Apr 2018. Vol. 26. No 01 ISSN 2307-2083
International Journal of Research In Medical and Health Sciences

http://www.ijsk.org/ijrmhs.html

RELATIONSHIP BETWEEN INTIMATE PARTNER VIOLENCE AND FAMILY PLANNING AMONG WOMEN ATTENDING NYARUSIZA HEALTH CENTER

[1]Narcisse Ntawigenera, [2]Laurence Musengamana, [3]Yvonne Uwimana

[1]Assistant Lecturer, Department of Public Health, Catholic University of Rwanda
[2] Data Manager, Nyarusiza Health Center, Nyamagabe district
[3] Nurse, Kayanga Health Center, Gasabo district

E-mail: [1]narcinta@gmail.com, [2]lmusengamana@yahoo.fr, [3]uyvonne911@gmail.com

ABSTRACT

Intimate partner violence is a global social issue that infringes on women's rights, endangers their safety, and affects their overall wellbeing. It is associated with a number of reproductive and mental health problems. This study was aimed to examine the relationship between intimate partner violence and family planning. The study was conducted through a cross-sectional study. The study population was women who attend Nyarusiza Health Center services. The sample size was 97 women selected conveniently and data was collected from a self administered questionnaire given to respondents.

The results showed that 75.3% of respondents have experienced intimate partner violence. From study findings, 49.32% of women experiencing Intimate Partner Violence use contraceptive method as family planning method, while 20.54% use natural method, and 30.14% have no family planning method. On the other hand, 75% of women who have not experienced Intimate Partner Violence use contraceptive method as family planning method, 8.33% use natural method and 16.66% have no family planning method. The Chi-Square test showed that there is no significant relationship between experience of Intimate Partner Violence and used family planning method (Pearson Chi-Square=4.901, P=0.086). Even if the highest proportion (65%) has on the same time experienced Intimate Partner Violence and unwanted pregnancy, the Pearson Chi-Square test showed that there is no significant association between the two variables (Pearson Chi-Square=2.883, P=0.089). On the same trend, the Chi-Square test rejected the dependence between Intimate Partner Violence and abortion (Pearson Chi-Square=0.335, P=0.563). Therefore, it has been concluded that there is no significant relationship between Intimate Partner Violence and Family planning.

The findings of research indicate that there is a need to include intimate partner violence screening and its treatment in reproductive health programs, to promote men's involvement in fertility control programs, and to improve the social and political response to intimate partner violence.

Keywords: *Intimate Partner violence (IPV), Reproductive health, Family Planning, contraceptive method, natural family planning method.*

1. INTRODUCTION

Intimate partner violence refers to any behavior within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship. Such behavior includes acts of physical aggression, such as slapping, kicking and beating; psychological abuse, such as intimidation and humiliation; forced intercourse and other forms of sexual coercion (WHO, 2002). In countries with relatively low levels of awareness about Intimate Partner Violence, the consequences of violence are perceived to be limited to the woman's death or severe bodily harm (Fox et al, 2007). Nonetheless, in addition to injuries as a direct result of violence, Intimate Partner Violence can have long-lasting adverse effects on a woman's reproductive health (Coker, 2007).

Globally, approximately one in three women who have ever been in a relationship has experienced Intimate Partner Violence (WHO, 2013). Women face a greater risk of violence from an intimate partner than from anyone else (Claudia & al, 2006).

The highest rates are found in Africa, the eastern Mediterranean, and Southeast Asia. Approximately 37 percent of women in each of those regions experience Intimate Partner Violence, compared to 23 percent in high-income regions. Some women may be especially vulnerable to Intimate Partner Violence and the associated negative consequences, including young women and women in crisis or conflict settings (WHO, 2012). Other factors that increase the risk include early marriage, partner's alcohol abuse, and witnessing domestic violence as a child. Intimate Partner Violence imposes significant health and rights consequences on women, including poor physical, mental, and reproductive health, and on their infants and children, who are at greater risk for a variety of poor health and development outcomes. The negative effects extend to national development that is hampered by lost productivity and increased health and other social services cost (WHO, 2012).

