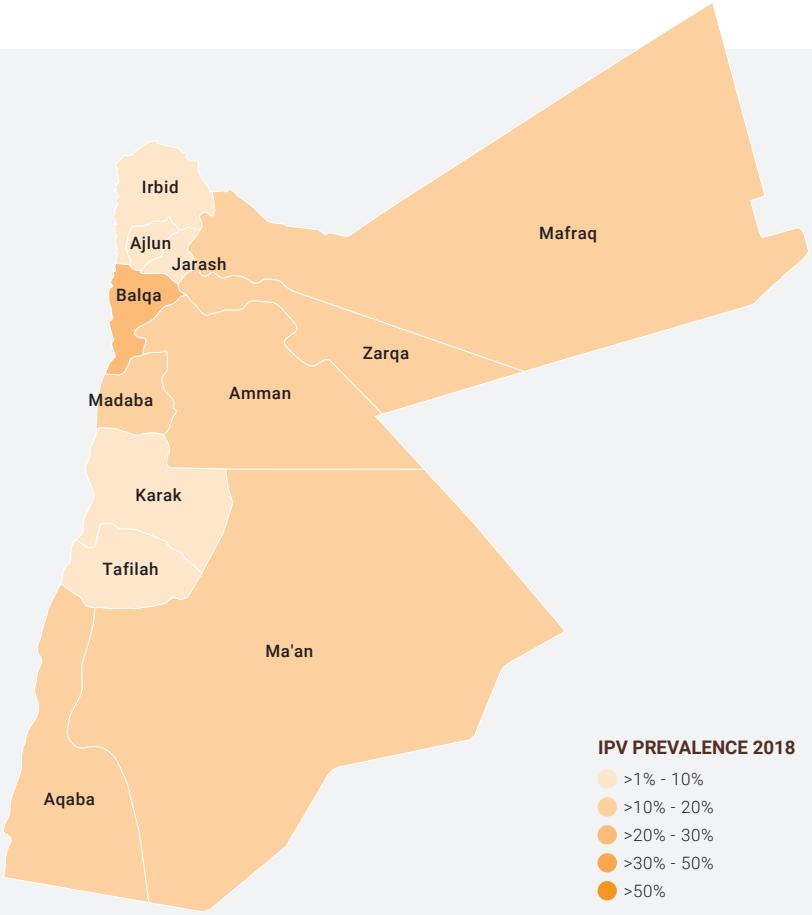
The 2017-2018 Jordan DHS estimated that nationally 13.8 per cent of ever-partnered women had experienced physical and/or sexual violence by a current or former partner in the previous 12 months, a figure that ranges from 3.0 per cent in Karak, to a high of 24.3 per cent in the Balqa Governorate (figure 5).

FIGURE 4:
IPV PREVALENCE AT SUB-NATIONAL LEVEL IN NIGERIA (DHS 2018).



Data Source: Nigeria DHS 2018

FIGURE 5:
IPV PREVALENCE AT SUB-NATIONAL LEVEL IN JORDAN (DHS 2017-2018).



Data Source: Jordan DHS 2017-2018

Subnational data contributes to the identification of **similar patterns** in IPV prevalence across borders. For instance, the border of Ethiopia and Kenya shows similar levels of IPV between the Kenyan North-Eastern province (5.8 per cent) and the Ethiopian Somali province (5.8 per cent), as well as between the Kenyan Eastern province (25.1 per cent) and the Ethiopian Oromia province (25.3 per cent) (figure 6).

The Manica province (22.5 per cent) and the Gaza province (21.9 per cent) in Mozambique also show similar rates of IPV prevalence with the bordering Manicaland province (23.6 per cent) and the Masvingo province (20.8 per cent) in Zimbabwe (figure 7).

FIGURE 6:
IPV PREVALENCE AT SUB-NATIONAL LEVEL IN THE BORDER AREAS OF ETHIOPIA (DHS 2016) AND KENYA (DHS 2014).

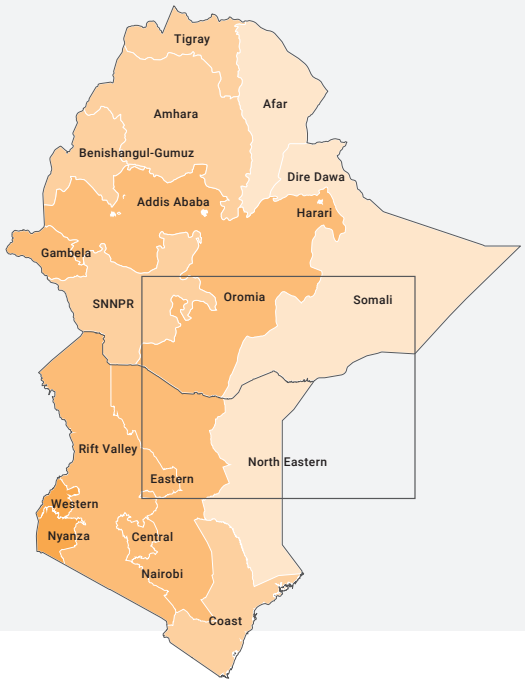
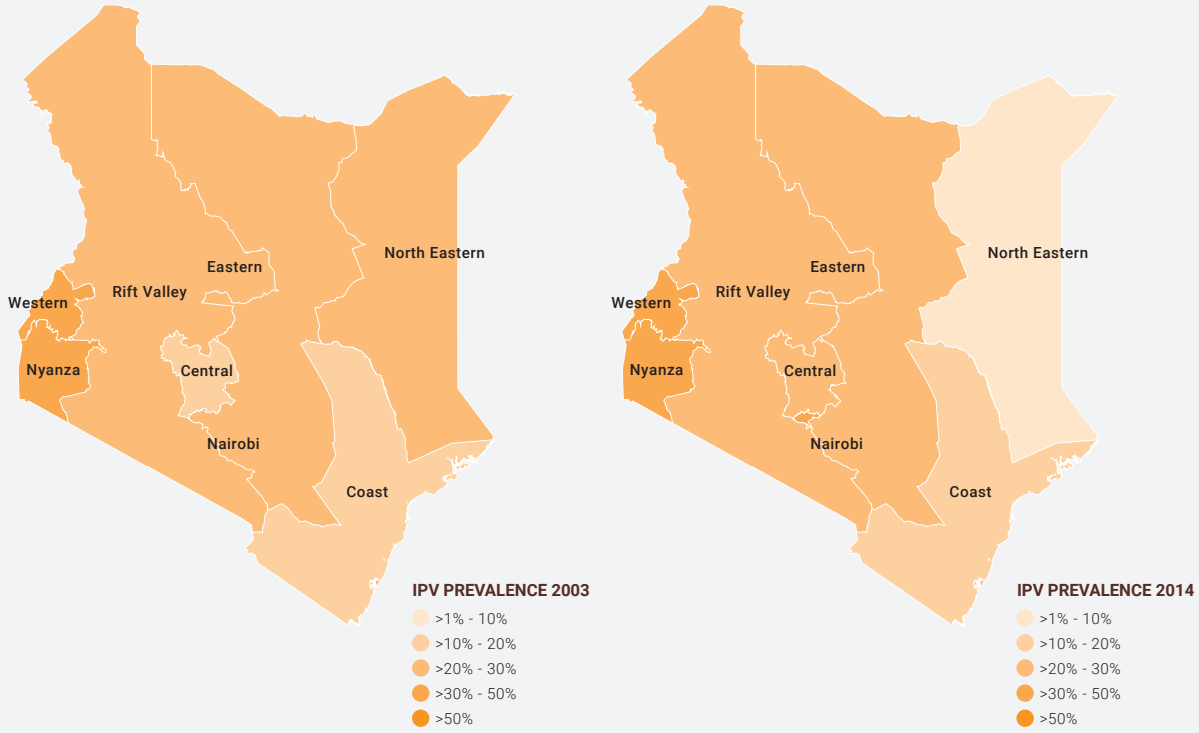


FIGURE 7:
IPV PREVALENCE AT SUB-NATIONAL LEVEL IN THE BORDER AREAS OF MOZAMBIQUE (DHS 2015) AND ZIMBABWE (DHS 2015).

2.3. Sub-national comparisons over time

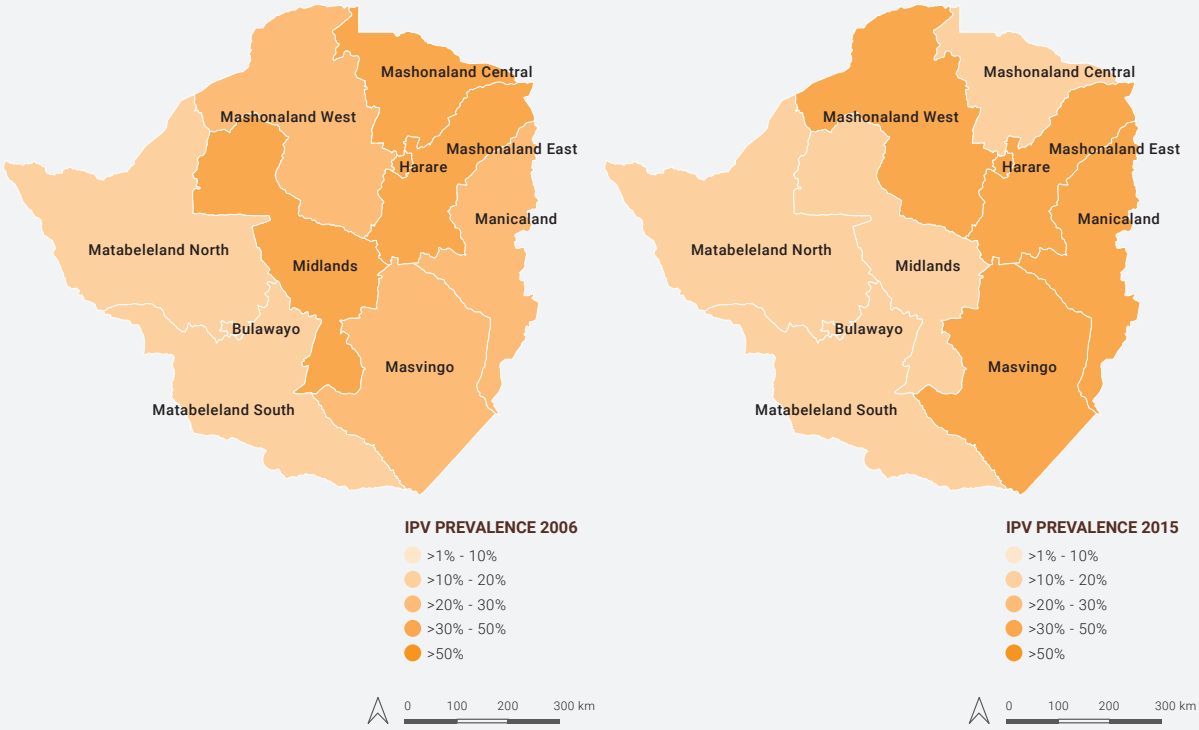
For the 25 countries where data is available for two or more time points, sub-national data allows for comparisons over time, giving an idea of the direction the prevalence of partner violence is heading, including in specific areas within a given country.

FIGURE 8:
IPV TREND AT SUB-NATIONAL LEVEL IN KENYA FROM 2003 TO 2014.



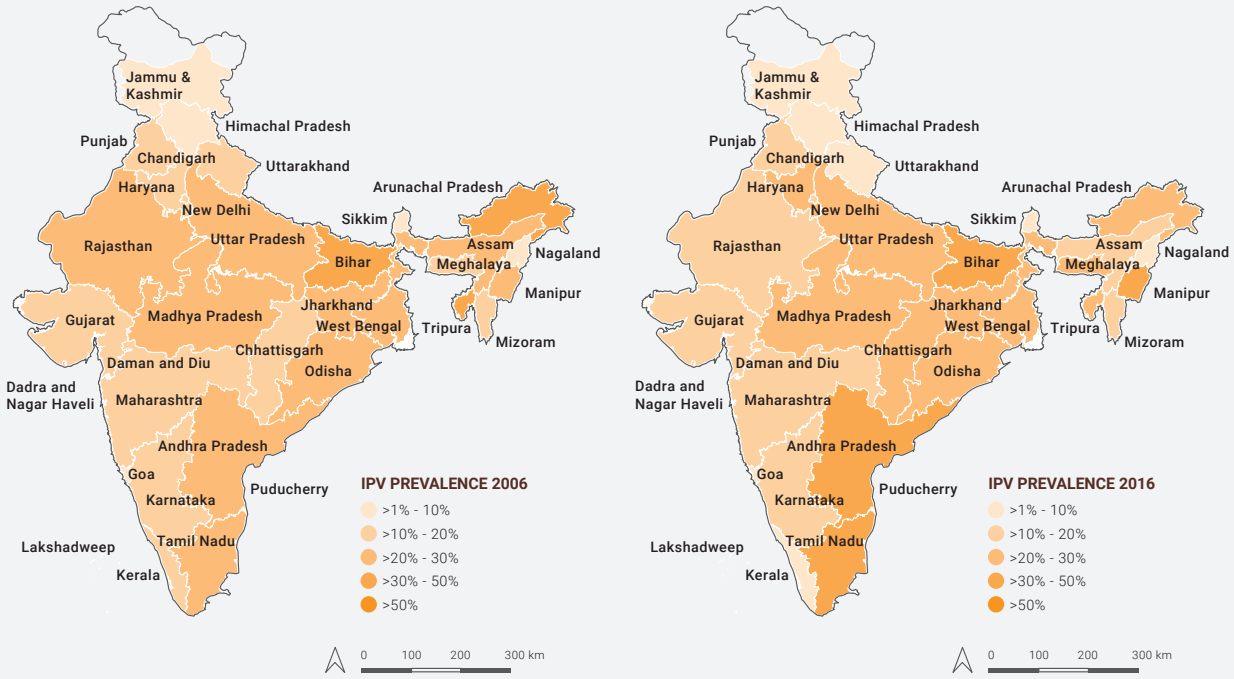
In Kenya, DHS data shows that in the North-Eastern province there was a substantial decrease in reported IPV prevalence, from 21.5 per cent in 2003 to 5.8 per cent in 2014. Conversely, reported IPV prevalence increased in Nairobi from 21.2 per cent in 2003 to 34.5 per cent in 2014 (figure 8).

FIGURE 9:
IPV TREND AT SUB-NATIONAL LEVEL IN ZIMBABWE, FROM 2006 TO 2015.



