Decisions and dynamics: Unpacking the impact of contraceptive decisions on domestic violence

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Articles

Women's empowerment in the form of intra-household bargaining power, employment, and education have been documented to both reduce and increase the prevalence of intimate partner violence (IPV). Using data from the latest wave of the National Family Health Survey (NFHS-5), this article investigates how a woman's contraceptive use decisions could affect IPV, and shows that independently deciding to use contraceptives puts her at a greater risk of physical, sexual, and emotional violence.

Violence against women is a pervasive global issue, with roughly one in three women experiencing physical or sexual abuse by a partner during their lifetime (World Health Organization (WHO), 2021). In general, violence against women carries severe immediate and long-term consequences for women, including physical injuries, permanent disabilities, reproductive health complications, mental health issues, and even death (Durevall and Lindskog 2015, Yount *et al.* 2011, WHO, 2013). Given the well-documented adverse effects of domestic violence (DV), and the rise in violence against women during the Covid-19 pandemic (United Nations (UN), 2022), we examine a relatively unexplored potential determinant of DV – women's contraceptive use decisions (Ojha and Babbar 2024).

While prior research has examined how DV affects fertility and contraceptive practices (Kupoluyi 2020, Mundhra *et al.* 2016), typically identifying correlations, we argue that contraception decisions themselves are significant predictors of DV. We analyse how a woman's decision to use contraceptives affects the likelihood of DV. We use data from the latest wave of the National Family Health Survey (NFHS-5) conducted during 2019-2021 in India.

Recent studies on the determinants of DV, in particular intimate partner violence (IPV), highlight the complex relationship between women's empowerment and IPV. Factors like intra-household bargaining power, employment, and education have been documented to both reduce (Bhattacharyya *et al.* 2011, Erten and Keskin 2018, Heath 2014), and increase IPV prevalence (Anderberg *et al.* 2016). Our research contributes to this field by focusing specifically on how a woman's *independent* decision-making regarding contraceptive use might influence IPV.

A woman's sole decision to use contraceptives is a complex interplay with her risk of DV and as such, *a priori*, it is not entirely obvious how a woman's contraceptive use decision would affect DV. While exercising autonomy in contraceptive choices could reflect greater bodily control and assertiveness, potentially reducing IPV risk, such decisions could also be perceived as challenging male dominance in patriarchal societies, provoking backlash and increasing IPV (Field *et al.* 2021). These dynamics underscore a critical distinction, often overlooked in research on contraceptive practices: the difference between joint and individual contraceptive decisions within households (Haque *et al.* 2021, Mutombo and Bakibinga 2014). While family planning offers clear benefits, the costs extend beyond accessing services and encompass social, psychological, and cultural aspects that often act as barriers in developingcountries. Understanding whether a women makes contraceptive decisions independently or jointly is crucial, as motivations for contraceptive practices can vary significantly between women and men.

Our study

The main empirical challenge in identifying the causal effect of women's independent decision to use contraception on the incidence of IPV is that the choice to use contraceptives may be 'endogenous' on several accounts. Endogeneity may arise due to reverse causality from IPV to the decision to use contraception, measurement error in the self-reported contraceptive use decision variable, selection issues, as well as omitted variable bias.[1] To address the issue of endogeneity and estimate the causal effect, we employ an instrumental variable (IV) approach, exploiting the exogenous variation in the neighbourhood average of women's exposure to family planning messages through radio as our instrument for their decision to use contraceptives.[2]

Our analysis shows that independently choosing to use contraceptives puts the woman at a greater risk of IPV – physically, sexually, and emotionally. Specifically, when the decision is made solely by the woman, the risk of physical violence rises by 9.3 percentage points (pp). The impact is even more pronounced for sexual and emotional violence, with increases of 11.2 pp and 29.5 pp, respectively.

