International Journal of Reproduction, Contraception, Obstetrics and Gynecology
Iweka RO et al. Int J Reprod Contracept Obstet Gynecol. 2025 Dec;14(12):4115-4124
www.ijrcog.org
pISSN 2320-1770 | eISSN 2320-1789

DOI: https://dx.doi.org/10.18203/2320-1770.ijrcog20253874

Original Research Article

Exploring the relationship between family planning and intimate partner violence: a mixed-methods study

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Received: 16 October 2025
Accepted: 13 November 2025

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ABSTRACT

Background: Family planning is vital for reducing maternal morbidity and mortality, but in many developing countries, women's access to it may be influenced or restricted by their partners due to prevailing gender norms. Given the inconsistent global and regional findings on the link between intimate partner violence (IPV) and family planning use, this study aims to examine their association within our local context.
Method: A descriptive cross-sectional study using qualitative and quantitative methods was carried out with 421 women, their spouses, and healthcare providers at the family planning clinic of the University of Benin Teaching Hospital in Benin City, Nigeria. Quantitative data were analysed using statistical package for the social sciences (SPSS) 25.0, and p values of less than 0.05 were considered statistically significant. The qualitative data were analysed thematically.
Result: The mean age group was 35.9±7.23, and the prevalence of IPV was 7.1%. Also, 92.6% reported that their husbands agreed with the chosen method of family planning, of which 87.2% did not require persuasion of their husbands before agreement. Of those whose husbands refused the family planning method, 19.4% attempted to convince their husbands, and 80.6% did not try to persuade them. About 30.0% experienced physical violence, 40.0% endured psychological violence, 13.3% faced sexual violence, and 16.7% experienced economic violence. The impact of family planning on IPV includes insomnia (73.3%), starvation (10.0%), suicidal ideation (10.0%) and body pain (6.7%). The qualitative analysis also showed cases of sexual, physical, and emotional IPV, especially from family planning.
Conclusion: Although the occurrence of IPV was low among the study population, it showed that IPV affects family planning demand. This underscores the importance of enhancing family planning acceptance among couples by implementing couple counselling, increasing public awareness, empowering women, ensuring legal protection, and incorporating intimate partner violence (IPV) prevention into family planning services.

Keywords: Family planning, Intimate partner violence, Contraceptive use, Reproductive health, Gender-based violence

INTRODUCTION

Family planning is essential in preventing maternal morbidity and mortality by decreasing unwanted pregnancies, unsafe abortion and their complications.[1] Due to interactions between men and women, especially their spouse, the decision to use family planning may be interfered with by the spouse, especially in developing countries where the rights of women are documented to be restrictive.[1] This is made worse by social, cultural and economic reasons, especially in developing countries where married women are made to be submissive to their husbands.[2] For men to assert authority when they disagree with the decision of the woman, they may resort to intimate partner violence.[2] Unfortunately, in some climes in African settings, intimate partner violence is seen as a way of chastising or correcting a woman by her spouse.[2]

Intimate partner violence, also called spousal or domestic violence, is a significant social and public health concern.[3]

It is pervasive and inimical to the dignity of mankind. According to the World Health Organization (WHO), intimate partner violence is defined as any behaviour by an intimate partner or ex-partner that causes physical, sexual or psychological harm, including physical aggression, sexual coercion, psychological abuse and controlling behaviours.[3,4] This act of violence could be in the form of beating or hitting the spouse, forced sexual acts, threats and insults, isolation or restricting resources.[3]

In Nigeria, domestic violence is widely acknowledged to be of great concern, not just from a human rights perspective but also from an economic and health perspective.[5] In 2015, Nigeria passed the comprehensive Violence Against Persons Prohibition (VAPP) Act 2015, which was signed into law on 25 May 2015.[6] This act aimed to eliminate violence in private and public life, prohibit all forms of violence, including physical, sexual, psychological, domestic, harmful traditional practices; discrimination against persons and to provide maximum protection and effective remedies for victims and punishment of offenders. In addition, Nigeria is a signatory to the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW).[7] Nonetheless, despite legislation and ongoing efforts to protect women and vulnerable populations against violence, much remains to be done in protecting victims and prosecuting perpetrators.[5]

