Social Science & Medicine 133 (2015) 2–10

Contents lists available at ScienceDirect

Social Science & Medicine

journal homepage: www.elsevier.com/locate/socscimed

Intimate partner violence, modern contraceptive use and conflict in the Democratic Republic of the Congo

Rachel Kidman [a, *], Tia Palermo [a], Jane Bertrand [b]

[a] Program in Public Health, Department of Preventive Medicine, Stony Brook University, Health Sciences Tower, Level 3, Room 078, Stony Brook, NY 11794, USA

[b] Department of Global Health Systems and Development, Tulane University School of Public Health and Tropical Medicine, 1440 Canal Street, Suite 1900, New Orleans, LA 70112, USA

ARTICLE INFO

Article history:
Available online 16 March 2015

Keywords:
Intimate partner violence
Modern contraception
Conflict
Democratic Republic of the Congo
Family planning
Sexual violence

ABSTRACT

Intimate partner violence (IPV) has been found to be negatively associated with contraceptive use in developing countries, but evidence from Africa is mixed. This study examines whether the above association differs in conflict settings, which have the potential for both higher levels of violence and more limited access to family planning. We use nationally representative data from the Democratic Republic of the Congo to examine the relationship between individual- and community-level IPV and modern contraceptive use, and to explore whether conflict modifies the relationship between IPV and contraceptive use. Nationally, only 6% of women reported current modern contraceptive use, while 53% reported experiencing physical IPV and 32% reported experiencing sexual IPV. In multivariate models, we found that individual-level sexual IPV was positively associated with current using modern contraceptive use, but that a combined measure of physical and sexual IPV did not demonstrate a similar association. Community-level IPV was not associated with individual-level contraceptive use. Conflict exposure was neither an independent predictor nor modifier of contraceptive use. Results suggest improved access to family planning should be a priority for programming in DRC, and efforts should ensure that sufficient resources are allocated towards the reproductive health needs of women in both conflict and non-conflict regions.

© 2015 Elsevier Ltd. All rights reserved.

1. Introduction

The highest rates of intimate partner violence (IPV) globally are found in Central Africa, where 66% of ever-partnered women report experiencing IPV (Devries et al., 2013). Negative health consequences of IPV include sexually transmitted infections, chronic pain, physical disability, psychological sequelae, and substance abuse (Campbell, 2002; Campbell and Soeken, 1999; Ellsberg et al., 2008; Heise et al., 2002; Peterman and Johnson, 2009; Rees et al., 2011). Additionally, research in developing countries has consistently found that IPV is a risk factor for mistimed and unwanted pregnancy (Gazmararian et al., 1996; Heise et al., 2002; Miller et al., 2010; Pallitto and O'Campo, 2004; Valladares et al., 2002), largely through its influence on contraceptive use (Coker, 2007). The application of this last finding to African settings has, however, been challenged (Alio et al., 2009). Moreover, we know of no study that examines the interplay between IPV and family planning in conflict areas. This is a critical oversight: women in conflict settings typically have less access to family planning and may experience greater levels of IPV – a dangerous combination. Even for those without personal experience of IPV, heightened IPV levels may deter many women from initiating contraceptive use. Drawing on data from the Democratic Republic of the Congo, this paper fills three important gaps: first, it investigates the relationship between individual IPV and current modern contraceptive use in an African context; second, it extends such investigations to test the role of community IPV prevalence; and third, it examines whether these associations differ by conflict setting status.

1.1. IPV and family planning

Women who experience IPV may have limited control over family planning, either because they are subjected to more frequent

* Corresponding author.
E-mail addresses: rachel.kidman@stonybrook.edu (R. Kidman), tia.palermo@stonybrook.edu (T. Palermo), bertrand@tulane.edu (J. Bertrand).

http://dx.doi.org/10.1016/j.socscimed.2015.03.034
0277-9536/© 2015 Elsevier Ltd. All rights reserved.

and forced sex or because they are unable to negotiate condom use successfully (Campbell et al., 2013; Coker, 2007). Specifically, studies show that some women fear raising the issue of contraception, lest their partner react violently (Bawah et al., 1999; Ezeh, 1993; Fort, 1989; Heise et al., 2002). Partners may interpret a request to use contraceptives as evidence of the wife's infidelity, an accusation of the husband's infidelity, or a general affront to his masculinity (Heise et al., 2002).

Consistent with the above pathways, there is an extensive literature documenting the relationship between IPV and poor reproductive health outcomes in the developed world, with much of this literature focused on contraceptive use (Coker, 2007). Far fewer studies have been conducted in developing country contexts, despite the higher prevalence of IPV in these regions (Devries et al., 2013), and studies that have examined this relationship report conflicting findings. Prospective studies in India (Stephenson et al., 2013) and in urban areas of South Africa and Zimbabwe (Kacanek et al., 2013) confirm the negative relationship between IPV and contraceptive use observed in more developed countries. Other studies, however, challenge the applicability of these findings to the African context. In a South African study, women with a past history of domestic violence were *more* likely to ask their current partners to use a condom, though we note that IPV in the past year was not related to condom use (Jewkes et al., 2003). Similarly, a Nigerian study found women exposed to physical IPV had a *greater* likelihood of using modern contraception (Okenwa et al., 2011). Further, a cross-sectional study that pooled data from six African countries found partner IPV was associated with *greater* likelihood of ever having used a method of modern and traditional contraception (Alio et al., 2009). Possible explanations posed by the authors include a desire to avoid pregnancy in unfavorable circumstances, a desire to protect against HIV with violent partners, and finally, that contraceptive use incited IPV (reverse causation) (Alio et al., 2009). Taken together, the heterogeneity of findings suggests the interplay between IPV and modern contraceptive use is highly dependent on context, and warrants unique investigation by country (Okenwa et al., 2011).