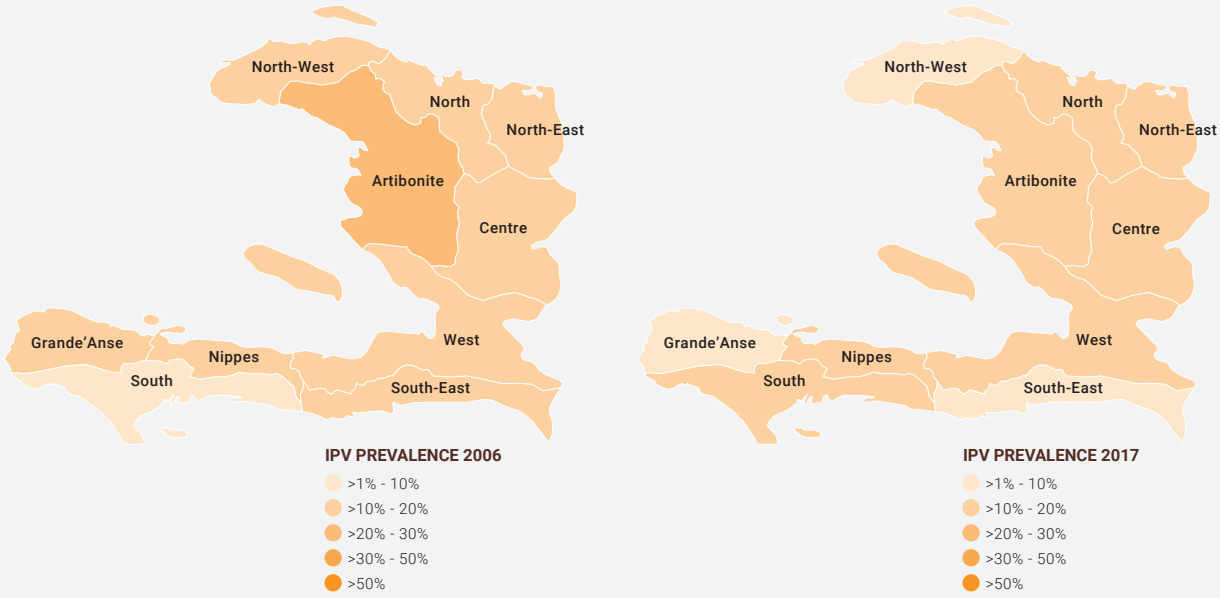
In Zimbabwe, DHS data also indicate a substantial decrease in IPV prevalence in the Midlands, Mashonaland Central and Mashonaland Eastern provinces, from 38.9, 31.3 and 34.6 per cent respectively in 2006 to 17.9, 19.3 and 20.2 per cent in 2015 (figure 9).

FIGURE 10:
IPV TREND AT SUB-NATIONAL LEVEL IN INDIA, FROM 2006 TO 2016.



In India, over the 10 years between 2006 and 2016, DHS data reveals reported increases in IPV in Tamil Nadu (21.0 to 35.2 per cent), Chhattisgarh (16.5 to 27.5 per cent) Andhra Pradesh (24.9 to 34.8 per cent), and Manipur (27.2 to 33.7 per cent). While decreases have been observed in Rajasthan (27.2 to 19 per cent), Uttaranchal (16.4 to 8.6 per cent), Kerala (10.9 to 9.5 per cent), Assam (26 to 17.3 per cent), Arunachal Pradesh (31.9 to 23.3 per cent) and Tripura (30.7 to 22.3 per cent). Finally, while IPV prevalence decreased only slightly in Bihar (44.1 to 37.5 per cent), it remains the State with the highest prevalence of IPV (figure 10).

FIGURE 11:
IPV TREND AT SUB-NATIONAL LEVEL IN HAITI, FROM 2006 TO 2017.



In Haiti, the Artibonite department experienced a decrease in reported IPV from 23.8 per cent in 2006 to 15.1 per cent in 2017 (figure 11). Further analysis of Haiti data is provided as a case study.

3 IPV prevalence among **women living in rural and urban areas** compared to national averages

Nancy Durrell McKenna© UNFPA

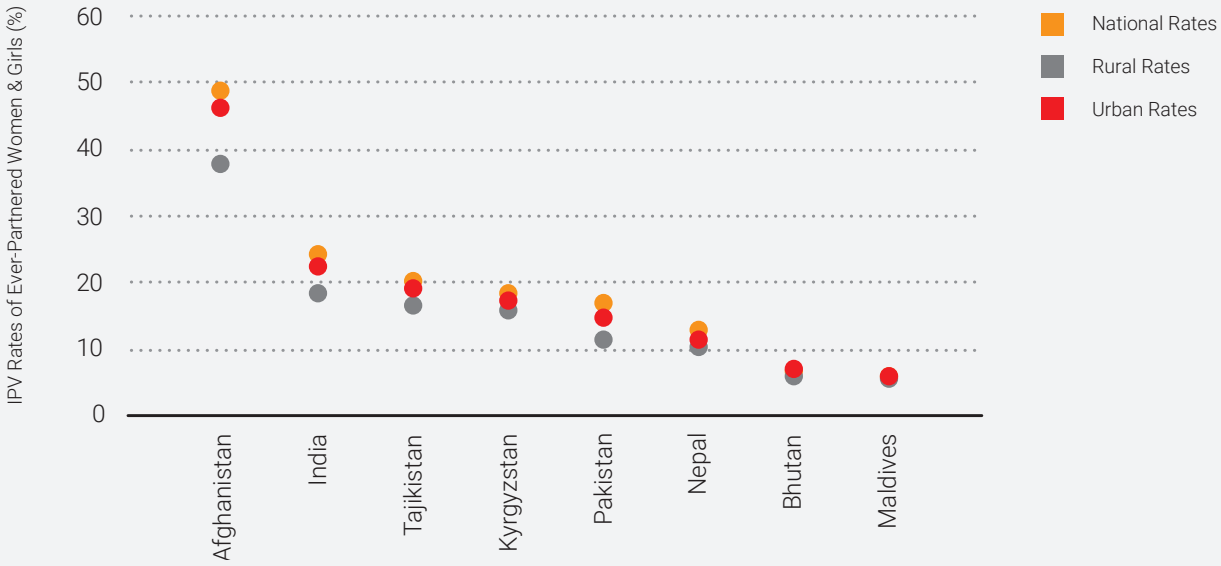
It is generally assumed that IPV prevalence is higher in rural areas compared to urban areas[6 7] (figure 12). This assumption was reflected in the current analysis with rural IPV prevalence in most regions higher than urban. The exceptions were countries in Latin America and the Caribbean. Fifty-four countries had available data disaggregated by urban and rural areas. IPV prevalence was higher in rural areas in 39 out of 54 countries when compared to urban areas- with 25/39 (64.1%) countries having an absolute difference of more than 2%. Where prevalence of IPV was higher in rural areas, the difference in prevalence was more than 10% in Burundi, Afghanistan and Timor-Leste. Among the 15 countries with higher IPV prevalence in urban areas, absolute differences of more than 2% were found in 13 countries. Only Honduras had an urban IPV prevalence of more than 10% when compared to rural areas. Some of the reasons for the high IPV disparity between rural and urban women could be attributed to the low socio-economic status of women and girls living in those areas, more tolerant attitudes and perceptions towards IPV, and the need to seek interventions from legal authorities when needed.

6 Edwards, K. (2015). Intimate Partner Violence and the Rural-Urban-Suburban Divide: Myth or Reality? A Critical Review of the Literature. *Trauma, Violence & Abuse, 16*(3), 359-373. doi:10.2307/26638364

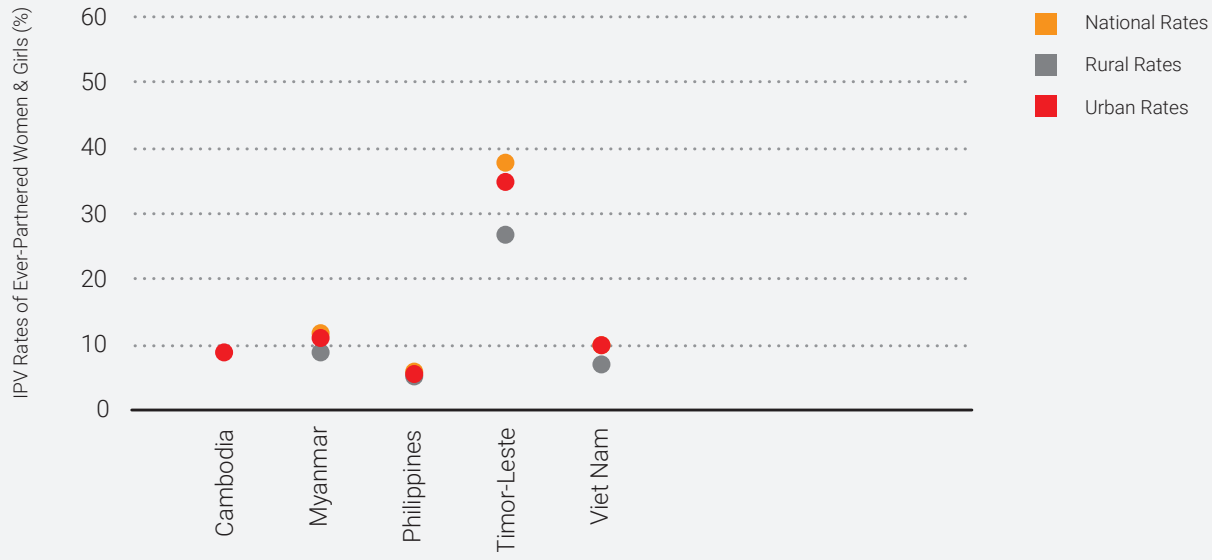
7 Peek-Asa, C., Wallis, A., Harland, K., Beyer, K., Dickey, P., & Saftlas, A. (2011). Rural disparity in domestic violence prevalence and access to resources. *Journal of women's health (2002), 2*0(11), 1743-1749. https://doi.org/10.1089/jwh.2011.2891

FIGURE 12:
IPV PREVALENCE AMONG EVER-PARTNERED WOMEN AND GIRLS AGED 15-49 YEARS, NATIONAL AND BY PLACE OF RESIDENCE, LATEST DATA, CLUSTERED BY SDG REGION.