Globally, intimate partner violence is common.[2] However, common in developing countries in Africa and elsewhere where cultural norms support intimate partner violence as a way of 'correcting' the spouse.[2] In Nigeria, like ss developing countries, intimate partner violence is usually treated as a family affair that should be settled between the couple and extended family if need be, but should not be reported to law enforcement authorities.[2] Therefore, victims do not seek help, and culprits are not prosecuted or punished.[2] These victims are usually women, as studies have shown that both genders who live in households where women lack decision-making and financial autonomy are more likely to support intimate partner violence.[2] Also, studies have shown that uneducated women in low-income backgrounds and rural areas tend to experience and endorse the perpetration of intimate partner violence.[2]

According to the World Health Organization (WHO), a 2018 analysis of prevalence data from 2000-2018 across 161 countries and areas, 1 in every 3 women experiences some form of domestic violence globally.[4,8] A recent report by the WHO showed the prevalence estimates of lifetime intimate partner violence range from 33% in the African region, 33% in the Southeast Asia region, 31% in the Eastern Mediterranean region, 25% in the WHO Regions of the Americas, 22% in high-income countries of Europe as well as 20% in the Western Pacific.[4] This violence was noted to be perpetrated more by men than by women.[4] About 38% of all murders of women are committed by intimate partners.[4] The prevalence of intimate partner violence ranged from 15 to 71% worldwide in a multi-country study by the (WHO) on women's health and domestic violence across 15 countries worldwide in 2006.[9] Also, studies have shown the prevalence of intimate partner violence about 78.8% in Igbo communities, Nigeria, 70.1% in Ethiopia and lower prevalence of 10% in a nationwide study in Philippines.[10]

Studies on the relationship between family planning and intimate partner violence have shown mixed findings globally.[1] These mixed findings were also recorded in parts of Africa.[1] While some studies showed a correlation between intimate partner violence and an increase or decrease in the use of family planning methods, others did not show any relationship at all.[1] This difference can be attributed to different social and cultural values that exist worldwide, including among Africans.[1]

Given these inconsistencies in the findings about whether there is an association between the use of family planning and intimate partner violence. It is pertinent to conduct this study to ascertain if there is any association between demand for family planning and intimate partner violence in our environment, and to fill the gap in the different demographic literatures. Also, it will help in addressing the negative relationship between intimate partner violence and poor uptake of family planning or harnessing a positive relationship between reduction of intimate partner violence and increased use of family planning could be one step toward increasing the prevalence of contraceptive usage. We presently do not know the relationship between intimate partner violence and the use or non-use of contraception in Benin City, Nigeria, to our knowledge. Therefore, we conducted this study aimed at determining the impact of family planning demand on intimate partner violence in our environment.

This study aims to ascertain the impact of family planning demand on intimate partner violence. The specific objectives included are to ascertain the prevalence of intimate partner violence in women on family planning and the impact of family planning demand on intimate partner violence.

METHODS

The study was carried out at the University of Benin Teaching Hospital (UBTH) family planning clinic in Benin City, Nigeria. The study design was a descriptive cross-sectional study using mixed methods (quantitative and qualitative methods). The study duration was six months, from 01 March to 31 August 2024. The study population were all women who were present for family planning clinic follow-up. All women who have been attending the family planning clinic for at least six months, who present at the clinic and gave consent for the study, while critically ill patients or those who refused consent were excluded from the study. The sample size (n) for the quantitative study was calculated using the Cochran formula for descriptive studies, where n=minimum sample

size, z=standard normal deviate at 1.96 (at 95% confidence interval), and p=prevalence of the characteristic of interest and q=1-p.[28]

$$n = z^2pq/d^2$$

The reference study by Bishwajit et al showed that women who experienced both physical and psychological abuse had 52% higher odds of not using any contraception. Based on this, the minimum sample size for the present study was set at 421. All eligible women were consecutively recruited until the required sample size was reached. In total, 436 respondents were assessed for eligibility; 15 did not meet the inclusion criteria, resulting in 421 participants being enrolled and included in the analysis (Figure 1).

