Intimate partner violence and women's reproductive health

Janet Fanslow

Abstract

Intimate partner violence (IPV) is common among women. An estimated 30% of all women globally report experiencing physical or sexual violence by a husband, intimate partner or ex-partner. It is important for those working in reproductive health settings to be aware that sexual assault can occur in the context of relationships. IPV can also include reproductive and sexual coercion. Reproductive coercion includes behaviours that interfere with contraception use and/or pregnancy, while sexual coercion includes behaviours related to pressuring or coercing a person to have sex without using physical force. Past or current IPV in a woman's life can have profound implications for all aspects of her reproductive health, and healthcare providers need to have the skills to identify IPV, and provide appropriate support and referrals as required.

Keywords domestic violence; intimate partner violence; reproductive coercion; reproductive health; sexual assault; sexual coercion; spouse abuse

> *"As painful as it is to admit that we are being abused, it is even more painful to come to the conclusion that the person we love is someone we cannot afford to be around."~ Survivor of domestic violence*

Background

Intimate partner violence is defined as attempted, threatened or actual physical, sexual or mental abuse by a current or former intimate partner. The term "domestic violence" is used in many countries to refer to intimate partner violence but in some settings domestic violence also is used to describe child abuse and neglect, and elder abuse and neglect. Men are the most common perpetrators of intimate partner violence against women, although intimate partner violence (IPV) can also occur in same sex relationships, and, in some cases, is perpetrated by women against men.

Globally, intimate partner violence accounts for the largest proportion of the problem of violence against women, with an estimated 30% of women likely to experience physical or sexual IPV in their lifetime. While substantial, it is also likely that these prevalence rates are underestimates, due to the social stigma associated with disclosing victimization. The physical and mental health effects resulting from experience of IPV are also considerable; a consequence of this is that the rates of IPV among women presenting to healthcare services are even greater than IPV rates within the general population. However, IPV is frequently under-recognised by healthcare providers, as many women do not disclose abuse unless they are directly asked about it by a healthcare provider.

One of the reasons that healthcare providers may find identification of IPV a challenge is that it can encompass a broad range of abusive behaviours. The Power and Control Wheel, developed by the Domestic Abuse Intervention Program in consultation with over 200 women who had experienced violence, has been widely used internationally to help people recognize and name the tactics that are used within violent relationships. This model highlights that, through use of these tactics, the abuser can wind up with significant levels of power and control over a woman, in ways that compromise her autonomy. The ability to recognize and help women name these tactics is an important step in helping to identify and counteract the cumulative effects of experiencing abuse. Copies of the Power and Control Wheel are available at: http://www.theduluthmodel.org/training/wheels.html.

> *"I remember walking up to her and smacking her full force, I grabbed her by her neck, and I kind of held her against the car. Then, I walked her over to the bushes and threw her in there, and I just started choking her. It was with every bit of rage, every bit of anger I've ever had." ~ Confession of a violent offender*

What are some of the risk factors for intimate partner violence?

Current scholarship seeking to explain the factors that increase a man's likelihood of perpetrating IPV emphasize the multifactorial nature of the problem, noting that influences at the societal, community, relationship and individual levels all play a role. The World Health Organization (2002) has summarised some of factors that increase a man's risk of abusing his partner across these levels (Table 1).

Dynamics of intimate partner violence and effects on reproductive health

A violent episode can be a single act, or a series of violent acts that may persist over a period of minutes, hours, or days. A violent episode may involve single or multiple types violence (e.g., physical violence, sexual violence, psychological/emotional abuse, all three types together). Violent episodes tend to occur at multiple times throughout an abusive relationship and, without intervention, often increase in frequency and severity over time. Thus it is not surprising that there are immediate and long-term physical, mental health and reproductive health consequences

Janet Fanslow *PhD (University of Auckland), Associate Professor, Social and Community Health, School of Population Health, University of Auckland, Auckland, New Zealand. Conflicts of interest: none declared.*

Please cite this article in press as: Fanslow J, Intimate partner violence and women's reproductive health, Obstetrics, Gynaecology and Reproductive Medicine (2017), http://dx.doi.org/10.1016/j.ogrm.2017.02.003