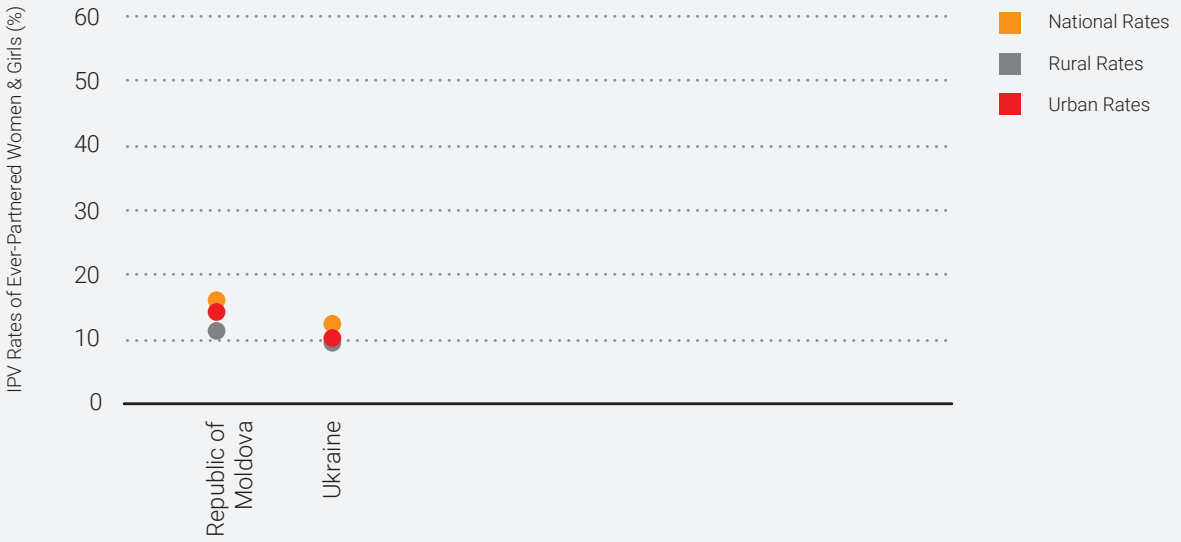
Central and Southern Asia



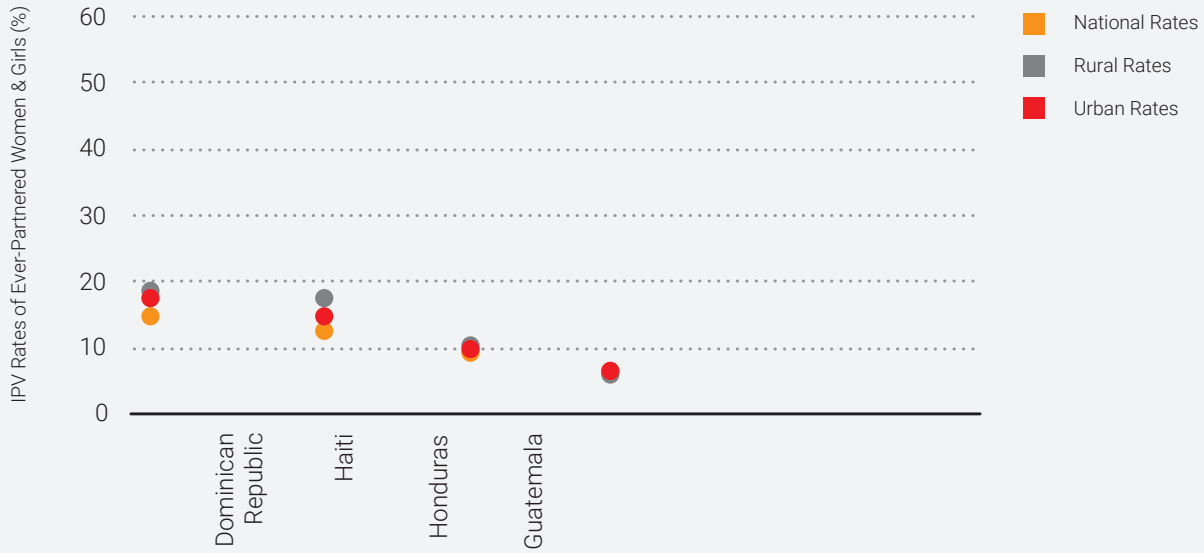
Eastern and South-Eastern Asia



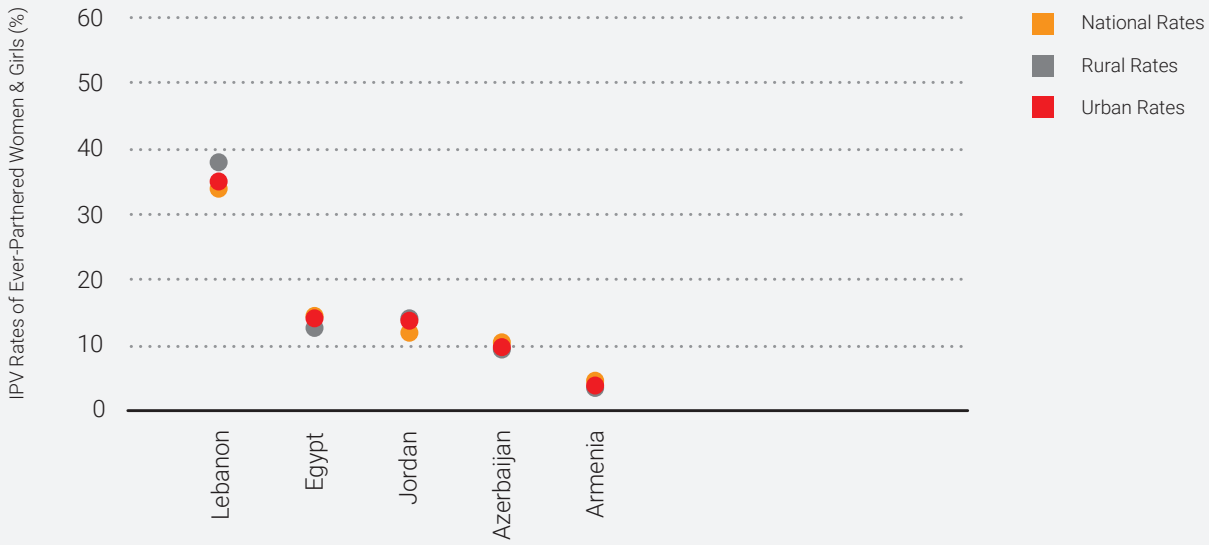
Europe



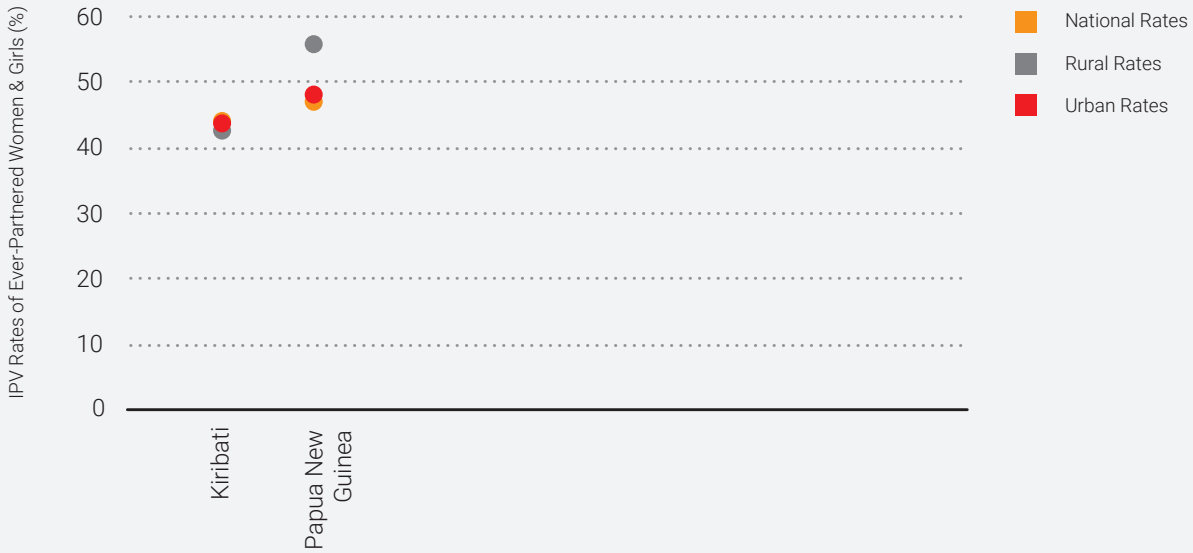
Latin America & Caribbean

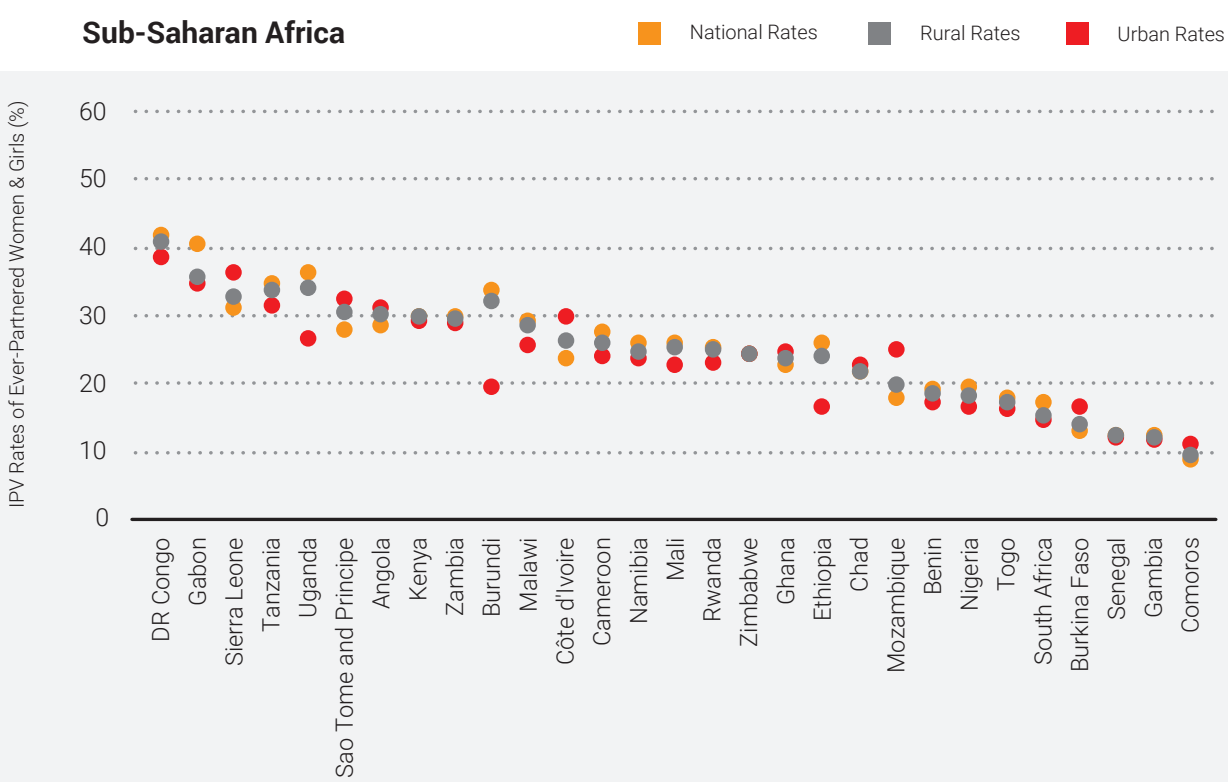


North Africa and Western Asia



Oceania




Sub-Saharan Africa
National Rates
Rural Rates
Urban Rates
IPV Rates of Ever-Partnered Women & Girls (%)
60
50
40
30
20
10
0
DR Congo
Gabon
Sierra Leone
Tanzania
Uganda
Sao Tome and Principe
Angola
Kenya
Zambia
Burundi
Malawi
Côte d'Ivoire
Cameroon
Namibia
Mali
Rwanda
Zimbabwe
Ghana
Ethiopia
Chad
Mozambique
Benin
Nigeria
Togo
South Africa
Burkina Faso
Senegal
Gambia
Comoros


Georgina Goodwin© UNFPA

4 IPV prevalence and **age distribution**

© UNFPA

Sixty-eight countries, included in this report, had IPV data by age groups, and data was mostly collected from national DHS and a few other surveys that collected data in a comparable way. While seven age groups were analysed in this current report, the IPV dashboard includes additional age group categories for specific countries, e.g. Cambodia. In most countries (86.7 per cent), IPV prevalence [8] was highest among women in the younger age groups, i.e. aged 15-34 years, compared with older women aged between 35-49 years (figure 13). Women and girls in the 15-19 year age groups had the highest prevalence across all age groups, and this was especially evident in Burundi, Central African Republic, Dominican Republic, Ghana, Haiti, Honduras, Lao People's Democratic Republic, Myanmar, Namibia, Nepal, Nicaragua, Papua New Guinea, Peru and Zimbabwe.

In seven countries, however, IPV rates of women in the older age groups, between 35-49 years, were higher than those between 15-34 years: Afghanistan, Armenia, Cambodia, El-Salvador, Kyrgyzstan, Tajikistan and Ukraine. Reported IPV was consistently lowest among women aged 45-49 years in most countries. These data suggest that violence starts early in intimate relationships.[9,10] This includes comprehensive sexuality education as a key way of engaging young people.

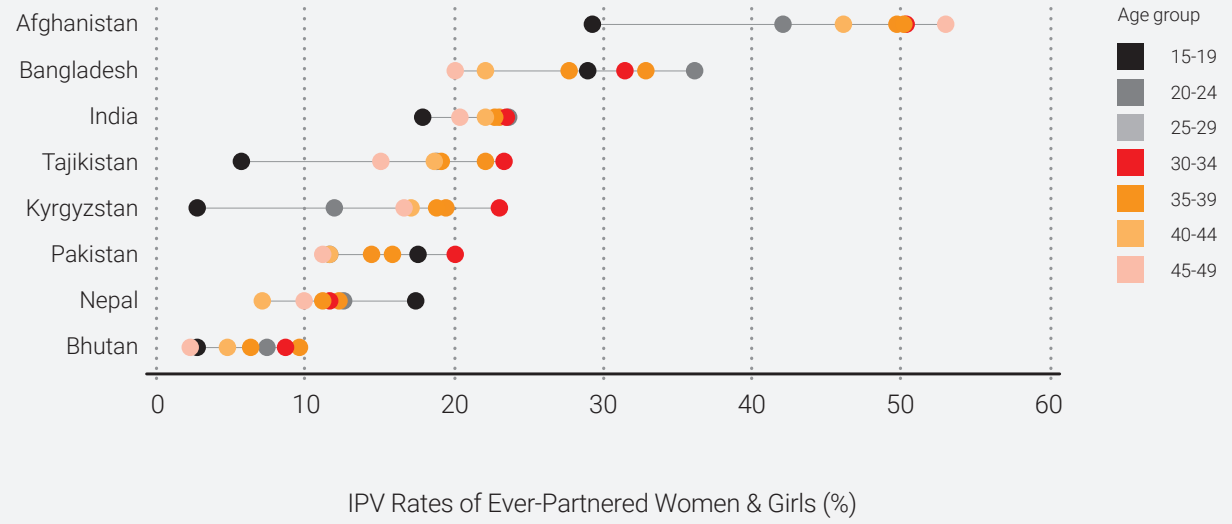
8 Data on intimate partner violence (IPV) collected by accredited surveys such as national demographic health surveys (DHS), United Nations agencies and other accredited IPV surveys, and reported as proportion of ever-partnered women and girls aged 15-49 subjected to physical and/or sexual violence by a current or former intimate partner in the previous 12 months.

9 CDC Fact Sheet. Available from: https://www.cdc.gov/violenceprevention/intimatepartnerviolence/fastfact.html.

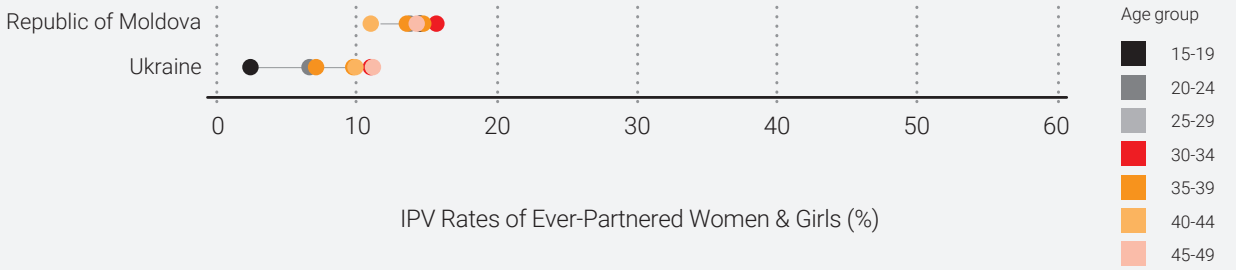
10 Bogat GA, Garcia AM, Levendosky AA. Assessment and psychotherapy with women experiencing intimate partner violence: integrating research and practice. Psychodyn Psychiatry. 2013 Summer;41(2):189-217. doi: 10.1521/pdps.2013.41.2.189. PMID: 23713618.

FIGURE 13:
IPV PREVALENCE AMONG EVER-PARTNERED WOMEN AND GIRLS AGED 15-49 YEARS BY AGE GROUPS, CLUSTERED BY SDG REGION[11]

Central and Southern Asia

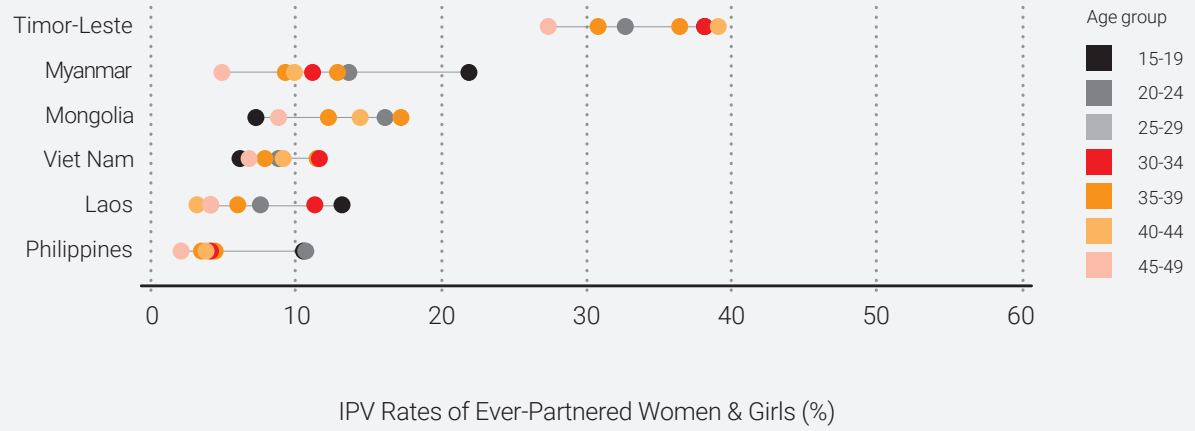


Europe

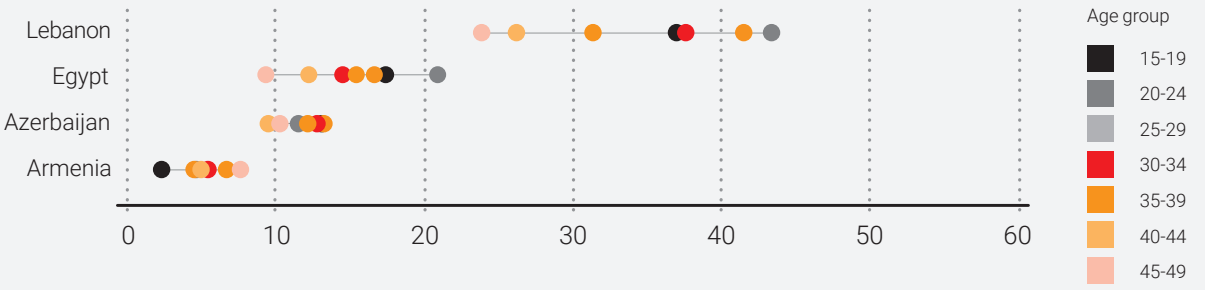


11 For more details on SDG regional classifications, please refer to https://unstats.un.org/sdgs/indicators/regional-groups