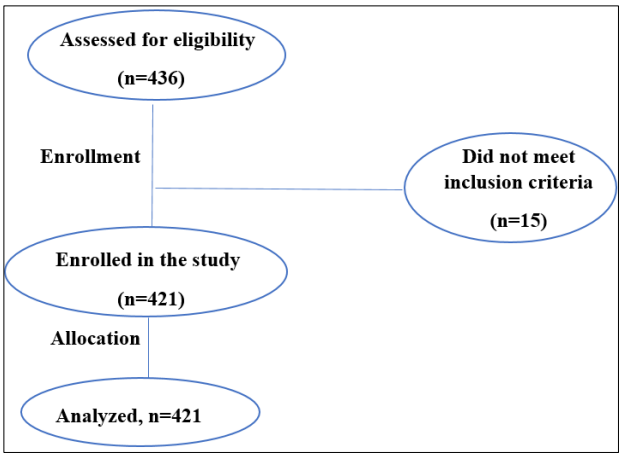

Figure 1: Inclusion and exclusion criteria flow chart.

The quantitative data was collected using an interviewer-administered semi-structured questionnaire, while the qualitative data was obtained via key informant interviews of the 6 health professionals (3 doctors and 3 nurses) and focus group discussion involving 6 postnatal women, 6 clients who wanted contraception removal and 6 male spouses.

Quantitative data were analysed using statistical package for the social science (SPSS) 25.0. Chi-square analysis and logistic regression were done, and p values of less than 0.05 were considered statistically significant. Qualitative data were analysed using themes. Quantitative results are presented in tables and charts, while qualitative results are presented in prose.

RESULTS

Quantitative analysis

The results highlight significant associations between intimate partner violence (IPV) and family planning factors among the study population. In this study, the age distribution shows that the majority of participants (50.4%) fell within the 31-40 years age bracket, with a mean age of 35.9 years.

In Table 1, the most common method of family planning among respondents is the implant, used by 47.3% of individuals. The IUD is the second most popular method, utilised by 26.6% of respondents. Injectable contraceptives are used by 20.9% of the participants. Oral contraceptives are used by 3.1%, while condoms are used by 1.2%. The safe period method is employed by 0.5% of individuals, and both bilateral tubal ligation and withdrawal methods are used by 0.2% each. Regarding the duration of family planning, 55.3% had been on family planning for more than a year, while 6 months to 1 year constituted 38.5%, and new users less than 6 months were 6.2%.

Table 1: Family planning characteristics.

Characteristics	Frequency (n=421)	Percentage (%)
Method of family planning		
Implant	199	47.3
IUD	112	26.6
Injectable	88	20.9
Oral contraceptives	13	3.1
Condoms	5	1.2
Safe period	2	0.5
Bilateral tubal ligation	1	0.2
Withdrawal	1	0.2
Past family planning method (n=273)		
Oral contraceptives	52	19.0
Injectables	81	29.7
Condom	16	5.9
Implant	83	30.4
IUD	41	15.0
Duration of family planning		
<6 months	26	6.2
6 months–1 year	162	38.5
>1 year	233	55.3
Partner agreement with FP		
Yes	390	92.6
No	31	7.4

In Figure 2, among the 421 respondents, 7.1% reported a history of domestic violence. In contrast, a significant majority of 92.9% have indicated that they have no history of domestic violence.

Table 2 highlights the types and impacts of domestic violence experienced by the 30 respondents who reported IPV. Among them, 30.0% experienced physical violence, 40.0% psychological violence, 13.3% sexual violence, and 16.7% economic violence. Insomnia was the most common adverse effect, reported by 73.3%, while 10.0% experienced starvation and suicidal thoughts, and 6.7% reported body pain. Regarding family planning discontinuation, 33.3% intended to stop using their current method, while 66.7% did not. Among IPV survivors

considering family planning, 46.7% preferred injectables, 50.0% implants, and 3.3% IUDs. The main reason for their method choice was concealability (83.3%), while 16.7% preferred reversible options. In terms of the perceived impact of family planning on IPV, 46.7% felt it increased their partner's violence, 30.0% believed it reduced violence, and 13.3% saw no change. A small percentage felt it made their partner much more violent (3.3%) or slightly less violent (6.7%).