Recognising that our instrument may not be fully exogenous if it is correlated with unobserved cultural and social norms at the neighbourhood level, which may also affect our outcomes of violence, we supplement our analysis by utilising the methodology introduced by Conley *et al.* (2012) which allows departures from full exogeneity of the instrument. We find that the positive effect of a woman's decision to use contraception on all three forms of IPV is robust to a fairly large degree of instrument endogeneity. Our results remain robust to alternative estimation techniques and inclusion of husband's characteristics such as husband's age, employment status, education and alcohol consumption, gender-based attitudes towards IPV, and neighbourhood-level cultural norms as additional controls. We further validate our findings with falsification analyses and placebo tests.[3]

Notably, there is demographic variation in the impact observed. Younger and employed women face a higher risk of IPV when making contraception decisions alone. The result on employed women corroborates the 'male backlash' effect stemming from the destabilisation of gender norms. This suggests that IPV occurs more often when the normative support for the husband's dominance is high, even though the structural status of women is relatively high. Our results are driven by women in rural areas, women belonging to backward castes, women who have yet to complete fertility (defined as the difference between a woman's actual number of children and ideal number of children) and those who have fewer children.

Additionally, we find that women with employed husbands are more at risk. We believe that the balance of power between couples (driven here by employment) is an important predictor of IPV. When a conflict is created between the reality and the idea of male superiority, then the woman is at a higher risk. In the sample of employed husbands, the woman's deviation from the norm and deciding independently without involving her partner (who is considered to be superior) puts her at a greater risk of IPV. These insights underscore the importance of implementing male-focused family planning outreach programmes, especially in rural areas where resistance to contraception use persists. Such initiatives could encourage joint decision-making around contraception by couples and help reduce IPV.

Concluding remarks

Our results are best understood with the caveat that specific dynamics of DV and contraceptive practices may differ across cultural contexts. While we believe that our results are relevant in other developing country settings with largely patriarchal setups and high DV rates, more work needs to be done to quantify the generalisability of our results across such contexts.

The issue explored in this paper is both timely and pertinent. Our findings highlight the urgent need for comprehensive women's empowerment programmes that prioritise sexual and reproductive health, particularly family planning and contraceptive use. Furthermore, government initiatives should include efforts to improve men's understanding of contraceptive practices, especially in households where husbands are employed.

This paper underscores the importance of empowering women to make independent contraceptive choices, as a critical component of gender equality and overall well-being. However, achieving genuine empowerment requires addressing deeply ingrained gender norms and potential male resistance. While our study does not directly examine interventions targeting men's attitudes toward contraceptives, existing research suggests that positive male attitudes towards family planning are linked to a reduced risk of IPV (UNFPA and Population Fund of India, 2023). Future research should investigate the effectiveness of programmes that foster supportive partnerships and challenge harmful gender norms related to reproductive health.

Notes:

1. For instance, women experiencing IPV might be more likely to use contraception to avoid pregnancy with an abusive partner. Other unobservable factors, like pre-existing social norms that correlate with both IPV and a woman's contraceptive decision-making, may also serve as sources of potential endogeneity.
2. Instrumental variables can be used in empirical analysis to address concerns about endogeneity. The instrument (here, exposure to family planning messages through radio) is correlated with the explanatory variable (decision to use contraceptives) but does not directly affect the outcome of interest (IPV), conditional on the controls. The instrument can therefore be used to measure the causal relationship between the explanatory factor and the outcome of interest.
3. In the falsification test, we show that such a result is not obtained if we consider any randomly assigned IPV outcome in our model. In other words, we associate a random woman i's instance of DV with woman j's contraceptive use decision, instrumented by the average exposure of women residing in a neighbourhood to family planning messages through the radio. For the placebo tests, we use variables known not to be influenced by contraceptive decisions such as the woman's haemoglobin levels, knowledge about tuberculosis, anaemia levels, and her age at menarche. We find no effect on these outcomes of women's contraceptive use decision.

Further Reading

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