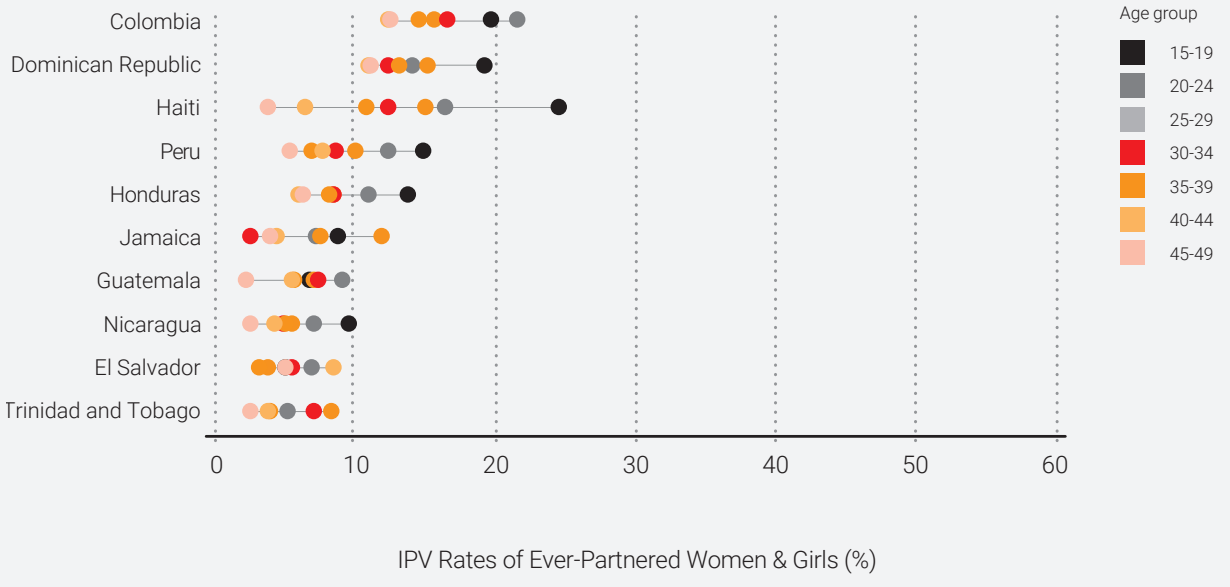
Eastern and South-Eastern Asia



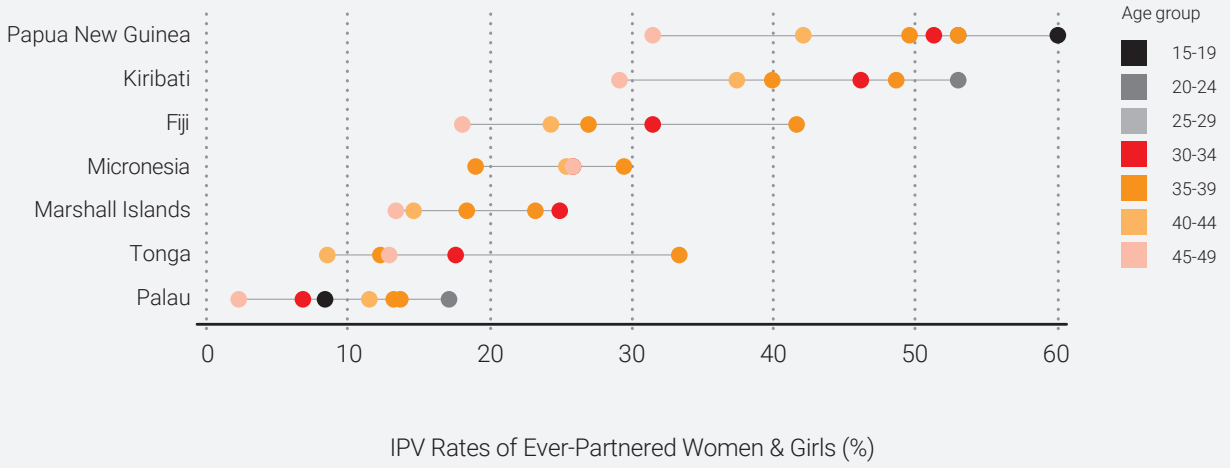
North Africa and Western Asia



Latin America and Caribbean

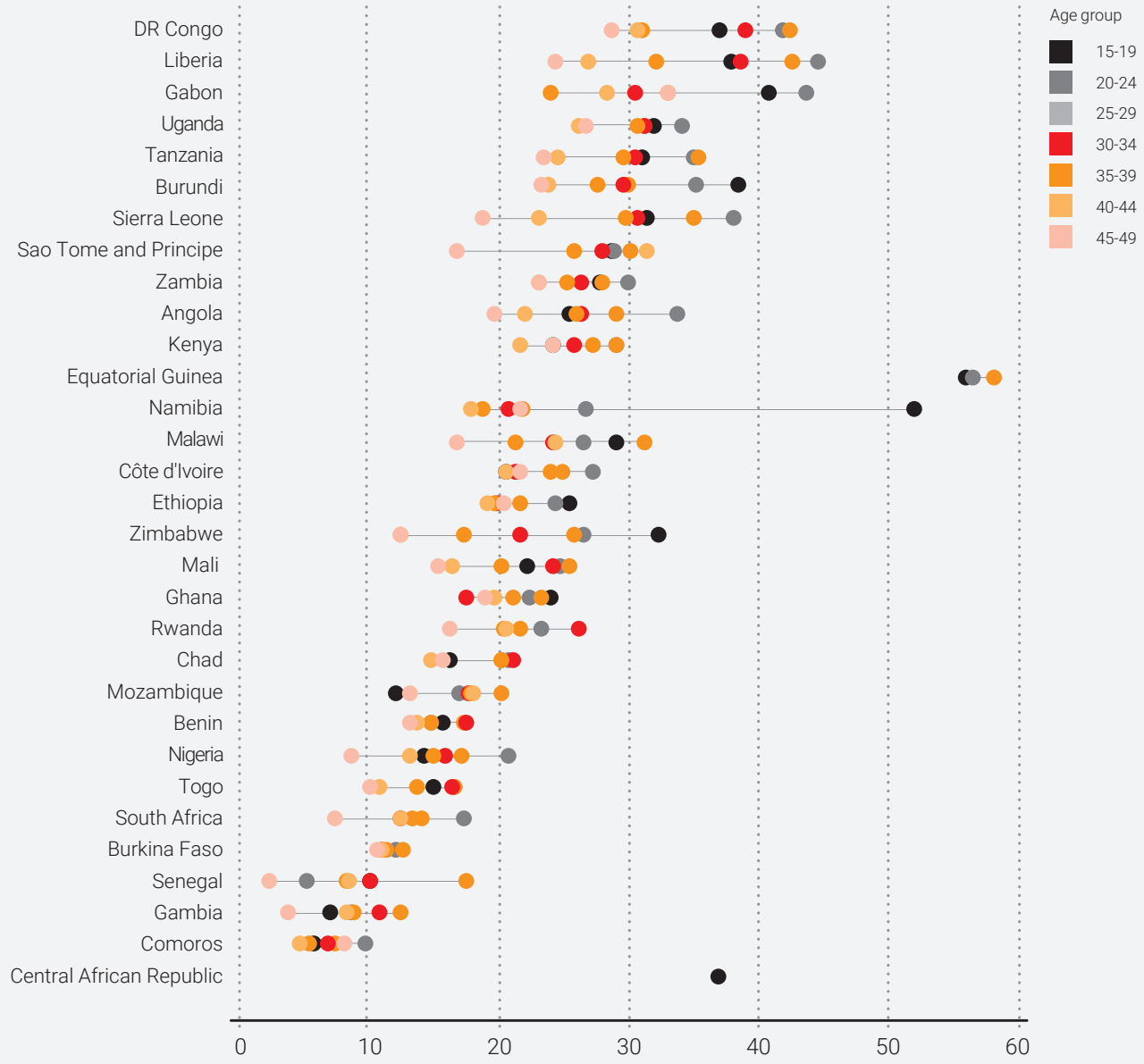


Oceania



IPV Rates of Ever-Partnered Women & Girls (%)

Sub-Saharan Africa



IPV Rates of Ever-Partnered Women & Girls (%)

© UNFPA

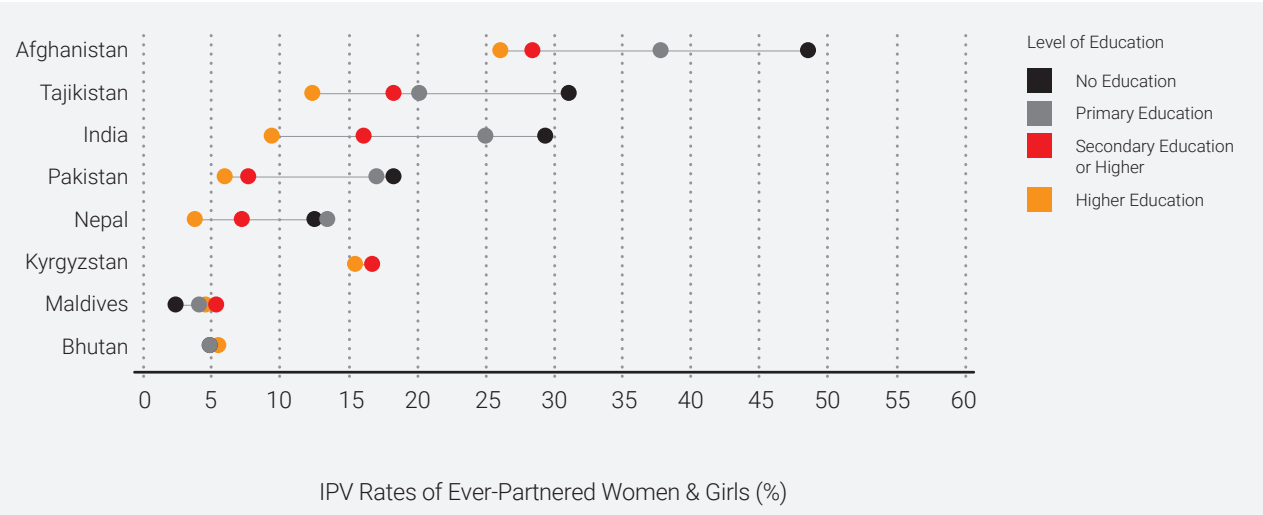
5 IPV prevalence by **level of education**

Gonzalo Bell© UNFPA

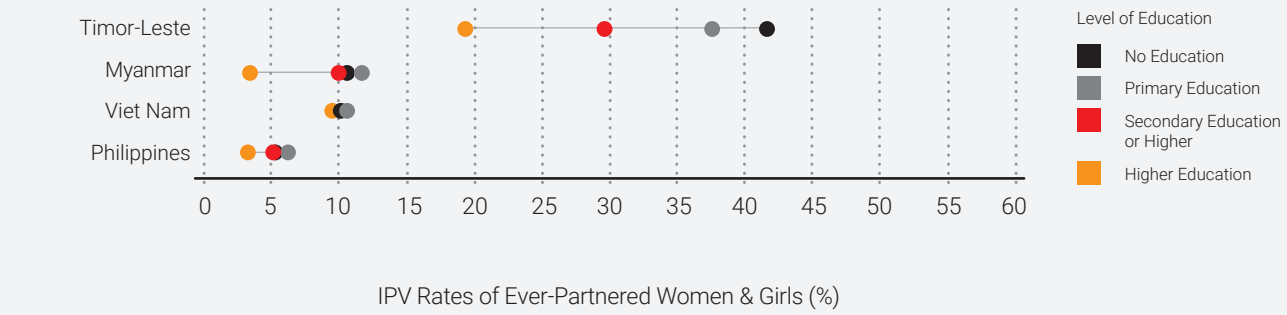
Overall, data from 54 countries with available data disaggregated by educational level showed that in a majority of countries (79.6 per cent), IPV rates were highest among women with the lowest level of education i.e. primary only or no education (figure 14). When comparing IPV rates among women with no education versus those with higher education, IPV prevalence was higher among women with no education – with absolute per cent difference in prevalence exceeding 10 per cent in 17 countries. The largest differences were observed in countries in Central and Southern Asia, Eastern and South-Eastern Asia and sub-Saharan Africa. Higher IPV prevalence among women with low educational attainment is not surprising as it has been hypothesized to be associated with limited opportunities for girls, e.g. in choice of partner and early marriage, employability, poverty, and a lack of voice and representation. While in a few countries a higher prevalence of IPV was reported among women with higher education compared with those with no formal education (i.e. Bhutan, Gambia, Lebanon, Maldives, Malawi, Mozambique, Papua New Guinea and Senegal), evidence of the protective effects of secondary (or more) education is overwhelming.

FIGURE 14: IPV PREVALENCE AMONG EVER-PARTNERED WOMEN AND GIRLS AGED 15-49 YEARS BY LEVEL OF EDUCATION, CLUSTERED BY SDG REGION.