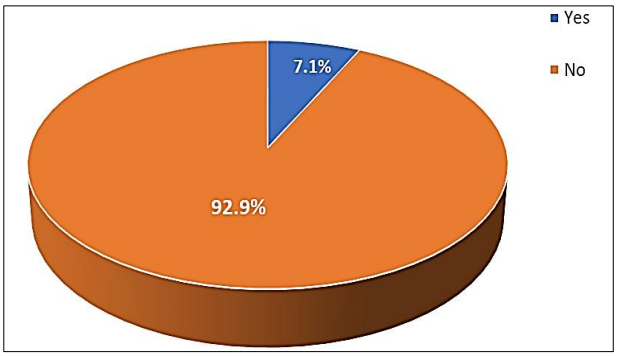

Figure 2: Domestic violence versus no domestic violence data.

In Table 3, among the 30 respondents who reported experiencing domestic violence, none had ever reported the incidents to law enforcement. About 63.3% considered it a family affair and did not report it, 23.3% did nothing, 10.0% sought spiritual help, and 3.4% personally retaliated. Regarding perceived solutions for gender-based violence (GBV) related to family planning, 26.7% suggested making laws to protect women. 13.3% believed that women should stop using family planning methods. 40.0% felt that couples counselling should be compulsory. Additionally, 20.0% thought that women should be allowed to use family planning methods without needing consent from their partners.

In Table 4, the study found a strong association between a history of IPV and partner acceptance of family planning. Among individuals with a history of IPV, only 43.3% reported that their partner accepted family planning, compared to 96.7% among those without IPV. This difference was statistically significant, with a Chi-square value of 115.111 and a p value of less than 0.001. Duration of family planning use also varied significantly between the two groups. Those with a history of IPV were more likely to have used family planning for shorter durations, particularly between 6 months and 1 year.

In contrast, those without a history of IPV had longer and more consistent use, with a significant Chi-square value of 16.396 and a p value of less than 0.001. When examining the types of contraceptive methods used, no significant differences were found between those with and without a history of IPV. The Chi-square value was 7.147 with a p value of 0.067, suggesting that contraceptive method choice is not strongly associated with IPV history.

In this study, nulliparous women, single women, those using family planning for less than 6 months, and those whose partners do not accept family planning have significantly higher odds of experiencing intimate partner violence (Table 5).

Table 2: Effect of domestic violence on family planning.

Variables	History of IPV		χ^2	P value
	Yes (n=30), N (%)	No (n=391), N (%)		
Partner acceptance of FP				
Yes	13 (3.3)	377 (96.7)	115.111+	<0.001
No	17 (54.8)	14 (45.2)		
Duration of FP				
<6 months	3 (11.5)	23 (88.5)	16.396	<0.001
6 months – 1 year	21 (13.0)	141 (87.0)		
≥1 year	6 (2.6)	227 (97.4)		
Contraceptives				
Implants	14 (7.0)	185 (93.0)	7.147	0.067
IUD	3 (2.7)	109 (97.3)		
Injectables	10 (11.4)	78 (88.6)		
Others	3 (13.6)	19 (86.4)		

Statistically significant: + Fisher's exact

Qualitative analysis

Thematic analysis of gender-based violence and contraceptive use

This comprehensive thematic analysis explores the relationship between gender-based violence (GBV) and contraceptive use, based on focused group discussions conducted with women and men, and key informant interviews conducted by healthcare professionals at the University of Benin Teaching Hospital in Nigeria. The analysis reveals several key themes that throw light on the complex challenges and dynamics surrounding family planning and intimate partner relationships.

By examining these themes in detail, we gain valuable insights into the multifaceted nature of reproductive health decision-making and its impact on gender relations within Nigerian society.

Contraceptive methods and preferences

The interviews reveal a wide range of contraceptive methods utilized by women in this community, including injectables, implants, and intrauterine contraceptive devices (IUCDs). Women reported using various methods, with one participant stating, "I use 3-monthly injection," while others mentioned, "Implant (Implanon – 3 yearly)." This diversity in contraceptive choices reflects not only the availability of options but also the individual preferences and needs of women in managing their reproductive health.

Table 3: Attitude of women towards IPV (n=30).

