Domestic Violence and Reproductive Health

A Qualitative Description of Women's Experience in Lagos, Nigeria

Samuel Ojima Adejoh, Bether Glory Anozie, and Abolaji Awodein

Contents

Abstract

This chapter presents reviewed research findings and case studies presented. The findings from the case studies were the results from a study conducted among 25 participants who were survivors of domestic violence in Lagos, Nigeria.

S. O. Adejoh (✉)
University of Lagos, Lagos, Nigeria

Department of Social Work, University of Free State, Free State, South Africa
e-mail: sadejoh@unilag.edu.ng

B. G. Anozie · A. Awodein
Department of Social Work, University of Lagos, Lagos, Nigeria

R. Baikady et al. (eds.), *The Palgrave Handbook of Global Social Problems*,
https://doi.org/10.1007/978-3-030-68127-2_37-1

Research studies found that the lifetime prevalence of physical or sexual partner violence, or both, varied from 15% to 71% in 10 low- and middle-income countries. Causes of domestic violence identified include being a smoker/alcoholic, low level of education, type of occupation, financial dependency, temperament, and childhood history of observing and experiencing abuse. Other factors are being married more than once as a woman, divorced or separated, marriage at a young age, larger family size, and psychoactive substance use. Consequences of domestic violence include physical, psychological, mental health disorder, and health and reproductive health emergencies. The different types of domestic violence experienced by women include physical abuse/violence, sexual violence, verbal and emotional violence, spiritual violence or cultural violence, social violence, and economic or financial violence. The effects of domestic violence on women's health include bowel disorders, pelvic pain and several reproductive tract infections, unhappy sexual life, unintended pregnancy, inability to use contraceptives, maternal mortality, and risk of pregnancy complications, induced abortion, miscarriage, and low birth weight.

The universality of domestic violence against women makes it an urgent social problem that must be addressed holistically as it affects not just the health of the woman but also that of the unborn child, those who might be pregnant, those nursing children, their family relationships, the community, and the society. Advocacy, continuing education, and research are the engine room for addressing domestic violence against women and the effects on their reproductive health.

Keywords

Domestic violence · Health · Women · Effect · Consequences

Introduction

The chapter is structured into three main sections. The first section presents findings from reviewed studies and this begins with the introduction, forms of domestic violence and their prevalence rates, causes of domestic violence, consequences of domestic violence, and types of domestic violence. The second section presents findings on domestic violence and women's reproductive health, specific issues are physical violence, low birth weight, unwanted pregnancy, abortion and malnutrition, physical violence and premature birth and loss of pregnancy, domestic violence and mental health of women, sexual violence, and contraction of sexually transmitted diseases. The third section presents lived experiences in the form of case studies and finally, the conclusion.

Domestic violence is defined as "physical violence occurring within intimate relationships and in a domestic setting" (Morgan & Chadwick, 2009). Although domestic violence is a neutral term, in most cases, it is a gender-specific situation of men perpetrating violence against women and when women strike out against men within relationships or families, it is usually in self-defense (Ogbuji, 2004). Men

who had more controlling power were more likely to be violent against their partners (Garcia-Moreno et al., 2006).

Prevalence

The World Health Organization's (WHO) multicountry study on women's health and Violence Against Women (VAW) found that the lifetime prevalence of physical or sexual partner violence, or both, varied from 15% to 71% in 10 low- and middle-income countries (Garcia-Moreno et al., 2006). Similar studies of antenatal clinic attendees in tertiary hospitals in Nigeria reported prevalence of domestic violence ranging from 7.8% in Port Harcourt (Jeremiah et al., 2011), 14.0% in Jos (Gyuse & Ushie, 2009), and 14.2% in Abeokuta (Fawole et al., 2008). In Nigeria, which is the most populated country in sub-Saharan Africa, a previous study has reported a lifetime prevalence of physical violence against women as 52.1% in the south–south zone, 31.0% in the north-central, 29.6% in the south–east, 28.9% in the south–west, 19.7% in the north–east, and 13.1% in the north–west zone (National Population Commission, 2009).