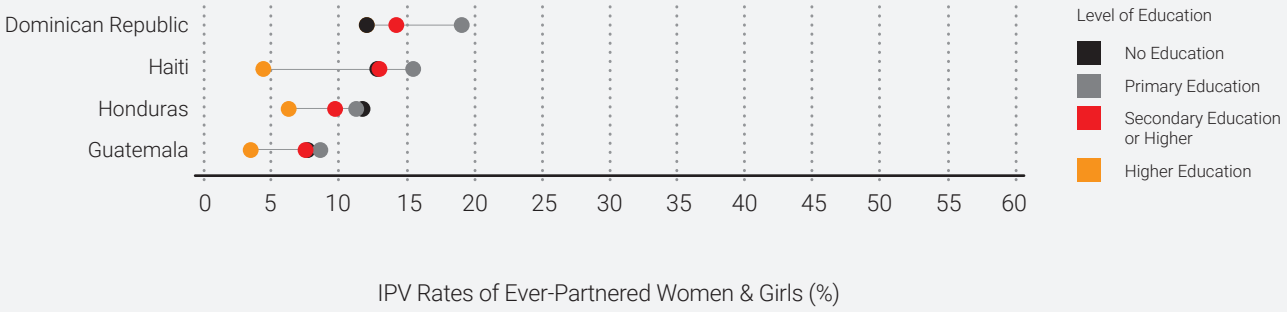
Central and Southern Asia



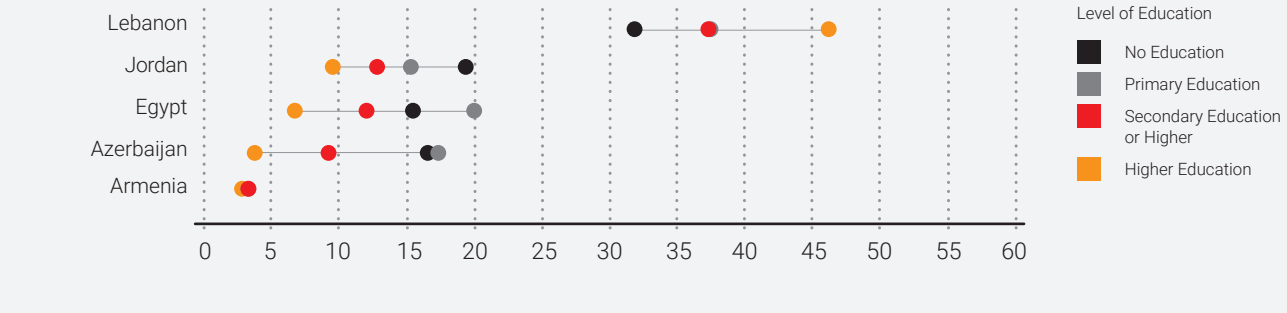
Eastern and South-Eastern Asia



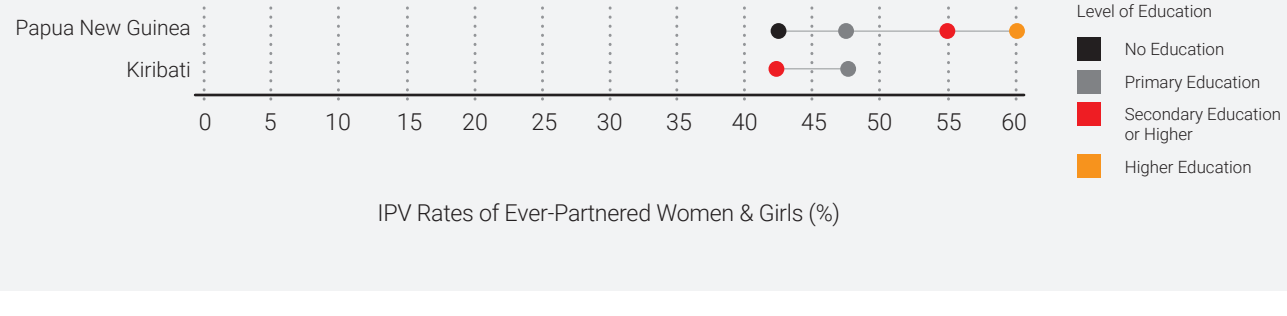
Latin America and Caribbean



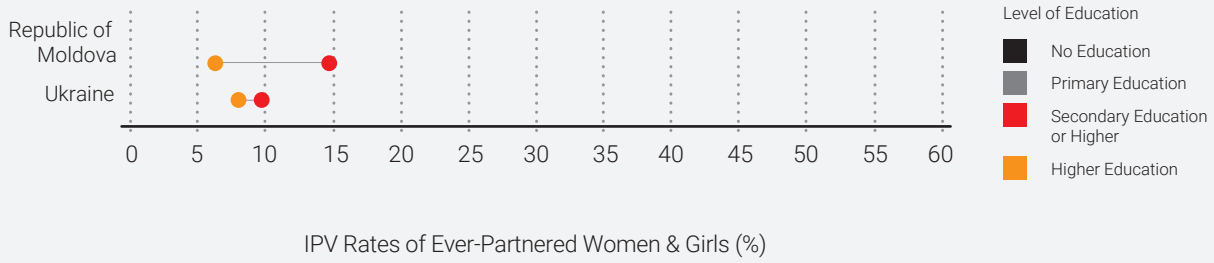
North Africa and Western Asia



Oceania

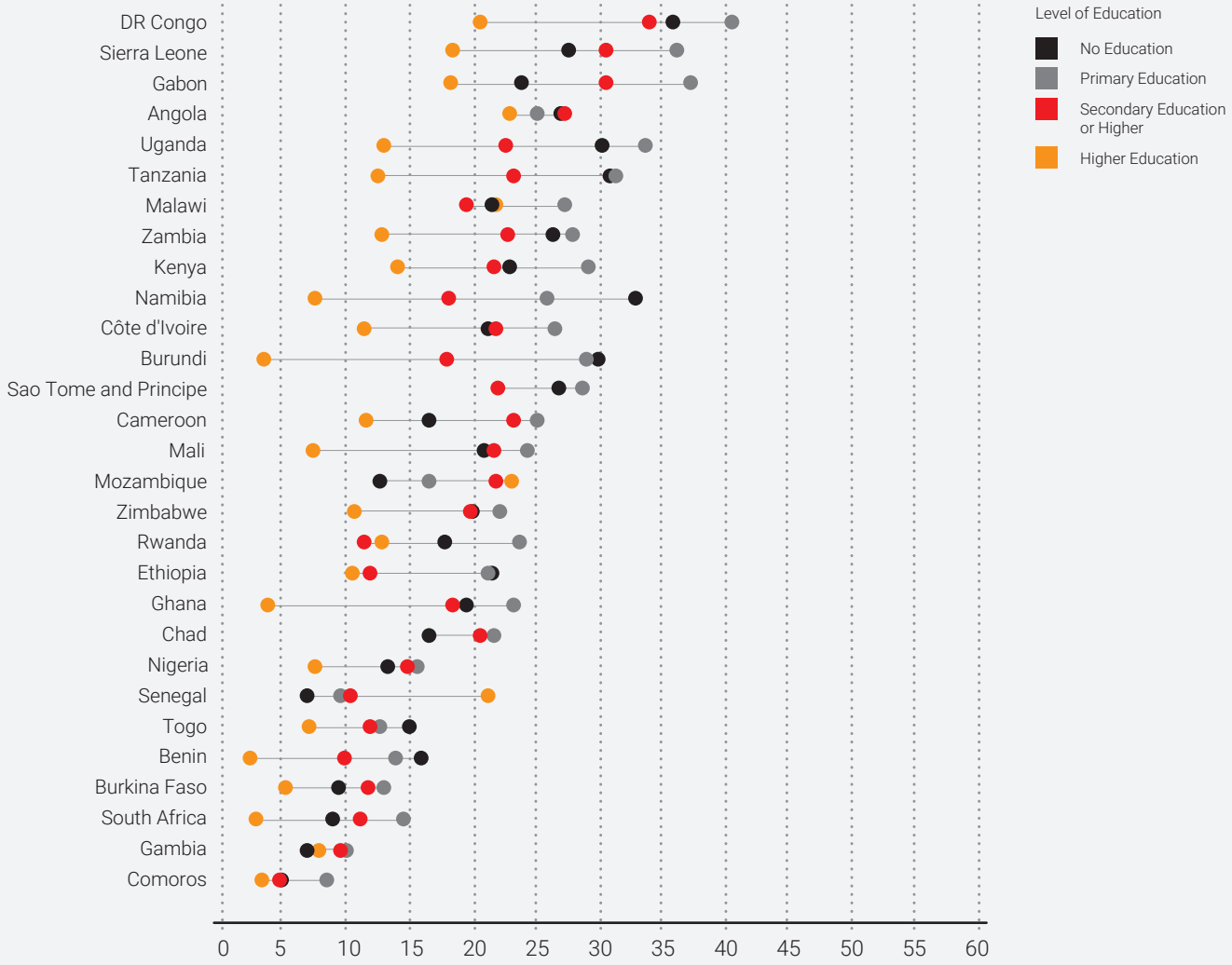


Europe



IPV Rates of Ever-Partnered Women & Girls (%)

Sub-Saharan Africa



IPV Rates of Ever-Partnered Women & Girls (%)

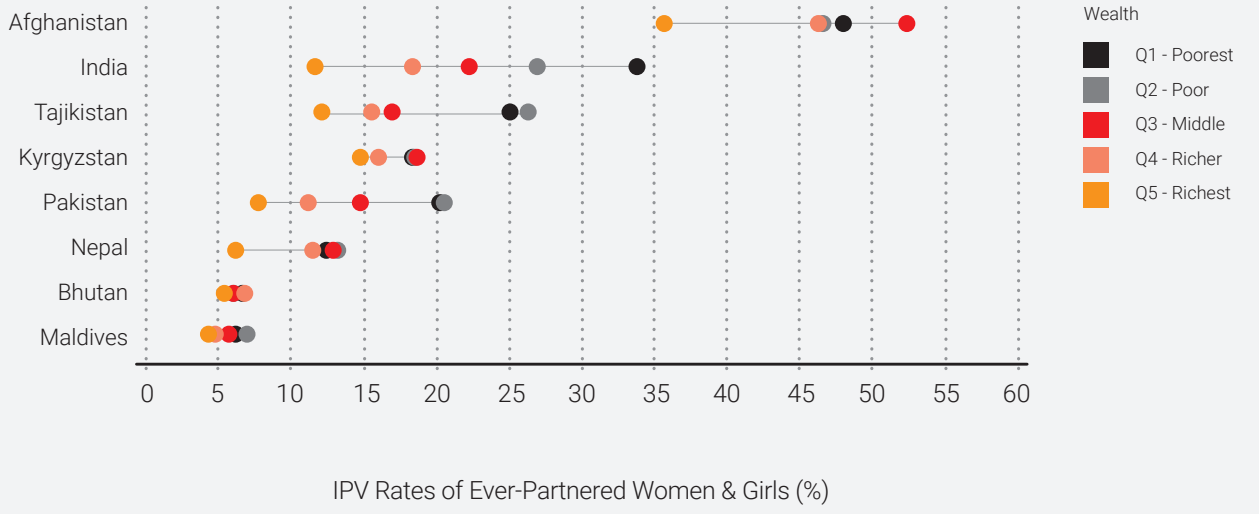
6 IPV prevalence by **wealth**

© UNFPA

In countries where information on household socioeconomic status and groupings was available, most (90 per cent of countries) reported higher IPV prevalence in the poorest households (Q1) compared with the richest households (Q5). Higher IPV prevalence among those in the richest household wealth group was reported in a few countries including: Burkina Faso, Côte d'Ivoire, Lebanon, Mozambique, Papua New Guinea and Sierra Leone (figure 15). These results are indicative of the possible association between poverty stress and increased women's risk of violence, as women in the lowest wealth groups are more likely to face economic insecurities preventing access to basic goods and services, including response services for IPV.[12]

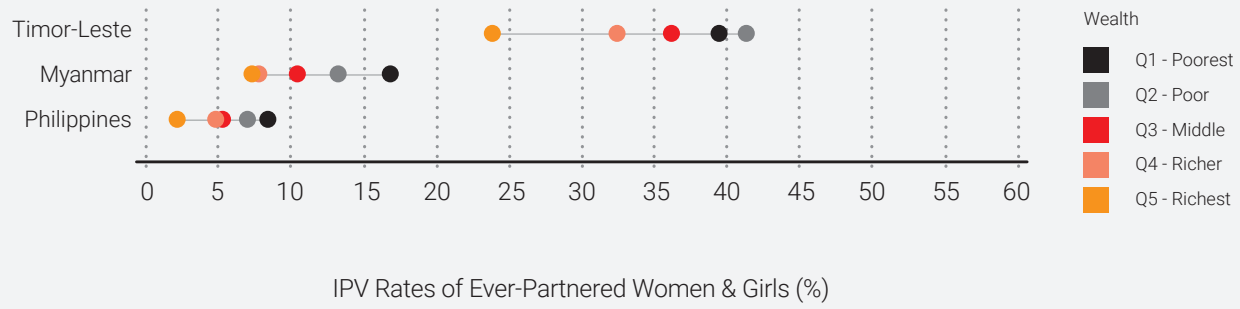
FIGURE 15:IPV PREVALENCE AMONG EVER-PARTNERED WOMEN AND GIRLS AGED 15-49 YEARS BY WEALTH QUINTILE, CLUSTERED BY SDG REGION

Central and Southern Asia

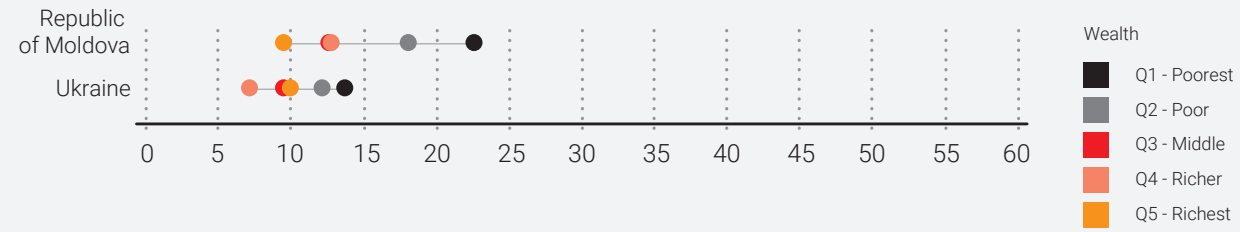


12 Jewkes R. Intimate partner violence: causes and prevention. Lancet. 2002 Apr 20;359(9315):1423-9. doi: 10.1016/S0140-6736(02)08357-5. PMID: 11978358.