Characteristics	N	%
Type of domestic violence		
Physical	9	30.0
Psychological	12	40.0
Sexual	4	13.3
Economic	5	16.7
Adverse effects		
Insomnia	22	73.3
Starvation	3	10.0
Suicidal Ideation	3	10.0
Body pain	2	6.7
Intent to discontinue FP		
Yes	10	33.3
No	20	66.7
Preferred FP post-IPV		
Injectable	14	46.7
Implants	15	50.0
IUD	1	3.3
Reason for preferred FP method		
Hidden	25	83.3
Reversible	5	16.7
Perceived effect of FP on IPV		
Less violent	2	6.7
Less violent	9	30.0
No difference	4	13.3
More violent	14	46.7
Much more violent	1	3.3

Interestingly, the consultant gynaecologist noted that "The men generally prefer to use implants," suggesting a preference among male partners for longer-acting contraceptive methods. This preference may be attributed to several factors, including the extended effectiveness of implants, their reliability in preventing pregnancy, and potentially lower interference with sexual activity compared to other methods. The consultant's observation highlights the importance of considering male perspectives in family planning strategies, as their preferences can significantly influence contraceptive uptake and continuation.

The range of contraceptive methods discussed also included IUCDs, which were associated with specific concerns. As one healthcare provider noted, "The IUCD is the type most women complain about because their husbands would not enjoy sex due to discomfort from the thread of the IUCD." This statement shows the importance of considering not only the medical efficacy of contraceptive methods but also their impact on sexual relationships and partner satisfaction.

The diversity of contraceptive choices reflected in the interviews demonstrates the complexity of family planning decisions. These choices are influenced by a number of factors, including effectiveness, duration of action, side effects, ease of use, and impact on sexual relationships. Understanding these factors is necessary for healthcare providers and policymakers in designing comprehensive family planning programs that cater to the diverse needs and preferences of both women and men in the community.

Intimate partner violence related to contraceptive use

The analysis reveals that intimate partner violence related to contraceptive use is a concerning reality for some women in this community. Healthcare professionals confirmed the occurrence of IPV in this context, with the consultant stating, "Yes, there have been case of IPV" and further specifying, "There have been cases of sexual, physical, emotion IPV especially from family planning." The nurse also reported instances of "Verbal and psychological IPV" related to contraceptive use.

These reports of violence highlight the interplay between reproductive choices, relationship dynamics, and gender-based power imbalances. The reasons for IPV in this context appear to be many-sided, including disagreements over contraceptive use, side effects impacting sexual relationships, and issues of control and decision-making within partnerships. The consultant's observation that IPV can occur "especially from family planning" suggests that contraceptive use may exacerbate existing relationship tensions or trigger new conflicts.

The analysis also reveals instances where women felt compelled to discontinue contraceptive use due to pressure or threats from their partners. The nurse recounted a particularly troubling case: "There was a case the client insisted on removal because her husband exited her from the house due to her refusal to remove it. She was forced to remove it and her husband refused to come for counselling."

This example illustrates the extreme consequences some women face when their contraceptive choices conflict with their partners' wishes, highlighting the urgent need for interventions that address gender-based violence in the context of family planning.

Table 4: Relationship between intimate partner violence and use of family planning.

Variables	History of IPV		χ^2	P value
	Yes (n=30) N (%)	No (n=391) N (%)		
Partner acceptance of FP				
Yes	13 (3.3)	377 (96.7)	115.111+	<0.001
No	17 (54.8)	14 (45.2)		
Duration of FP				
<6 months	3 (11.5)	23 (88.5)	16.396	<0.001
6 months – 1 year	21 (13.0)	141 (87.0)		
≥1 year	6 (2.6)	227 (97.4)		
Contraceptives				
Implants	14 (7.0)	185 (93.0)	7.147	0.067
IUD	3 (2.7)	109 (97.3)		
Injectables	10 (11.4)	78 (88.6)		
Others	3 (13.6)	19 (86.4)		

Statistically significant: + Fisher's exact

Table 5: Predictors of intimate partner violence among respondents.