A rights-based approach to family planning and reproductive health accounts for the full range of barriers that may interfere with a woman's ability to make free, informed, and voluntary decisions about her reproductive health and behavior, including contraceptive use (Gilles, 2015). Seen through this lens, addressing Intimate Partner Violence is a strategy for enabling otherwise disempowered women to gain some control over one aspect of their lives. Intimate Partner Violence is a violation of multiple human rights, including the right to life and security of the person, the right to equality, and the right to the highest attainable standard of health (WHO, 2013). The growing emphasis on a rights-based approach to reproductive health care promotion and provision presents a key opportunity to address the negative impact of Intimate Partner Violence.

In a global review, the World Health Organization notes that "Women in violent relationships, or who live in fear of violence, may have limited control over the timing or circumstances of sexual intercourse". Women exposed to Intimate Partner Violence may not be able to choose when to have sex, protect themselves from HIV and other sexually transmitted infections, or insist on contraception. It is sometimes accompanied by reproductive coercion, in which a male partner directly interferes with a woman's desires for her pregnancy (Jay & al, 2014). The controlling behavior that often characterizes violent relationships can constrain a woman's access to health care, including family planning, and exacerbate health problems associated with Intimate Partner Violence. These women also experience higher rates of unintended pregnancy (Hindin, Kishor & Ansara, 2015). The empowerment gives freedom of choice, thus also can enable women to make better choice of modern family planning method. In the other hand, women have an opportunity to discuss with their partners on family planning. This has an impact not only to family planning, but also to reproductive health that in turn has good perinatal and maternal outcome thus reduce neonatal and maternal mortality rate (Kiday et al, 2015). This was also supported by other studies by which the findings suggested that women who were empowered have greater odds of using family planning methods (Tadesse, 2013).

Awareness is still limited regarding the relationship between Intimate Partner Violence and reproductive health and the appropriate role of policymakers and health care providers in identifying, responding to, and supporting victims. This study aims to examine the relationship between intimate partner violence and family planning among clients in Nyarusiza health center located in Nyamagabe district, Southern province of Rwanda, and the effects of intimate partner violence associated to family planning.

2. MATERIALS AND METHODS

This research was a descriptive and analytical cross-sectional study. The experience of Intimate Partner Violence among women in reproductive age and family planning were variables of the research. The study population was the women in reproductive age (between 18 and 50 years) attending Nyarusiza Health Center services. Those who have attended Nyarusiza Health Center services without having a husband or an identifiable intimate partner were excluded from the study. The Yamane's simplified formula for finite population was used to determine the sample size. This is defined as: $n = \frac{N}{1+N(e)^2}$,Where n= sample size, N=population, e=precision. From the records of Nyarusiza Health Center, it is estimated that there are 3465 women who attend its services. The sample size representative was calculated like this: $n= 3465/1+3465(0.1)^2= 97.19$. Then, the sample size has been 97 women. The data was obtained from a self administered questionnaire given to 97 respondents. The questionnaires were completed voluntarily by all selected respondents. The questionnaire used was close-ended questions by

Apr 2018. Vol. 26. No 01 ISSN 2307-2083
International Journal of Research In Medical and Health Sciences

http://www.ijsk.org/ijrmhs.html

which are offered a set of answers from which they are asked to choose the one that most closely represents their views. They were consisting of three sections. The first one concerned socio-demographic characteristics of respondents. The second section was related to the Intimate Partner Violence experience and the last section was related to family planning. Data collection was carried out within the month of May 2016. Data was analyzed by using the SPSS 17.0 software package. The statistic measurements are presented as frequency, percentage and cross tabulations. In addition, the correlation between experience of Intimate Partner Violence and Family Planning issues were estimated using Chi-Square Tests.