A WHO study reported that lifetime prevalence of physical or sexual partner violence or both in 15 countries varied from 15% to 71% (Garcia-Moreno et al., 2006). In New Mexico, 58.7% of women experienced lifetime physical and/or sexual IPV, and 40.1% of women reported partner-perpetrated injuries. In Pakistan, 44% of women reported "lifetime marital physical abuse" and 23% of women reported abuse during pregnancy. These physically abused women also reported verbal abuse and 36% of them reported sexual coercion. The wife's education, consanguinity, and duration of marriage were significant risk factors, similar for lifetime marital abuse and abuse during pregnancy (Fikree et al., 2006). A study showed that 15.9% of women in Minneapolis reported physical abuse by their partners and 52% of them reported abuse during pregnancy. According to the Australian Bureau of Statistics (2006) Personal Safety Survey, approximately one in three Australian women have experienced physical violence during their lifetime, nearly one in five women have experienced some form of sexual violence and nearly one in five have experienced violence by a current or previous partner (Tables 1 and 2).

Causes of Domestic Violence

Studies have identified predictors of domestic violence, and these being social determinants that encompass both social conditions and social relations. Social conditions range from education and economy to position in the family and society, whereas social relations include relationship with husband, interaction and support from immediate and distant family members, neighbors, friends, and coworkers (WHO, 2005). Risk factors related to husband may include age, being a smoker/alcoholic, low level of education, type of occupation, financial dependency, health, temperament, and childhood history of observing abuse, especially those who saw

Table 1 Forms of domestic violence and their prevalence rates (%)

S/N	Countries	Physical abuse	Sexual abuse	Emotional abuse
1	Afghanistan	45.8%	7.5%	37.3%
2	Bangladesh	49.6%	27.2%	28.7%
3	Cambodia	15.0%	10.2%	32.0%
4	India	27.6%	6.5%	12.7%
5	Maldives	15.5%	4.4%	18.5%
6	Nepal	23.6%	7.7%	12.3%
7	Pakistan	23.6%	5.3%	25.8%
8	Papua New Guinea	44.4%	24.2%	51.1%
9	Philippines	13.5%	5.2%	21.6%
10	Vietnam	4.6%	5.7%	47.0%

Source: UNFPA (2018)

Table 2 Women who reported that they or a woman they know experienced violence since COVID-19

S/N	Countries	Physical abuse	Sexual abuse	Verbal abuse
1	Albania	5%	8%	10%
2	Cameroon	17%	19%	20%
3	Colombia	10%	10%	15%
4	Côte d'Ivoire	8%	10%	12%
5	Jordan	15%	12%	20%
6	Kenya	52%	42%	65%
7	Kyrgyzstan	5%	3%	11%
8	Morocco	7%	5%	35%
9	Nigeria	17%	18%	21%
10	Paraguay	9%	10%	13%
11	Thailand	7%	13%	17%
12	Ukraine	6%	10%	16%

Source: UN Women Count (2021)

their mothers being victims of domestic violence (Somach & AbouZeid, 2009; Fageeh, 2014). Kishor & Johnson (2004) identified several risk factors associated with domestic violence against women that operate at the level of relationship. Their study revealed that women, who had married more than once, divorced or separated, tend to report experiencing domestic violence more than those who had married only once. Women who married at a young age and those who have larger family sizes with many children were also reported to be likely to have higher rates of domestic violence experience. Alcohol misuse among men has particularly been identified as an associated risk factor for wife beating in Nigeria (Fawole et al., 2005). Women who engaged in harmful use of alcohol and other psychoactive substances were also likely to be victims of domestic violence. Obi and Ozumba (2007) found that domestic violence was significantly associated with financial disparity in favor of the female, influential in-laws, educated women, and couples within the same age group.