Past studies have also investigated the role of community level IPV in family planning. Women living in communities in which IPV is highly prevalent may fear reprisals if they suggest contraceptive use, regardless of prior personal experiences with IPV (Hung et al., 2012; Pallitto and O'Campo, 2005). Specifically, Hung et al. (2012) suggests that community IPV levels may reflect norms around violence and unequal gender relations. By signaling that violence is a culturally accepted response, community-level IPV may operate to deter other women from using contraception. Their fear may not be unfounded: McQuestion (2003) found that women living in Colombian communities characterized by high IPV had 64% higher odds of experiencing IPV themselves, independent of individual risk factors. In addition, community IPV levels may reflect gender norms more broadly, including power imbalances that inhibit contraceptive negotiation.

While further qualitative work appears warranted in this area, there is emerging evidence of an empirical association. For example, Speizer et al. (2009) reported that community prevalence of IPV was associated with lower use of contraception among South African youths. In a related investigation, Hung et al. (2012) found that community prevalence of IPV had a similar and independent correlation with birth spacing (the primary reason for contraceptive use in sub-Saharan Africa (Jansen and William, 2005)). Further, Pallitto and O'Campo (2005) demonstrated an association between community-level measures of patriarchal control in Colombia and unintended pregnancy (McQuestion, 2003; Pallitto and O'Campo, 2004), a common correlate of IPV. Thus, there is evidence that community IPV rates are associated with reproductive outcomes, though studies have yet to explicitly examine contraceptive use.

1.2. IPV, family planning and conflict

Ensuring a woman's access to family planning is all the more difficult in times of prolonged conflict or war (McGinn et al., 2011). This is in part due to the restricted supply of family planning services (e.g., health systems collapse, human resources flee). Even when services are available, conflict may disrupt travel routes and/or create unsafe conditions for travel, thus creating another barrier to access (Mock et al., 2004). Prolonged conflict may also heighten the risk of IPV. Sexual violence may become 'normalized' in situations of conflict, thus increasing civilian rape and intimate partner sexual violence (IPSV) (for a review of conflict and IPV, see (Baaz and Stern, 2010)). Even after conflict ends, the learned behavior of returning soldiers and civilians may continue to perpetuate the epidemic of IPV. Some women who suffered war-related trauma also continue to experience psychological symptoms, which increases their risk for IPV (Saile et al., 2013). While the above pathways suggest that IPV would be elevated in conflict situations, only one empirical study has tested this hypothesis: Janko et al. (2014) found a significant, positive relationship between conflict and IPV. Finally support for this hypothesis comes from the observation that IPV prevalence estimates from conflict settings are high (Stark and Ager, 2011) as compared to global estimates (Devries et al., 2013). Further, men who have been affected by conflict (displaced, wounded, or witnessed violence) report perpetrating IPV at higher rates (Peacock and Barker, 2014).

Moreover, the epidemic of sexual violence – both from combatants and partners – may fundamentally alter the context in which family planning decisions are made. For example, the desire to avoid pregnancy in such dire circumstances may outweigh the fear of reprisals if a woman is caught using contraceptives. Despite the potentially heightened IPV risk and lowered access to family planning that accompanies war, we know of no studies examining the relationship between the two in a conflict zone.

1.3. The Democratic Republic of Congo

The DRC is characterized by high rates of IPV and low rates of family planning, making this a unique setting in which to study their association. Approximately a third of the women report intimate partner sexual violence, more than double the rates reported in neighboring countries (Hindin et al., 2008; Peterman et al., 2011). Contraceptive use, on the other hand, remains extremely low (20% report ever using a modern method; only 6% report currently using such), resulting in one of the highest total fertility rates globally (6.3) (Ministère du Plan et Macro International, 2008). In contrast, current modern contraceptive usage ranged from 13% to 33% in five neighboring countries with data available for the same time period (Macro International Inc., 2014).

Moreover, by focusing our investigation within the DRC, we are able to examine the association between conflict, IPV and contraceptive use. The country has been in a virtually continuous state of conflict since 1996, despite two peace agreements (Central Intelligence Agency, 2013). It is estimated that between 3.3 and 5 million people died as a result between 1998 and 2007 alone (Gambino, 2011; International Rescue Committee, 2007). Sexual violence, perpetrated by both military and civilians (Bartels et al., 2011; Johnson et al., 2010; Wakabi, 2008), has been a common feature of the conflict: based on a 2007 survey, it was estimated that 1.69 to 1.80 million women nationally, or between 642,000 and 704,000 in conflict-affected areas of Eastern DRC, had been raped in their lifetime (Peterman et al., 2011). Further, interviews with survivors highlight brutal tactics related to sexualized violence including gang rape, rape with instruments such as guns, and forced incest (Kelly et al., 2011). This is often followed by rejection

Download English Version:

https://daneshyari.com/en/article/7332654

Download Persian Version:

https://daneshyari.com/article/7332654

Daneshyari.com