3. RESULTS AND DISCUSSION

3.1 Experience of Intimate Partner Violence

Following results of the study, 75.3% of respondents (73 women) have experienced Intimate Partner Violence. 66% of them have reported that they were prevented from meeting their needs by their partners. Other forms of Intimate Partner Violence which are the most experienced are punching kicking (55%), threatening to be hitted (49%), using bad language and swearing (47%), forced sexual relations (46%) and banning the woman from contacting friends (45%).

3.2. Experience of intimate partner violence and family planning method

From study findings, 49.32% of women experiencing Intimate Partner Violence (36 women) use one of contraceptive methods as family planning method, while 20.54% (15 women) use natural family planning method and 30.14% (22 women) have no family planning method. On the other hand, 75% of women who have not experienced Intimate Partner Violence (18 women) use contraceptive method as family planning method, 8.33% (2 women) use natural method and 16.66% (4 women) have no family planning method (See Table 1).

Table 1

Experience of intimate partner violence and family planning method

		Family planning method			
		Contra-ceptive method	Natural family planning method	No family planning method	Total
Experience of IPV	Yes	36	15	22	73
	No	18	2	4	24
Total		54	17	26	97

3.3. Test of independence between experience of Intimate Partner Violence and Family Planning method

Table 2

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	4.901	2	.086
Likelihood Ratio	5.157	2	.076
Linear-by-Linear Association	3.696	1	.055
N of Valid Cases	97		

From the table above (Table 2), the probability of the chi-square test (chi-square=4.901) is P=0.086, greater than the alpha level of significance of 0.05. So we conclude that there is no significant relationship between experience of Intimate Partner Violence and Family Planning method.

Apr 2018. Vol. 26. No 01 ISSN 2307-2083
International Journal of Research In Medical and Health Sciences

http://www.ijsk.org/ijrmhs.html

3.4. Process of determination of family planning method

Table 3

Who chosen family planning method?

	Frequency	Percent
Wife	19	19.6
Husband	24	24.7
Both	30	30.9
None	24	24.7
Total	97	100.0

In this study, the results showed that 24.7% of respondents have said that their partners have greatly dominated in selecting family planning methods which they have adopted. These results are similar to the study done in Tanzania where the rural women on average did not feel free to decide over family planning matters, and the main obstacle was the husband (Rapp, 2009). According to the same study, the urban women mostly felt free to decide if and when they wanted to have children. They took that decision together with the husband, thought they could not decide that by themselves (Rapp, 2009). In this study, 19.6% of participants revealed that they determined themselves family planning method to use. On the other hand, 30.9% of respondents confirmed that the choice of family planning method was done by both, the woman and her partner.

3.5. Reaction of partner related to the choice of family planning method

Table 4
Reaction of partner related to the choice of family planning method

	Frequency	Percent
Accept the action to happen	15	15.5
Refusal of action to happen	16	16.5
Being flexible to one's desire	41	42.3
Sometimes disputes	10	10.3
Sometimes sign of violence	13	13.4
Searching motive to avoid act	2	2.1
Total	97	100.0

In this study, it has been found that reactions of partner after the choice of family planning method are the following: 16.5 % of the respondents have reported that their partners have reacted by refusing action to happen, 13.4% became violent and 10.3% have reacted by disputes. These results are different from the study done in Guinea where for instance the Guinean 2012 Demographic and Health Survey (DHS 2012) (Institute National des Statistiques, 2012), reported that more than half of women in the country believe a man is justified in beating his wife if she argues with him (77.6 %), goes out without his permission (82.7 %), or refuses sexual intercourse (69.7 %). In the DHS 2012, only 28 % of women said a woman is justified in refusing sexual intercourse with her husband no matter what her reason is. In such a context, using a discreet and concealable method such as injectable that is fully controlled by the woman enables her to safeguard her sexual and reproductive health, and achieve her contraceptive goals. Contraceptive methods other than the injectable, such as pills and implants, are more visible, more difficult to conceal, or easily detected by the male partner. They were therefore less preferred by victims of Intimate Partner Violence as their discovery could lead to the resumption of and/or an increase in violence (O'Hara, Tsai, Carlson & Haidar, 2013). The findings of this study demonstrated that the high number of partners of women attending Nyarusiza health center (42.3%) became flexible to the desire and decision taken by the woman, regarding family planning method.