Predictors	β (Regression coefficient)	Odds ratio	95% CI for OR		P value
			Lower	Upper	
Age (years)					
≤30	0.857	2.357	0.528	10.519	0.261
31–40	-0.117	0.889	0.229	3.456	0.866
≥40		1			
Parity					
0	-2.721	0.066	0.006	0.765	0.030
1–4	-1.350	0.259	0.066	1.016	0.053
≥5		1			
Religion					
Christianity	-2.549	0.078	0.006	0.969	0.047
Muslim	2.414	11.176	0.401	31.787	0.155
Traditionalist		1			
Marital status					
Single+	-3.715	0.024	0.001	0.657	0.027
Married	-4.007	0.018	0.001	0.223	0.002
Single/divorced		1			
Duration of FP					
<6 months	2.457	11.670	2.141	63.605	0.005
6 months – 1 year	0.921	2.512	0.767	8.224	0.128
≥1 year		1			
Residence					
Urban	-0.587	0.556	0.147	2.099	0.386
Rural		1			
Partner acceptance of FP					
Yes	-3.926	0.020	0.006	0.069	<0.001
No		1			

Reference category, R2=19.7–48.9%, CI=confidence interval

Another doctor shared another concerning case: "There was a case of BTL, despite counselling of couple. The spouse later requested that he needed more children. Efforts to let him understand the it was not reversible was not accepted by the man. This led to episodes of emotional and psychological violence." This situation underscores the importance of thorough counselling for permanent contraceptive methods and the need to ensure that both partners fully understand and agree to the implications of such decisions.

The occurrence of IPV related to contraceptive use raises important questions about women's reproductive autonomy and safety within intimate partnerships. It

highlights the need for comprehensive approaches that address not only the medical aspects of family planning but also the social, cultural, and relational contexts in which these decisions are made.

Strategies for addressing GBV and promoting contraceptive use

The analysis reveals several strategies suggested by healthcare providers and participants for addressing GBV and promoting contraceptive use. These include:

Couple counselling

Many respondents emphasized the importance of counseling both partners together. As one healthcare provider stated, "Couple counselling is very important in preventing IPV. As involvement of men in family planning counseling will help mitigate the occurrence of IPV and improve acceptance of family planning."

Public awareness and education

There was a consensus on the need for broader public education about family planning. As one respondent suggested, "Use fliers, public awareness through use of social media. They know negative, lets spread positive. There should be outreaches to the rural areas where the misconception is much."

Engaging religious and community leaders

Given the influence of cultural and religious beliefs on family planning decisions, engaging community leaders was seen as crucial. One participant noted, "There is also a place of enlightenment of religious leaders who can help in creating awareness."

Women's empowerment

Financial independence and education for women were identified as key factors in enabling women to make autonomous decisions about their reproductive health. As one respondent stated, "Financial independence is key as they have better opportunity to make personal decision, girl child education (literacy), government and policy to protecting women especially in decision making."

Legal protection

Some respondents called for stronger legal measures to protect women's reproductive rights. As one healthcare provider suggested, "There should be a contraceptive right to enable the woman to make her own rightful decision."

Integrating GBV prevention in family planning services

The analysis suggests a need for family planning services to incorporate screening and support for women experiencing GBV, as well as referral pathways to appropriate services.

In conclusion, this thematic analysis reveals the complex interplay between contraceptive use, intimate partner relationships, and gender-based violence in the Nigerian context. The findings show the importance of comprehensive family planning programs that not only provide a range of contraceptive options but also address the social and relational aspects of contraceptive use. Engaging men in family planning education and decision-making, providing counseling on managing side effects, and integrating gender-based violence prevention and response into reproductive health services emerge as vital strategies for promoting women's reproductive autonomy and safety.

Furthermore, the analysis highlights the need for broader societal efforts to challenge harmful gender norms and promote equitable decision-making within intimate partnerships. This includes addressing cultural and religious beliefs that may hinder contraceptive use, empowering women through education and economic opportunities, and implementing legal frameworks that protect women's reproductive rights. By adopting a holistic approach that considers the medical, social, and cultural dimensions of family planning, healthcare providers, policymakers, and community leaders can work together to create an environment that supports women's reproductive choices while fostering healthier, more equitable intimate partner relationships. This many-sided approach is essential for reducing the incidence of gender-based violence related to contraceptive use and promoting overall reproductive health and well-being in Nigerian society.

DISCUSSION

This study evaluated the relationship between impact of family planning demand on IPV by exploring the prevalence of intimate partner violence in women on family planning and how both impact on one another. Although, the overall prevalence of intimate partner violence in patients on family planning was low, the impact on their physical and mental wellbeing was found to be significant. This is due to due to information gap among the male partners who then result to various forms of violence.