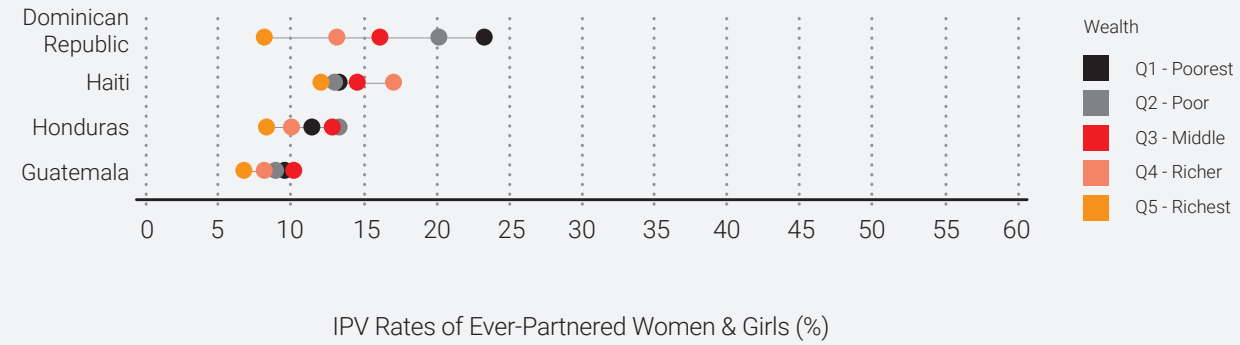
Eastern and South-Eastern Asia



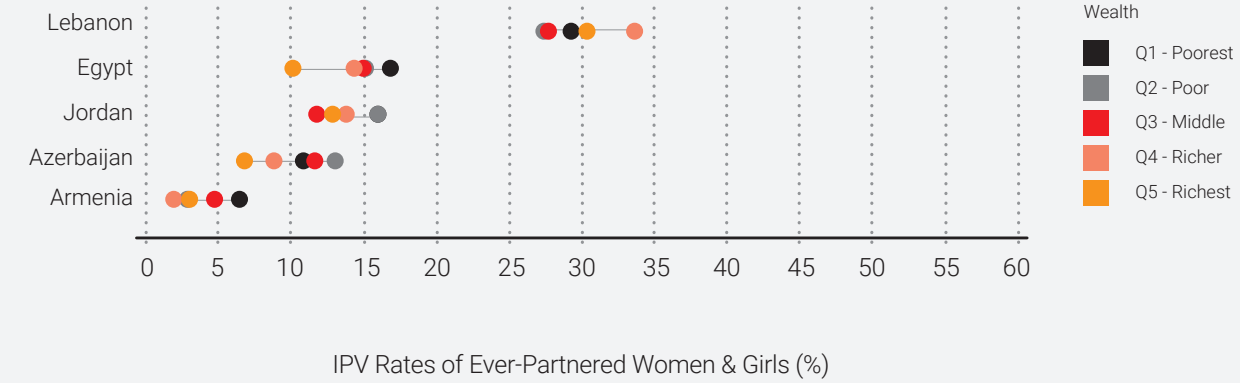
Europe



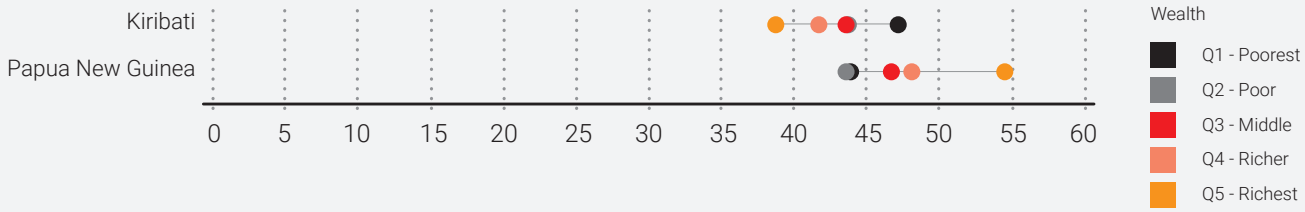
Latin America and Caribbean



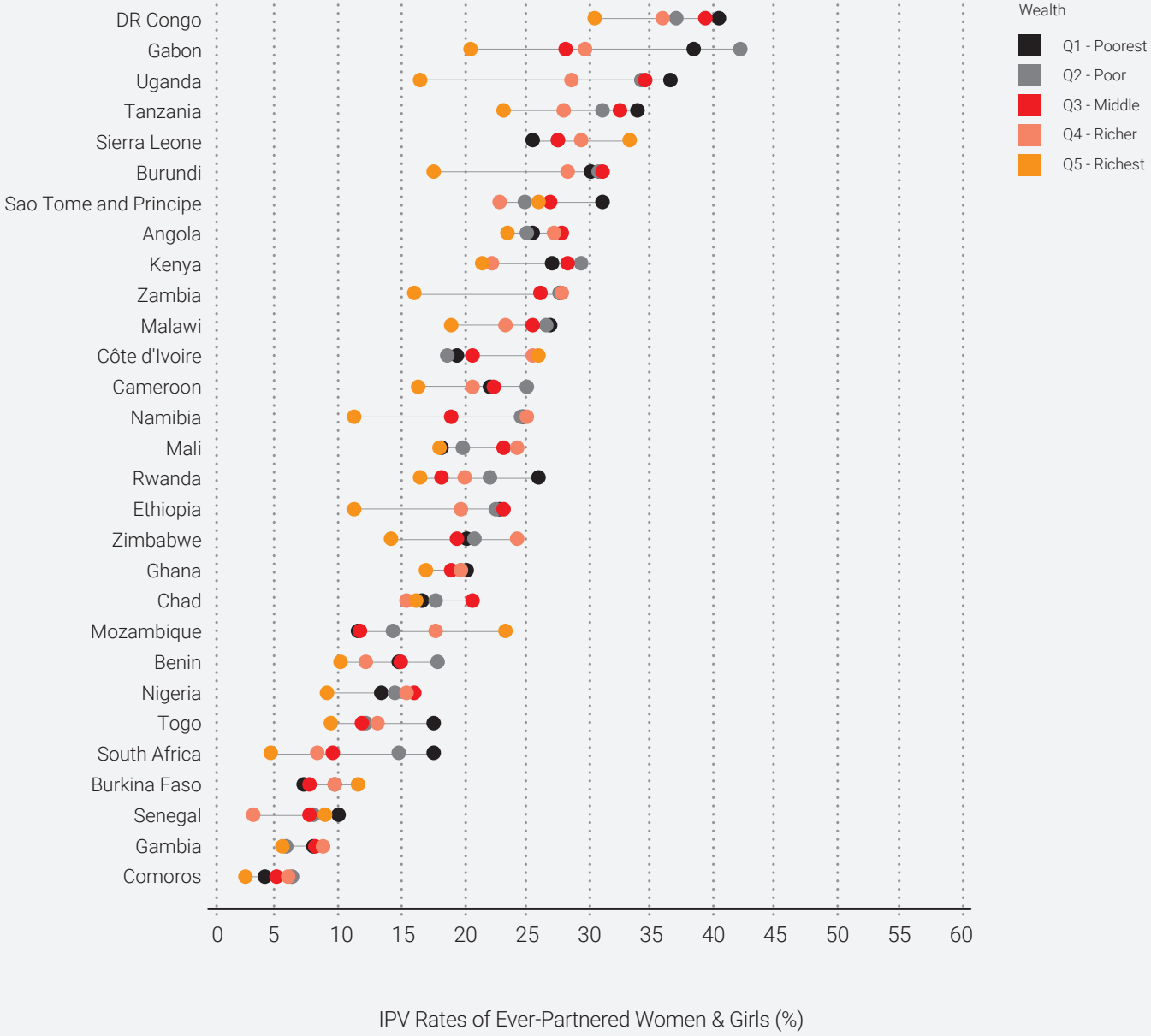
North Africa and Western Asia



Oceania



Sub-Saharan Africa



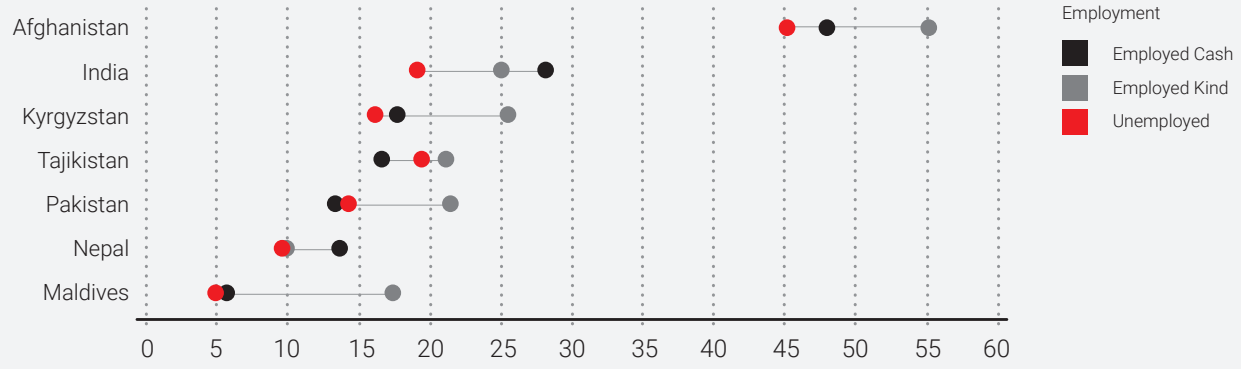
7 IPV **prevalence** and **employment**

Abbie Trayler-Smith© UNFPA

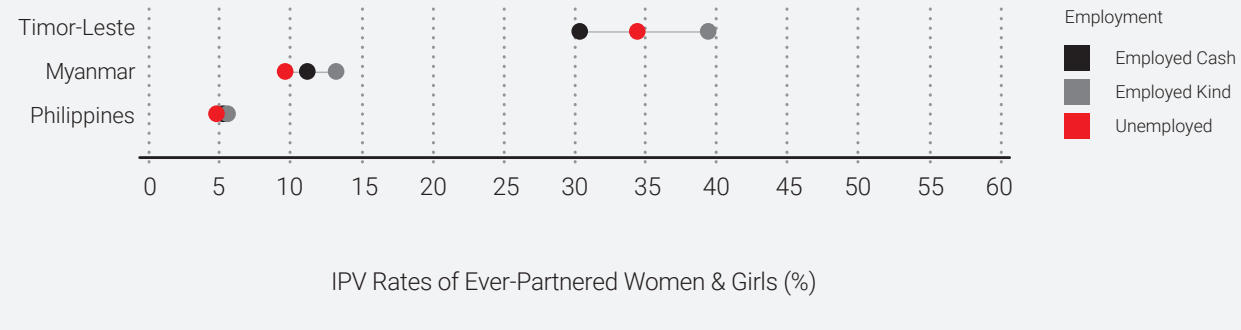
The highest rates of IPV were among women who are paid in-kind work (not cash) and found in most (27 of 51) countries, with a majority of countries located in Asia and sub-Saharan Africa (24 of 51 countries). When compared with those with either cash paid or paid in-kind work, IPV rates among women who were not working were higher in only 11 out of 51 countries, where disaggregated data on women's work status exists, with 3 out of the 10 countries in the North Africa and Western Asia region. Women in cash employment had higher IPV rates, when compared with women who were not working, in 62 percent of countries. While most regions had higher IPV prevalence for women with cash employment, in 4 out of 5 countries from North Africa and Western Asia, IPV prevalence was higher for women with no employment compared with those with cash employment (figure 16). These conflicting patterns suggest the need for a more thorough understanding of the links between women's economic empowerment and IPV in various regions.[13]

FIGURE 16: IPV PREVALENCE AMONG EVER-PARTNERED WOMEN AND GIRLS AGED 15-49 YEARS BY EMPLOYMENT STATUS, CLUSTERED BY SDG REGION

Central and Southern Asia

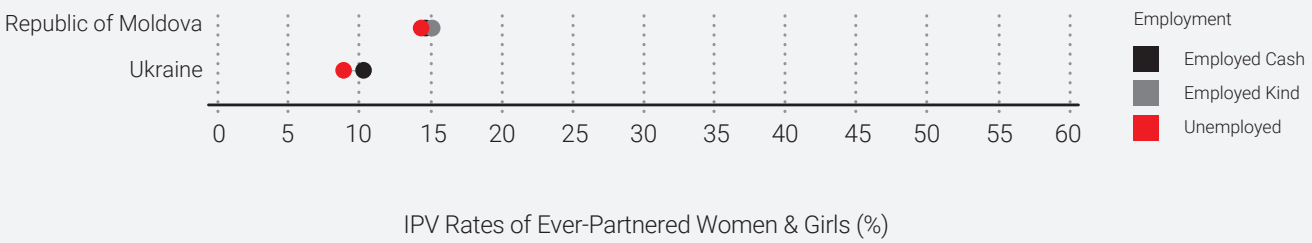


Eastern and South-Eastern Asia

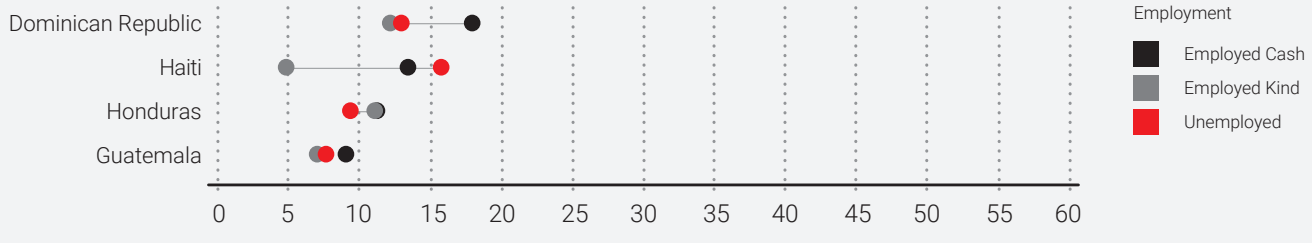


13 Vyas, S. and Watts, C. (2009), How does economic empowerment affect women's risk of intimate partner violence in low and middle income countries? A systematic review of published evidence. J. Int. Dev., 21: 577-602. https://doi-org.libproxy.uregina.ca/10.1002/jid.1500