Consequences

Survivors of sexual violence can suffer both immediate and prolonged psychological and mental problems (Josse, 2010), the most common being post-traumatic stress disorder (PTSD), anxiety, depression, insomnia, low self-esteem, perceived loss of control, and psychosis (García-Moreno et al., 2005; Moosa et al., 2012). Amoakohene (2004) found a variety of psychological and emotional consequences of violence, including fear, stress, depression, tension, and low self-esteem among married women. Similarly, Adu-Gyamfi (2014) reported mental and emotional effects of sexual abuse, including loss of sense of dignity, lack of respect, confidence, and self-esteem. The cumulative effect of repeated sexual violence may cause substance abuse, despair, low self-esteem, and perceived loss of control (García-Moreno et al., 2005; Moosa et al., 2012). The severe health problems, coupled with the emotional ones, may lead married women to develop suicidal death as the only means of thoughts and thinking escape (Luce et al., 2010). Throughout the world, at least one in three women (nearly one billion) has been beaten, forced to have sex, or harassed in some manner. About 70% of female murder victims were killed by their male partners. Every 2.5 min, one woman is exposed to sexual abuse in the United States (Turla & Özkanli, 2006). Amnesty international (2007) reported that a third (and in some cases two-thirds) of women are believed to have been subjected to physical, sexual, and psychological violence carried out primarily by husbands, partners, and fathers, while girls are often forced into early marriage and are at risk of punishment if they attempt to escape from their husbands. It has serious consequences on women's mental and physical health, including their reproductive and sexual health. These include injuries, gynecological problems, temporary or permanent disabilities, depression, and suicide, among others. Domestic violence on women's reproductive health is linked most times with their intimate partners, and intimate partner violence during pregnancy and the postpartum period may have negative consequences for the health of the mother, fetus, and child. In such cases, the violence is not just directed against the woman; it also involves the newborn child or one that is within its first year of life and growing up in an environment of violence (Ramirez-Baen et al., 2019).

Types of Domestic Violence

Domestic violence is not just about physical violence but extends to other forms of abuse such as sexual, social, psychological, economic, and spiritual abuses. Domestic violence against women is a common worldwide social and health problem. Domestic violence is perpetrated by, and on, both men and women (Susmitha, 2016). However, most commonly, the victims are women, especially in Nigeria. Although physical violence is repeatedly recognized by the public as the core form of domestic violence, there are equally damaging nonphysical behavior that must be categorized as abusive and these are identified as:

1. **Physical Abuse:** This includes openly hitting a victim by a perpetrator like punching, kicking, pushing, slapping, shaking, inflicting burns, choking, biting, hair pulling; using a weapon, for example, flogging with a stick, stoning, belting, spearing, etc. Physical violence refers to the use of physical force to inflict pain, injury, or physical suffering on a victim. Slapping, beating, kicking, pinching, biting, pushing, shoving, dragging, stabbing, spanking, scratching, hitting with a fist or something else that could hurt; burning, choking, threatening, or using a gun, knife, or any other weapon are some examples of physical violence (García-Moreno et al., 2005).
2. **Verbal and Emotional Violence:** Verbal violence includes the intent to humiliate, degrade, demean, threaten, force, or intimidate, and includes the use of derogatory language or continual "put-downs" to highlight a particular part of a person's being or their societal role. Consequently, the person may experience this violence as an attack on their identity resulting in psychological harm. As a result, verbal violence is closely related to emotional violence. Emotional or psychological violence can leave a person feeling that they are to blame for the problems in the family or in a relationship. Psychological abuse may result in depression, anxiety, stress, low self-esteem, and in the long run may lead to risk-taking behaviors.
3. **Sexual Violence:** This involves trying to force either a male or female to have sex or take part in sexual acts against their will. Or using an object or body part to penetrate the vagina, mouth, or anus without consent or permission, injuring sexual organs, intentionally hurting someone during sex, forcing someone to have unsafe sex, without protection against pregnancy or sexually transmitted diseases, forcing someone to take their clothes off or remain naked against their will, being made to pose for pornography or being made to look at pornography against their will, being forced to watch, observe, or take part in sexual activities, voyeurism or exhibitionism, criticizing sexually or making sexually degrading comments or names, and any other types of sexual harassment. Sexual abuse refers to physically forcing a partner to have sexual intercourse who does not want it, forcing a partner to do something that she found degrading or humiliating (García-Moreno et al., 2005), harming her during sex or forcing her to have sex without protection (World Health Organization, 2014).
4. **Spiritual or Cultural Violence:** It is when power and control is used to deny a partner or family member their human, cultural, or spiritual rights and needs. It can also include using religion or culture as an excuse to commit abuses to justify the behavior.
5. **Social Violence:** Social abuse and isolation is commonly used by perpetrators to separate the victim from supportive friends, family, and community agencies. This has particular relevance for women in rural and remote areas where there is limited access to cheap transportation and where firearms are more common; there is increased isolation from neighbors and support services, and communities are small. This abuse may also be more prevalent for women from culturally and linguistically diverse communities.