In this study, the prevalence of intimate partner violence among those on family planning was 7.1% which was low. The low prevalence was in line with the studies done in India (2.4%) by Mcdougal et al, and 8.7% in a study by Ahinkorah et al in a cross-country study in sub-Saharan Africa.[8,13] In contrast to our findings, other studies have recorded high prevalence of intimate partner violence amongst women on family planning. A study carried out by Alpsalaz et al in Anatolia Turkey showed prevalence IPV among women on family planning was 35.7%, a study by Dadras et al in 2015 55.89% experienced domestic

violence among the study population on family planning.[16,19] Another study in Ethiopia showed that 23.8% had IPV.[10] About half (51.2%) of the women who had intimate partner violence were on family planning methods.[11] This difference can be attributed to different social and cultural values that exist worldwide including within Africans. This study further evaluated the type of IPV mostly experienced by women on family planning. Among the 30 respondents who reported experiencing domestic violence, 30.0% experienced physical violence, 40.0% endured psychological violence, 13.3% faced sexual violence, and 16.7% experienced economic violence. This is similar to the findings in Guinea Conakry where the most common violence experienced was psychological violence, although their prevalence was higher 79.3%.[11] Also, similar finding by Alpsalaz et al showed that 7.5% sexual violence by their partners, 10.5% experienced physical violence, 12.6% experienced economic deprivation while 18.8% experienced verbal abuse.[19] A study that evaluated the types of IPV by Chen et al showed that 10.9% experienced physical intimate partner violence while 2.7%.[14] This is lower than the proportion of findings seen in our study; however, it shows that such form of IPV actually exists.

In our findings, the adverse effects of domestic violence reported include insomnia, affecting 73.3% of the respondents. Starvation and suicidal ideation were each reported by 10.0% of the respondents, while 6.7% experienced body pain. This shows the morbidities that can be associated with this covert mitigation of family planning by intimate partner violence. As a result of intimate partner violence, 33.3% of respondents indicated they planned to stop using their current method, while 66.7% did not intend to discontinue. This is similar to a study by Ahinkorah et al which showed that the overall prevalence of sexual violence within 1year of family planning resulted in 10% increase in unmet need for contraception.[13] During the qualitative interviews, the nurse recounted a particularly troubling case: "There was a case the client insisted on removal because her husband exited her from the house due to her refusal to remove it. She was forced to remove it and her husband refused to come for counselling." This example illustrates the extreme consequences some women face when their contraceptive choices conflict with their partners' wishes, highlighting the urgent need for interventions that address gender-based violence in the context of family planning

For clients' preference, those who experienced intimate partner violence and were considering family planning options, 46.7% preferred injectables, 50.0% preferred implants, and 3.3% preferred the IUD. When asked about their reasons for preferring certain family planning methods, 83.3% chose methods that are hidden from view, and 16.7% selected methods that are reversible. During the qualitative interviews one participant stating, "I use 3-monthly injection," while others mentioned, "Implant (Implanon – 3 yearly" while the consultant gynecologist noted that "The men generally prefer to use implants," suggesting a preference among male partners for longer-acting contraceptive methods. As one healthcare provider noted, "The IUCD is the type most women complain about because their husbands would not enjoy sex due to discomfort from the thread of the IUCD." This statement shows the importance of considering not only the medical efficacy of contraceptive methods but also their impact on sexual relationships and partner satisfaction. This preference may be attributed to several factors, including the extended effectiveness of implants, their reliability in preventing pregnancy, and potentially lower interference with sexual activity compared to other methods.

For women that had a previous history of intimate partner violence, few women (6.7) they stated that family planning made the partner much less violent largely due to their agreement to sexual intercourse due to safety of family planning, 30.0% felt it made their partner less violent, and 13.3% saw no difference. However, 46.7% felt that family planning made their partner more violent, and 3.3% believed it made their partner much more violent. During the interviews, the consultant's observation that IPV can occur "especially from family planning" suggests that contraceptive use may exacerbate existing relationship tensions or trigger new conflicts.