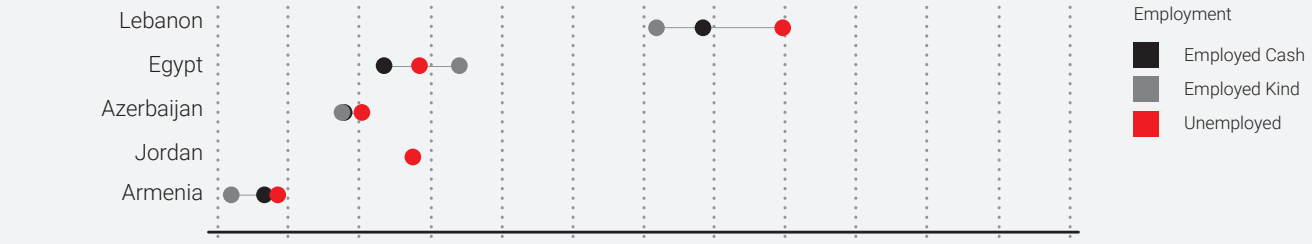
Europe



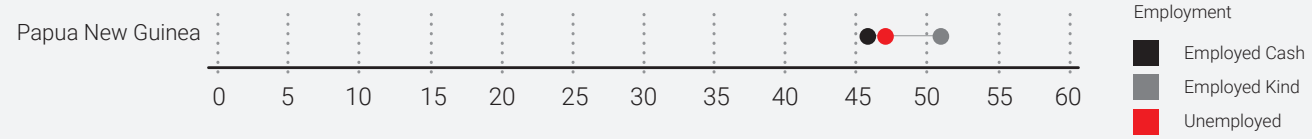
Latin America and Caribbean



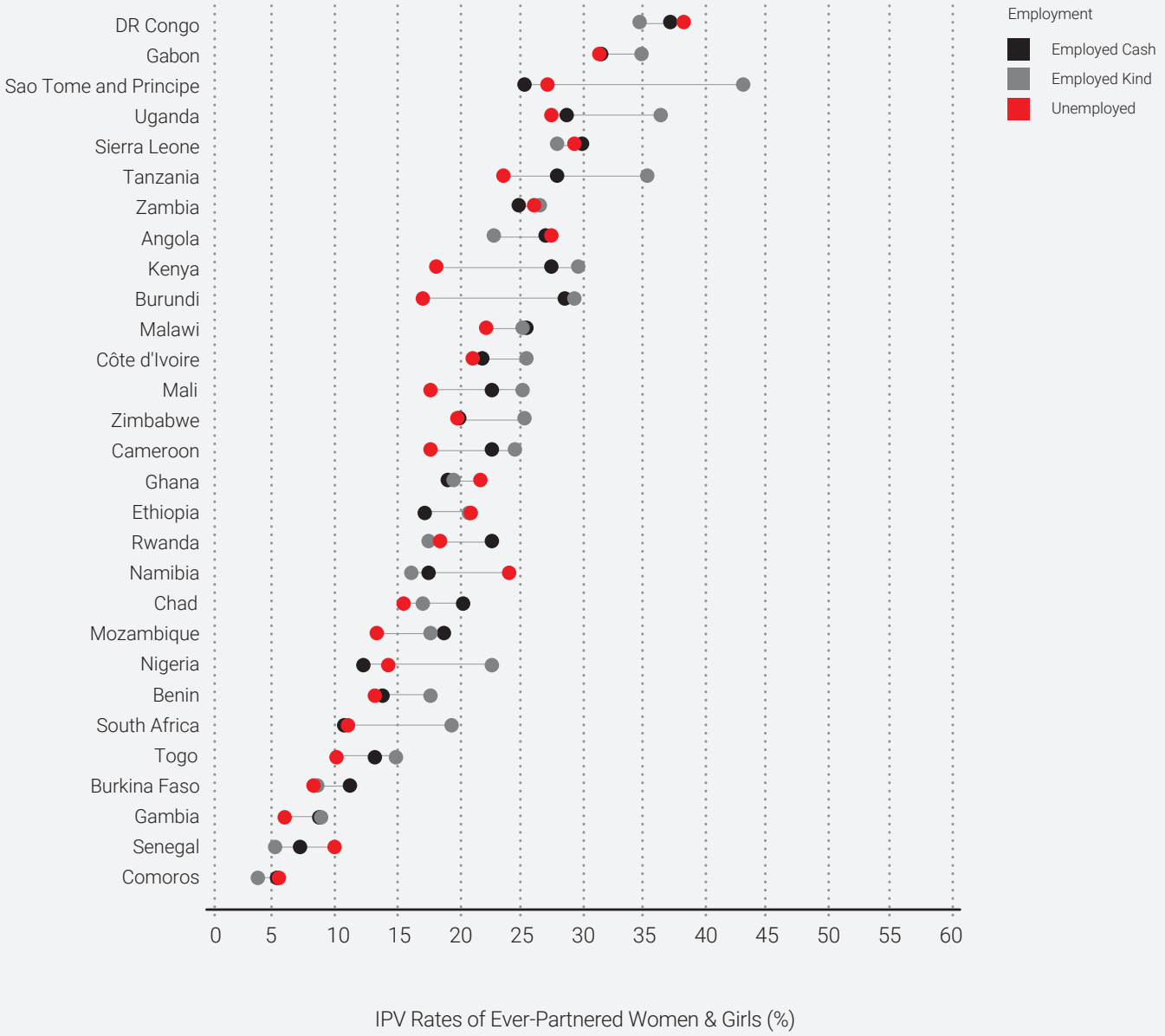
North Africa and Western Asia



Oceania



Sub-Saharan Africa



8 IPV trends **by region**

Christina Rizk© UNFPA

This report includes IPV trends for 17 countries that had data available from at least three DHS surveys. National IPV rates are presented as reflected in the reports. Note that we have not explored or adjusted for possible differences in sampling methodology or other differences for any of the included countries. That said, presentation of such data underscores the need and importance of relevant and high quality data to monitor progress made over time and contributions of various interventions.

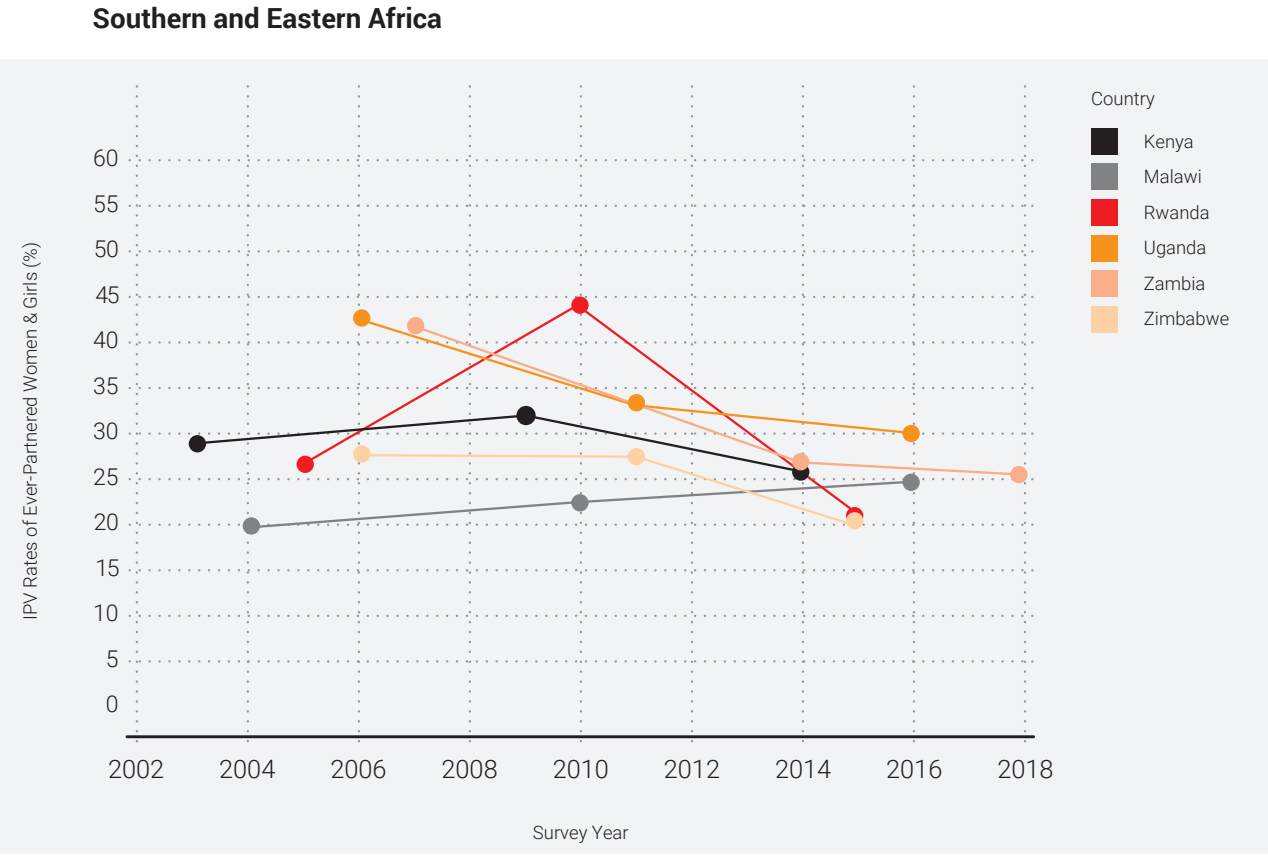
8.1. Sub-Saharan Africa

Seven out of the nine sub-Saharan countries with data available from at least three DHS surveys reported declines in IPV prevalence among 15-49 women over time. The largest decline between two time points was observed in Rwanda, where IPV prevalence declined by over 23 percentage points, from 44.3 per cent in 2010 to 20.7 in 2015. Overall declines observed in Cameroon, Kenya, Mali, Zambia, Uganda and Kenya were 9.9, 7.3, 6.2, 6.0, 3.4 and 1.4 per cent respectively. Malawi and Nigeria had an increase of 2.2 per cent and 2.8 per cent respectively. However, for Nigeria, there was an initial decline from 2008 to 2013, while for Malawi, the increase has been steady since 2004 (figure 17).

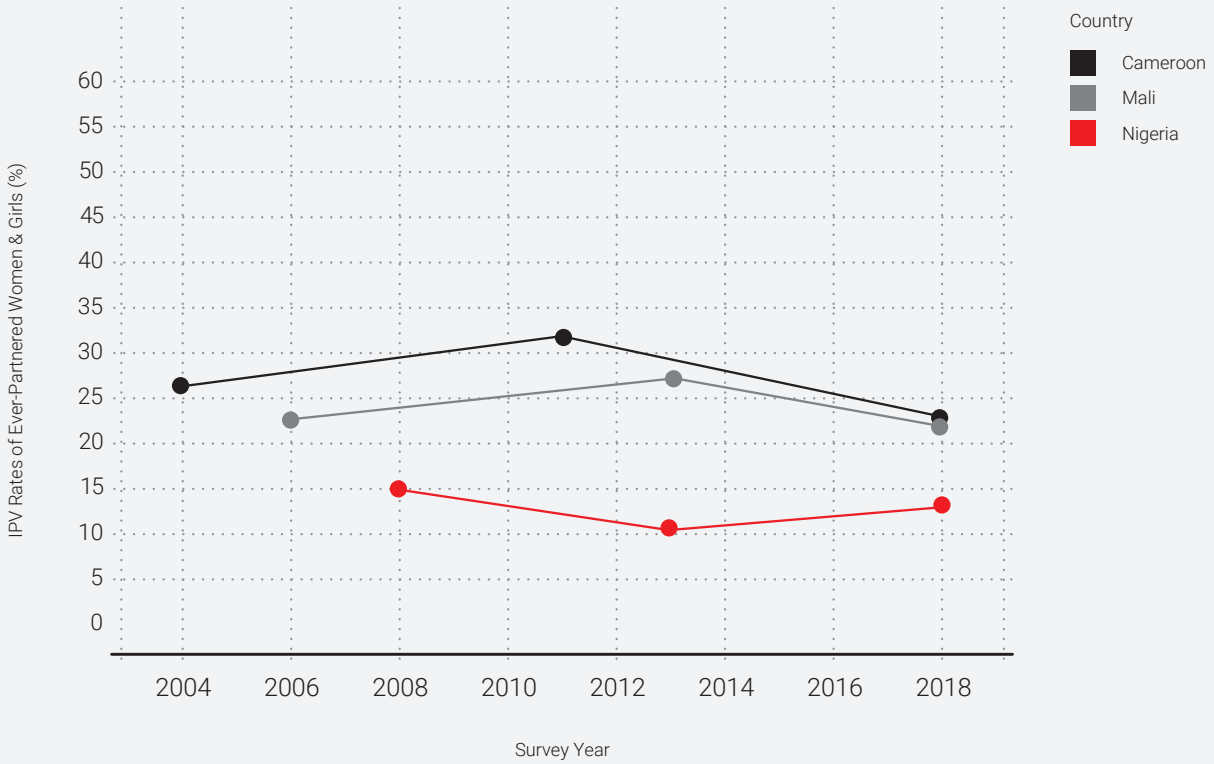
Initial increases were observed before eventual declines, however, for four countries:

Cameroon, Kenya, Mali and Rwanda. For instance, IPV prevalence rose steadily in Cameroon from 26.1 per cent in 2014 to 32.7 per cent in 2014 before an eventual decline to 21.5 per cent in 2018.

FIGURE 17: TRENDS OF THE IPV PREVALENCE AMONG EVER-PARTNERED WOMEN AND GIRLS AGED 15-49 YEARS IN SUB-SAHARAN COUNTRIES



Western and Central Africa

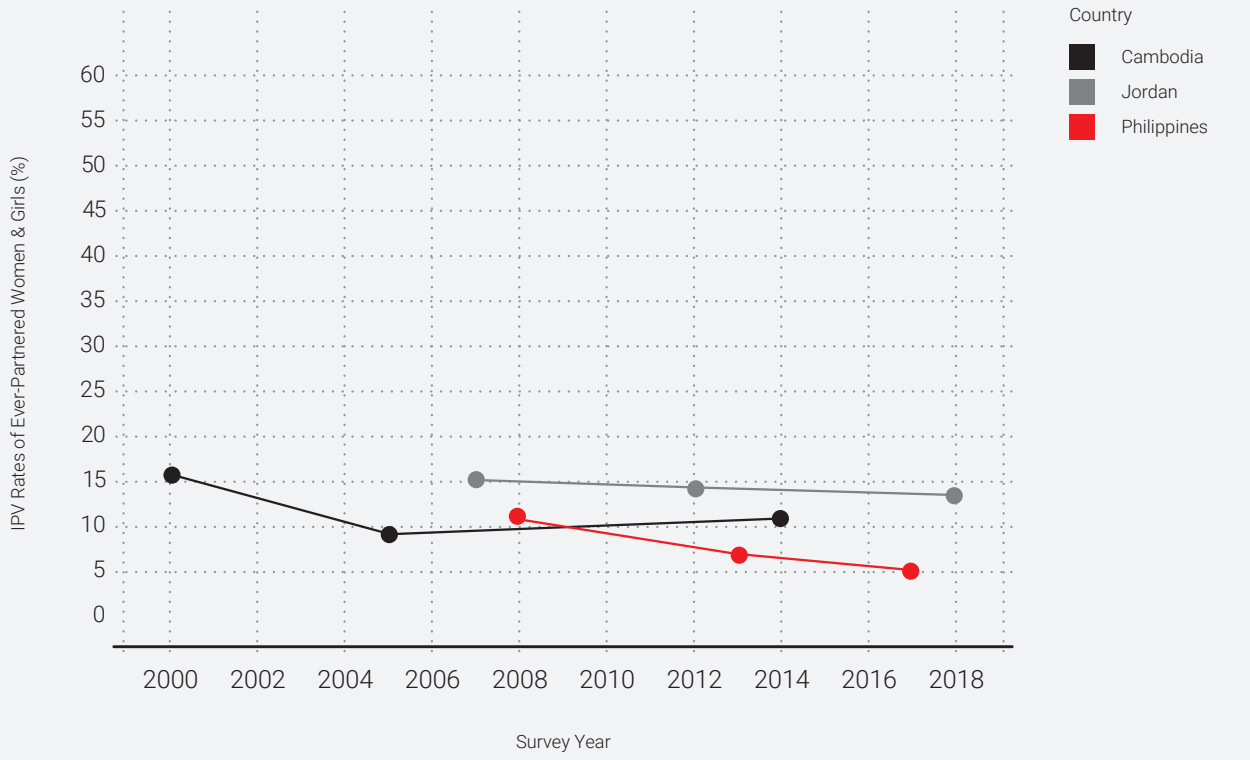



Javier Acebal© UNFPA

8.2. Asian Countries

IPV data was included for three Asian countries with at least three DHS data points. An increase in prevalence was observed in Cambodia (from 9.0 per cent in 2005 to 10.9 per cent in 2014), while slight declines were observed in Philippines (from 7.1 per cent in 2013 to 5.5 per cent in 2017) and Jordan (from 14.1 per cent in 2012 to 13.8 per cent in 2018). However, for Cambodia, there was a decrease in IPV prevalence from 15.4 per cent in 2000 to 9.0 per cent in 2005 before the increase observed in 2014 (figure 18).

