

Intimate Partner Violence in Pakistan: A Neglected Public Health Emergency

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Intimate partner violence (IPV) is defined as “behaviour within an intimate relationship that causes physical, sexual or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse and controlling behaviours”, by the World Health Organization (WHO).¹ It is a human rights and public health problem that is globally pervasive. WHO reports the global prevalence of physical and/or sexual IPV as 27% in women who have ever had an intimate relationship.² However, this metric excludes emotional/psychological IPV and is limited to women aged 15-49 years only. But there is no empirical evidence that women aged 46 and above are immune from IPV. Hence, this figure is understandably an underestimate of the true IPV prevalence. IPV has been linked to a plethora of deleterious fatal and non-fatal outcomes in women including suicide, injuries, gynaecological complications, sexually transmitted infections, adverse pregnancy outcomes and mental health disorders.²

The only nationally and subnational representative data on IPV in Pakistan is provided by the Demographic and Health Surveys (DHS) conducted by the DHS Programme.³ The ‘Country Report’ of the 2017-18 Pakistan DHS reported a combined (emotional, physical, and sexual) prevalence of having ever experienced IPV of 33.5% among ever-married woman aged 15-49 years, committed by their current or most recent husband.³ While the 2012-13 Pakistan DHS did not ask about sexual IPV and reported the combined emotional and physical prevalence of having ever experienced IPV of 38.5%.³ However, wide disparities were reported at the subnational level of provinces and within provinces, at the urban and rural levels.⁴ These disparities clearly suggest the need to study and understand the differing prevalence, risk factors, and spatial dynamics, as ultimately “all epidemiology is local”.⁵

Globally, various risk factors and correlates of IPV have been recognized, including lower educational attainment, partner’s controlling behaviour and alcohol use, acceptance of IPV-supportive attitudes, employment status against the backdrop of gender inequality and archaic cultural norms, patriarchal practices, and weak legal

protections.⁶ A multivariable analysis of the Pakistan DHS 2017-18 reported strong statistical association of IPV in women with husband’s use of alcohol, marital control, number of living children, and knowledge of parental physical IPV.⁴ The high prevalence of IPV among women who had knowledge of their own fathers having ever had physically beaten their mother has been reported in Pakistan, and termed “vertical/intergenerational transmission”.^{4,6} This suggests that such knowledge perhaps normalizes IPV with resultant acceptance and perpetuation of IPV in families across generations.

There have been laws on the books: Sindh 2013;⁷ Punjab 2016; KP 2021; Islamabad 2020/2021, to address IPV but empirical studies on enforcement, implementation, outcomes, and effectiveness are essentially nonexistent. Hundreds of women continue to be killed in the name of ‘Honor’ in the country.⁸ However, these cases are likely an underestimate of the true magnitude of the problem owing to the weak reporting. Various shelters and helplines abound in the country providing refuge and protection to the women victims of domestic violence and abuse,^{9,10} but there is a dearth of regular reporting on the profile of victims and the magnitude of the problem.

To effectively address the IPV problem in the country, a multi-pronged strategy would entail legal and policy reforms in terms of strengthening enforcement of existing IPV-related laws across all provinces; amendment of existing and enactment of new legislation to close loopholes and standardization of laws; establishment of fast-track courts ensuring timely justice. Institutional and system-wide interventions would entail integrating IPV screening and counselling into primary healthcare, maternal health, and family planning services; training of law enforcement personnel (police, judiciary), and healthcare providers on handling IPV cases sensitively and effectively; establishing multisectoral coordination units (health, police, social welfare, legal aid) at district level for IPV response; ensuring protection and safe shelters for survivors, including economic rehabilitation programmes. Community and Social Interventions would entail engaging religious and community leaders to raise awareness against IPV and challenging cultural norms that condone and justify IPV; launching nationwide awareness campaigns emphasizing that IPV is a heinous crime, societal failure and never a private matter; empowering

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women economically and educationally; finally, promoting positive masculinity programmes targeting men and boys to redefine and ingrain equitable gender roles. None of these aforementioned approaches are novel and reflect what common sense would dictate for creating a just society that treats all its members equally and ensures their safety.

To empirically determine the impact of IPV prevention and control measures, there needs to be a more active data collection for research and monitoring of trends. Establishing a national surveillance system for IPV through the Pakistan Bureau of Statistics and Health Information Systems would be one viable option. In addition to evaluating the effectiveness of existing IPV laws, shelters, and awareness programmes through supporting academic research on spatial, cultural, and socioeconomic determinants of IPV to guide targeted interventions. These activities would require more political and financial commitment on the part of federal and provincial governments to prioritize IPV prevention in national and provincial health and social protection policies.

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