3.6. Experience of intimate partner violence and unwanted pregnancy

The higher proportion of respondents (85.6%) has reported that in their life, they had unwanted pregnancy. Into this proportion, the highest proportion (65%) has on the same time experienced Intimate Partner Violence. However, the test of independence between experience of Intimate Partner Violence and unwanted pregnancy has rejected the existence of statistically significant association between two variables (Pearson Chi-Square=2.883, P=0.089), given the data provided in the table below (Table 5).

Apr 2018. Vol. 26. No 01 ISSN 2307-2083
International Journal of Research In Medical and Health Sciences

http://www.ijsk.org/ijrmhs.html

Table 5
Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	2.883	1	.089
Continuity Correction	1.859	1	.173
Likelihood Ratio	2.615	1	.106
Linear-by-Linear Association	2.854	1	.091
N of Valid Cases	97		

The probability of the Chi-Square test (Pearson Chi-Square=2.883) is P=0.089, greater than the alpha level of significance of 0.05. Thus, the association between experience of Intimate Partner Violence and unwanted pregnancy is not supported by this analysis. So, we conclude that there is no significant relationship between experience of Intimate Partner Violence and unwanted pregnancy.

3.7. Experience of intimate partner violence and abortion

This study revealed that 75.2% of respondents have experienced the abortion in their lifetime. The proportion of 57.7% has experienced on the same time the abortion and Intimate Partner Violence. This is similar to the study report done by World Health Organization where violent relationships are frequently marked by fear and controlling behaviors by partners, so it is not surprising that women in these relationships report more adverse sexual and reproductive health outcomes. The higher rates of adverse reproductive events can be explained by direct consequences of sexual violence and coercion, as well as by more indirect pathways affecting family planning (Moore, Frohwirth & Miller, 2010). As a result, women in abusive relationships have more unintended pregnancies (Silverman et al., 2007). Of the estimated 80 million unintended pregnancies each year, at least half are terminated through induced abortion (Singh, 2009), and nearly half of those take place in unsafe conditions (Sedgh et al., 2012). While unintended pregnancies carried to term have been associated with health risk to mothers and infants, illegal and unsafe abortions place women's health at even greater risk.

Despite previous observations, the test of independence between experience of Intimate Partner Violence and abortion has rejected the existence of statistically significant association between two variables. In fact, the probability of Pearson Chi-Square (Pearson Chi-Square=0.335) calculated is P=0.563, which is greater than the alpha level of significance of 0.05 (see Table 6). Then, we conclude that there is no significant relationship between experience of Intimate Partner Violence and abortion.

Table 6
Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	.335	1	.563
Continuity Correction	.094	1	.759
Likelihood Ratio	.327	1	.567
Linear-by-Linear Association	.332	1	.565
N of Valid Cases	97		

4. CONCLUSION AND RECOMMENDATIONS

From study findings, there is no significant relationship between Intimate Partner Violence and Family planning. In fact, the chi-square test showed that there is no significant relationship between experience of Intimate Partner Violence and the used family planning method (Pearson Chi-Square=4.901, P=0.086). In addition, the high number of male partners (42.3%) became flexible to the desire and decision taken by their female partner (the wife) when they have chosen the family planning method. Even if the highest proportion (65%) has on the same time experienced Intimate Partner Violence and unwanted pregnancy, the Pearson Chi-Square test showed that there is no significant association between the two variables (Pearson Chi-Square=2.883, P=0.089). On the same trend, the Chi-Square test rejected the dependence between Intimate Partner Violence and Abortion (Pearson Chi-Square=0.335, P=0.563). However, the high proportion (75.3%) of the respondents reported that they have experienced Intimate Partner Violence in their life.