Factors associated with a man's risk of abusing his partner

Individual factors

- Young age
- Heavy drinking
- Depression
- Personality disorders
- Low academic achievement
- Low income
- Witnessing or experiencing violence as a child

Relationship factors

- Marital conflict
- Marital instability
- Male dominance in the family
- Economic stress
- Poor family functioning

Community factors

- Weak community sanctions against domestic violence
- Poverty
- Low social capital

Societal factors

- Traditional gender norms
- Social norms supportive of violence

Reprinted from World Report on Violence and Health. Krug, Dahlberg, Mercy, Zwi, Lozano (eds). Chapter 4: Violence by intimate partners. Page 98 (2002).

Table 1

for women who experience abuse. In addition, the abusive partner can also directly target a woman's reproductive freedom. This can take the form of rape and sexual assault, but can also include reproductive coercion and sexual coercion.

Reproductive coercion is defined as behaviours that interfere with contraception use and/or pregnancy, such as threatening to end a relationship if the woman does not get pregnant, or if she does not terminate a pregnancy.

Control of contraception. Internationally, there is evidence that men who use violence against their intimate partners are more likely to interfere with a woman's access to contraception. This can be through controlling her access to healthcare services or family planning care, or through tactics such as hiding or destroying her contraceptive methods or refusing to use a condom. Use of these tactics by an abusive partner is sometimes called "birth control sabotage" (Box 1).

Sexual coercion (Box 2). This includes a range of behaviours that a partner may use related to sexual decision-making to pressure or coerce a person to have sex without using physical force.

Health outcomes for the women

A growing body of evidence documents the significant impact of intimate partner violence on women's health. Physical injury from IPV can range from minor bruises or cuts, through to long term disability or even death. In the United States, homicides accounted for 8.4% of pregnancy-related mortality, the second most common cause of injury related deaths in pregnancy. In India, up to 16% of all deaths during pregnancy were considered to be related to domestic violence. Chronic pain, gastrointestinal problems, and other gynaecological problems are also common among women who have experienced IPV. Women with violent partners are also at increased risk of contracting sexually transmitted infections; violent partners are more likely to have multiple concurrent partners, and forced sex increases the risk of transmission of infection.

Intimate partner violence can also create a substantial mental health burden for women, with anxiety, phobia and depression common problems among women who have been hurt by their partners. Women who have experienced IPV are also are at heightened risk for suicide and suicidal attempts.

Birth control sabotage

Examples of birth control sabotage include:

- Hiding, withholding, or destroying a partner's birth control pills
- Breaking or poking holes in a condom on purpose or removing it during sex in an explicit attempt to promote pregnancy
- Not withdrawing when that was the agreed upon method of contraception
- Pulling out vaginal rings
- Tearing off contraceptive patches

Box 1

Examples of sexual coercion, (which may occur in heterosexual or same sex relationships)

- Repeatedly pressuring a partner to have sex when they do not want to
- Threatening to end a relationship if a person does not have sex
- Forced non-condom use or not allowing other prophylaxis use
- Intentionally exposing a partner to a STI or HIV
- Retaliation by a partner if notified of a positive STI result

Box 2

Other effects of IPV and reproductive and sexual coercion

Pregnancy intendedness: women's experience of violence and sexual and reproductive coercion also impacts on pregnancy intendedness, with one study reporting that 28% of women who had experienced violence during pregnancy "wanted to be pregnant then", compared with 55% of women who had not experienced violence during pregnancy. Women who experienced IPV also reported that their male partners were less likely to want the pregnancy. Intendedness of pregnancy is strongly correlated with parental attachment and bonding to the child, and to later health and social outcomes of the child.

Termination of pregnancy: women who have experienced IPV are also more likely to terminate a pregnancy, with one study

Please cite this article in press as: Fanslow J, Intimate partner violence and women's reproductive health, Obstetrics, Gynaecology and Reproductive Medicine (2017), http://dx.doi.org/10.1016/j.ogrm.2017.02.003