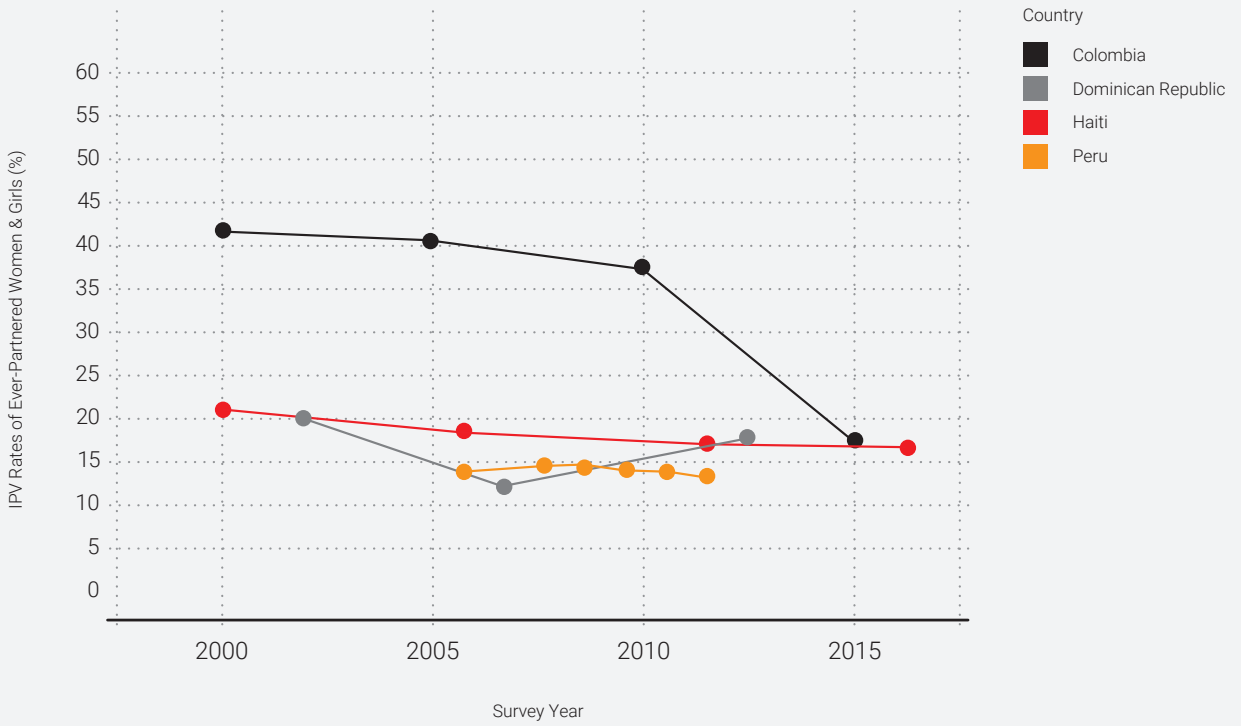
FIGURE 18: TRENDS OF THE IPV PREVALENCE AMONG EVER-PARTNERED WOMEN AND GIRLS AGED 15-49 YEARS IN ASIAN COUNTRIES



8.3. South America and Caribbean

Four countries from Latin America and the Caribbean had three or more IPV DHS data points. Colombia recorded the largest decline of 19 per cent from 2010 to 2015, while slight absolute per cent declines were recorded for Peru (2.8 per cent) and Haiti (1 per cent) since their last survey periods (figure 19). IPV prevalence initially declined in the Dominican Republic from 2002 to 2007 before increasing again in 2013.

FIGURE 19: TRENDS OF THE IPV PREVALENCE AMONG EVER-PARTNERED WOMEN AND GIRLS AGED 15-49 YEARS IN SOUTH AMERICA AND CARIBBEAN



Young Haitian mother after choosing her contraceptive method.©Maxence Bradley

Cover photo: Haitian woman doing laundry at her home. © Maxence Bradley

9 Haiti Case Study

Haitian woman selling fruits in Port-au-Prince. ©Maxence Bradley

Country background

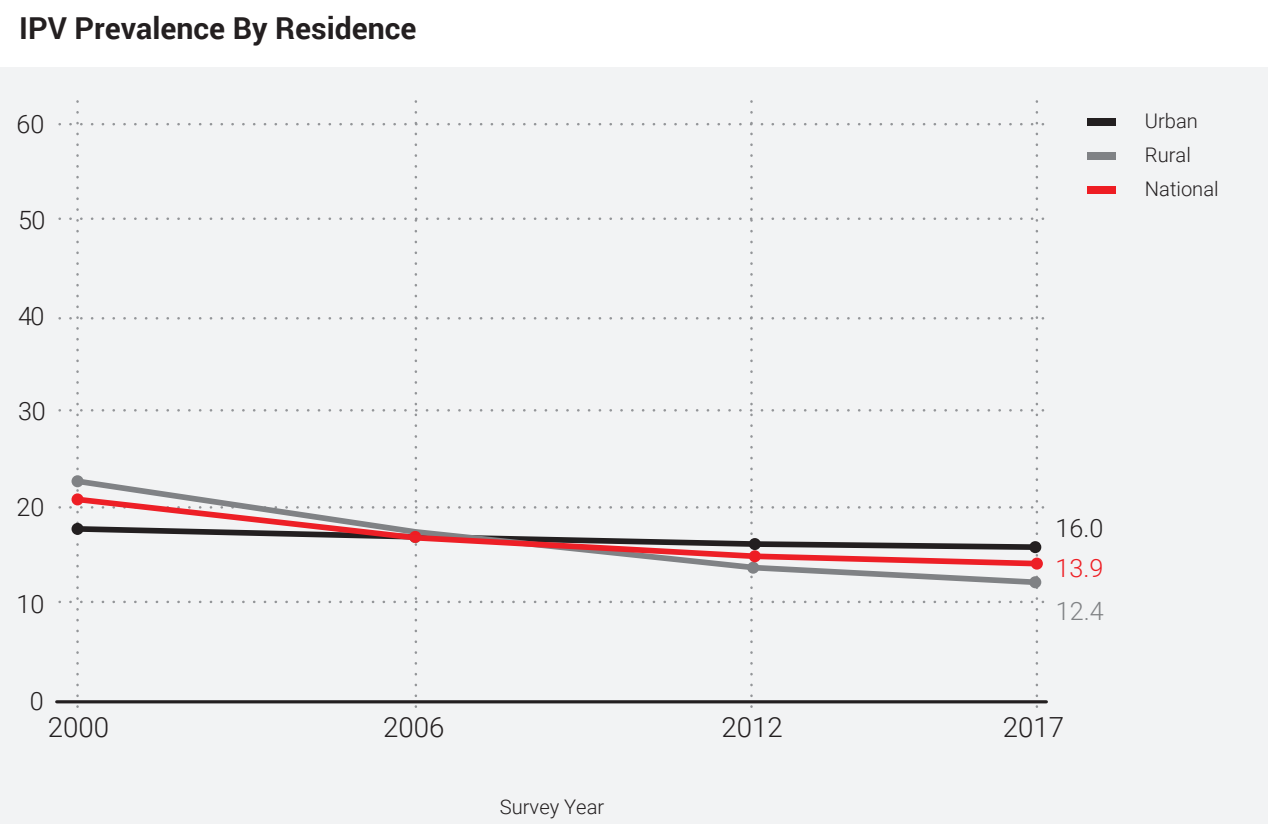
Haiti is the most fragile, poorest and least developed country in Latin America and the Caribbean. According to the UNDP Human Development Report, the Human Development Index (HDI) for Haiti in 2020 stands at 0.510 and the country is ranked 170th out of 189 countries and territories. Haiti is one of the most unequal countries in the world and the most unequal in the region, with a Gini coefficient of 0.61. In 2019, Haiti was ranked 144th out of 189 on the Gender Inequality Index, which reflects the challenges faced by women and girls and the systemic gender inequalities in social, economic and political sectors.

Chronic instability has led the country to permanent fragility of institutions, and caused insecurity and various forms of violence including all forms of violence against women. In Haiti, sexual and gender-based violence is endemic. The root cause is structural and linked to the low status of women in society. Further, the social and economic impacts of COVID-19 remain significant. Some civil society organizations have reported more cases of violence against women during the pandemic, though no national data is available.

Situation

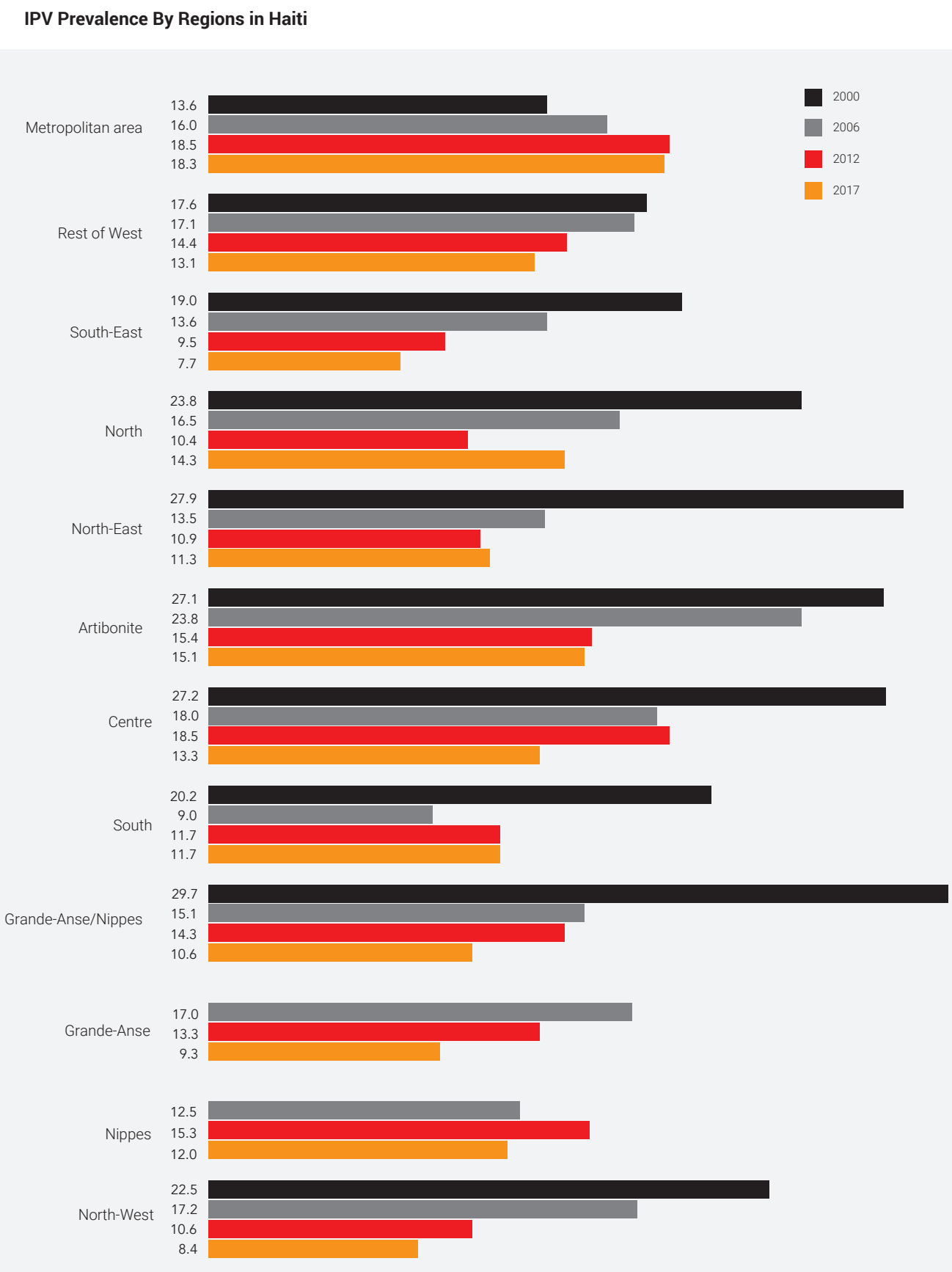
The intimate partner violence rates, based on nationally representative Demographic and Health surveys, are declining over time. The percentage of ever-partnered women who have experienced physical and/or sexual violence by an intimate partner in the past 12 months has decreased from 20.8 per cent in 2000 to 17.0 per cent in 2006, 14.9 per cent in 2012 and 13.9 per cent in 2017 (for more details see figure 20 and 21).

FIGURE 20: TRENDS OF THE IPV PREVALENCE AMONG EVER-PARTNERED WOMEN AND GIRLS AGED 15-49 YEARS IN HAITI



In 2017, intimate partner violence was more prevalent in urban settings, such as the Port-au-Prince Metropolitan area (18.0 per cent), compared with the rural South-East department (8.0 per cent).

FIGURE 21: IPV PREVALENCE BY PROVINCE TREND OF IPV PREVALENCE AMONG EVER-PARTNERED WOMEN AND GIRLS AGED 15-49 YEARS BY REGION IN HAITI



NB: *Data not available for Grande-Anse. Nippes for year 2000 and Camps for year 2000. 2006 and 2017*

It is important to highlight the tremendous action led by women's organizations since the end of the dictatorship. In 1994, the country established a Ministry of Women's Affairs and Women's Rights that has since been at the forefront of the fight against gender-based violence. In addition, the rise and the strengthening of civil society organizations, particularly women-led organizations, has contributed to increased awareness and response efforts around violence against women.

In 2005, a presidential decree favoured changing the laws regarding sexual assault and eliminating discrimination against women; a subsequent amendment of the penal code made sexual assault a crime punishable by law.

Data for evidence-based advocacy

National Government, Non Government, and grass roots organisations and collectives in Haiti will make use of the data provided through the geospatial IPV dashboard developed by UNFPA. It is a data-driven tool that facilitates decision-making for programming as well as the evidence based targeted response. As the UNFPA Country Office in Haiti is on the eve of a new programme cycle for 2022-2026, there is a strong need for accurate data and analysis to enable prioritization. Thus, compilation and analyses of data from various sources will be critical, including surveys, national health information management systems, police information, hotlines, governmental agencies, and national and international non-governmental organizations as service providers.

n order to end gender-based violence, quality and accessible multi sectoral response services must be made available. This must be accompanied by prevention programmes whcih challenge discriminatory gendered social norms including development of laws and policies, engagement of young people and men and boys.

In Haiti, to end all forms of violence against women including IPV, a combination of the following actions are required: i) make available quality and comprehensive data to drive effective decision making; ii) increase and improve access to health care including reproductive health; iii) enhance economic growth, economic empowerment and poverty reduction; iv) build trust and facilitate access to justice and legal assistance to combat impunity; v) strengthen and apply the legal framework; vi) increase women and girls' participation in governance and civil society dialogue; vii) carry out advocacy to fight against all forms of gender-based violence.

In order to end gender-based violence, quality and accessible multi sectoral response services must be made available. This must be accompanied by prevention programmes whcih challenge discriminatory gendered social norms including development of laws and policies, engagement of young people and men and boys.

Sabine Lamour, sociologist-feminist, professor and coordinator of SOFA, a pioneering women-led organization, is determined to protect hard-won progress for women in Haiti. "My position at the helm of SOFA also gives me the immense responsibility of preserving the political gains of the Haitian women's movement in a country that is destroying its institutions on a daily basis. It is also the responsibility of winning new battles and surpassing oneself to face the realities that are emerging in the complex dynamics of power relations in Haiti. It is also the responsibility to work to ensure that the rest of society recognizes that feminist organizations, particularly SOFA, are models for the rest of civil society," she says.

Haitian mother at a local clinic. ©Maxence Bradley

10 Conclusion

Using data from the UNFPA IPV dashboard, this report features levels, trends and sociodemographic and geographic, within and across countries, disparities in intimate partner violence in the past 12 months among ever-partnered women. Such data offers insights for evidence-based policymaking and programming, and targeted resource allocations in order to ensure leaving no one behind.

The 12-month IPV prevalence data should be interpreted together with data disaggregated by type of violence, IPV over a woman's lifetime, consequences of violence and within local contexts such as , laws and regulations on IPV and gender equality, help-seeking behavior, social norms, and attitudes towards IPV. It is important to bear in mind that the data presented in this brochure is likely to have under reported the true prevalence of violence. This is because women experiencing severe forms of violence are more likely to be missed from such prevalence surveys. This may be especially so in contexts where IPV is widely accepted and not condemned by the society, and where limited support measures are in place. Therefore, the findings in this brochure should be interpreted with these considerations in mind.

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