In this study, despite the existence of IPV, none of the women reported the incidents to law enforcement. This is because most clients (63.3%) considered it a family affair, while 10.0% sought spiritual help, 3.4% personally retaliated, and 23.3% did nothing. This shows the cultural limitation in addressing this scourge of intimate partner violence. In Africa, where patriarchy is practiced, such issues are hardly reported or addressed as they are seen as taboo to be reported. Hence, it should be resolved within the family, which in most cases the woman is made to submit to whatever decision the man takes as the "head of the home". From our findings, half of the clients who experienced IPV were aged 30years and below, half had a primary level of education, the majority (83.3%) were married and lived in urban areas (63.3%). All these were found to be statistically significant and showed a high difference between both groups that experienced IPV and those that didn't.

Among those with a history of IPV, 13 out of 30 individuals (43.3%) reported that their partner accepted family planning, while 17 out of 30 (56.7%) reported that their partner did not accept it. In contrast, among those without a history of IPV, almost all (96.7%) reported that their partner accepted family planning, while very few (3.3%) reported that their partner did not accept it. The chi-square test yielded a value of 115.111 with a p value of less than 0.001, indicating a highly significant difference between the two groups.

For the duration of use, majority (70%) had been on family planning for period between 6 months and a year while about one-fifth had been on family planning for over a year and few (11.5%) had used family planning for less than

6months. In the group without a history of IPV few individuals (5.9%) had used family planning for less than 6 months, while about one-third (36.1%) had used it for between 6 months and 1 year while about half had used it for more than a year. The Chi-square test yielded a value of 16.396 with a p value of less than 0.001, indicating a highly significant difference in the duration of family planning between the two groups.

In this study, among implant users, few (7.0%) had a history of IPV, while majority individuals (93.0%) did not. For IUD users, few clients (2.7%) had a history of IPV, compared to majority (97.3%) who did not. Among injectable contraceptive users, relatively few clients (11.4%) had a history of IPV, while majority (88.6%) did not. For those using other methods of contraception such as condoms, oral contraceptive pills few (13.6%) had a history of IPV, majority of the individuals (86.4%) who did not. The Chi-square test value was 7.147, with a p value of 0.067, indicating that the differences in contraceptive methods used by those with and without a history of IPV were not statistically significant. Therefore, the type of contraceptive method does not appear to be significantly associated with a history of IPV.

Regarding perceived solutions for GBV related to family planning, 26.7% suggested making laws to protect women. 13.3% believed that women should stop using family planning methods. 40.0% felt that couples counselling should be compulsory. Additionally, 20.0% thought that women should be allowed to use family planning methods without needing consent from their partners. In the qualitative studies, a doctor shared a case: "There was a case of BTL, despite counselling of the couple. The spouse later requested that he needed more children. Efforts to let him understand that it was not reversible were not accepted by the man. This led to episodes of emotional and psychological violence." This situation underscores the importance of thorough counselling for permanent contraceptive methods and the need to ensure that both partners fully understand and agree to the implications of such decisions.

CONCLUSION

This is the first mixed-method study in Sub-Saharan Africa involving both patients and healthcare workers to examine the relationship between IPV and family planning demand. Although IPV prevalence was low among women using family planning, the risk increased with higher demand and was significantly lower among women whose partners accepted family planning. Injectable and implant methods were preferred due to their discreet nature, aligning with sociocultural norms. In the African context, joint counselling is essential to promote partner acceptance, improve compliance, and reduce IPV risk. The study recommends integrating spouses into family planning counselling. Qualitative findings highlighted strategies such as couple counselling, public awareness, women's empowerment, legal protection, and incorporating GBV prevention into family planning services to improve contraceptive uptake and address IPV.

Strength of the study

To our knowledge, this first mixed-method study in sub-Saharan Africa that combines quantitative analysis, focus group discussions with patients and their partners, and key informant interviews with healthcare workers. This approach provides a comprehensive and holistic understanding of the subject matter, especially in our setting.

ACKNOWLEDGEMENTS

Authors would like to thank all clients and health workers who participated in this study.

Funding: No funding sources
Conflict of interest: None declared
Ethical approval: The study was approved by the Institutional Ethics Committee

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Cite this article as: Iweka RO, Sodje JD, Anya CJ, Nwaogwugwu JC. Exploring the relationship between family planning and intimate partner violence: a mixed-methods study. Int J Reprod Contracept Obstet Gynecol 2025;14:4114-24.