The recommendations point to the need to address the individual, household, institutional, and social norms and other macro-level risks by supporting parental and societal investment in women,

clarifying and enforcing laws to protect against all forms of violence, working more effectively with all members of households and communities, and engaging men in efforts to change gender norms. Dedicated funding and political commitment at all levels is needed to scale up promising approaches. The recognition of women as equal citizens, not victims, should be central in these efforts. In addition, the intimate partner violence screening and treatment should be included in reproductive health programs.

REFERENCES

1. Claudia, G.M. et al. (2006). Prevalence of Intima Partner Violence: Findings From the WHO Multi-Country Study on Women's Health and Domestic Violence. Lancet.

2. Coker, A.L. (2007). Does Physical Intimate Partner Violence Affect Sexual Health? A Systematic Review. Trauma, Violence and Abuse, 149-177.

3. Fox, A.M, Jackson, S.S., Hansen, N.B., Gasa, N., Crewe, M., Sikkema, K.J. (2007). In their own voices: Aqualitative study of women's risk for intimate partner violence and HIV in South Africa. Violence Against Women, pp. 583-602.

4. Gilles, K. (2015). Intimate Partner Violence and Family Planning: Opportunities for action. Washington, DC: Population Reference Bureau.

5. Hindin, Kishor and Ansara. (2015). Intimate Partner Violence in 10 DHS Countries. Contraception , 456-463.

6. Jay, G., Silverman and Raj,A. (2014). Intimate Partner Violence and Reproductive Coercion: Global Barriers to Women's Reproductive Control. PLOS Med 11, No 9.

7. Kiday, P., Msuya, S., Todd, J. Mtuya, C.C. Mtuy, T. and Mahande, M. (2015). Determinants of Modern Contraceptive use among women of reproductive age in Tanzania: Evidence from Tanzania. Demographic and Health Survey data. Advances in Sexual Medicine, 43-52.

8. Moore, A.M., Frohwirth, L. and Miller, E. (2010). Male reproductive control of women who have experienced intimate partner violence in the United States. Social Science and Medicine, 70(11):1737–1744.

9. O'Hara, K., Tsai, L.C., Carlson, C.E., Haidar, Y.M. (2013). Experiences of intimate-partner violence and contraception use among ever-married women in Jordan. East Mediterranean Health Journal.19:876–882.

10. Rapp, M.(2009). Freedom to choose. Women's possibility to take reproductive decisions in Babati, Tanzania. Bachelor's Thesis 15 ECTS. Södertörn University College, School of Life Sciences.

11. Sedgh, G. et al. (2012). Induced abortion: incidence and trends worldwide from 1995 to 2008. The Lancet, 625–632.

12. Silverman, J.G., Gupta, J., Decker, M.R., Kapur, N., Raj, A. (2007).Intimate Partner Violence against Women 13(6): 583-602.

13. Singh, S. (2009). Abortion worldwide: a decade of uneven progress. New York, Guttmacher Institute, 69.

14. Tadesse, M., Teklie, H., Yazew, G. and Gebreselassie, F. (2013). Women's Empowerment as a Determinant of Contraceptive Use in Ethiopia: Further Analysis of the 2011 Ethiopia Demographic and Health Survey and Health Survey. DHS Further Analysis Reports No. 82. Carlverton: ICF International.

15. WHO. (2012). World report on violence and health. Geneva: World Health Organization.

16. WHO. (2013). Global and Regional Estimates of Violence Against Women: Prevalence and Health Effects of Intimate Partner Violence and Non-Partner Sexual Violence. . Geneva: World Health Organization.