6. **Economic or Financial Violence:** Involves the unequal control of finances in a relationship or family and the deprivation of necessities.
7. **Intimate Partner Violence:** Intimate partner violence is marked by violent behavior perpetrated by one's spouse or partner through physical aggression, sexual aggression, or emotional abuse. Manifestations of intimate partner violence appear to be different across cultures. The World Health Organization (2010) defined intimate partner violence (IPV) 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."

   In the context of intimate partner violence (IPV), IPV can be classified into five qualitatively different types. These include coercive controlling violence (CCV), violent resistance, situational couple violence (SCV), mutual violent control violence, and separation-instigated violence (Beck et al., 2013). CCV refers to a pattern of emotionally abusive intimidation, coercion, and control combined with physical violence perpetrated against an intimate partner (Kelly & Johnson, 2008: 478). The coercive partner keeps the victim under surveillance, and failure to follow the rules established by them often results in punitive action (Kelly & Johnson, 2008; Tanha et al., 2009; Beck et al., 2013). Johnson maintains that the abuser may use one or a combination of several tactics to keep the victim under control. In heterosexual relationships, CCV is most often perpetrated by men. Johnson (2006), for instance, found that 97% of the CCV in the Pittsburgh sample were male-perpetrated. Violent resistance is the type of violence used by the victim of violence to resist violence from a coercive controlling partner. Various terms that have been used to describe this type of violence include female resistance, resistive/reactive violence, and self-defense (Kelly & Johnson, 2008; Beck et al., 2013).

   Situational couple violence (SCV) is a type of violence between partners when an individual is violent and noncontrolling in a relationship with a nonviolent partner or a violent but noncontrolling partner (Johnson, 2006). It is the most common type of violence in the general population and can be perpetrated by men or women against their partners. The intention behind this type of violence is not power, control, or coercion; it arises from situations, arguments, and conflicts between partners, which then escalates into physical violence (Kelly & Johnson, 2008). Mutual violent control violence occurs when both partners are violent and controlling towards each other (i.e., two intimate terrorists) (Beck et al., 2013).

   In separation-instigated violence, couples do not normally have a history of violence in their intimate relationship, and the violent episodes are triggered in response to traumatic experiences at the time of separation. Such violence is typically limited to one or two mild to more severe forms of violence episodes during the separation period (Kelly & Johnson, 2008). The various ways a person may react include lashing out, throwing objects at the spouse, destroying property, and trying to intimidate the spouse or new partner through various actions such as sideswiping (to strike along the side in passing) or damaging their car (Kelly & Johnson, 2008).

Domestic Violence and Women's Reproductive Health

One of the most significant problems associated with domestic violence is how it affects women's reproductive health. Female victims of domestic violence experience a wide range of injuries and medical problems. Several studies have found a cause-effect relationship between domestic violence and reproductive health problems. As the life expectancy of women grows longer, "adding health and meaning to life" becomes a significant dimension of health for everybody who understands (Kök et al., 2006). WHO (2013) argued that women in violent relationships are often cowed by fear and, as a result, may be unable to freely exercise their right of choice to have sexual intercourse or to protect themselves from unwanted pregnancies by using contraception. Studies have shown that sexual violence is a causal factor of chronic headaches, bowel disorders, pelvic pain, and several reproductive tract infections. Some unexplainable physical symptoms and lower health standards are observed among the women exposed to physical and sexual violence (Tomasulo & McNamara, 2007). The reproductive health of women experiencing violence is affected negatively due to an unhappy sexual life. Linares et al. (2005) reported that while women who are not experiencing violence "love" their spouses, women experiencing violence usually "hate" or "fear" their husbands. It is obvious that women with negative feelings toward their spouses cannot live a happy family and sexual life. Indeed, Akyüz et al. (2008) found that women exposed to violence defined their sexual life as unhappy and found it hard to share their sexual problems with their partners. A study conducted in Uganda (Kaye et al., 2006) showed that men often believe that a woman's clandestine use of contraceptives is a justifiable reason for beating her. In Estonia, Laanpere et al. (2013) found that women with experience of both physical and sexual violence were significantly less likely to have used contraception during their most recent sexual encounters. They were also less likely to have used condoms and more likely to have undergone repeated induced abortions. Using demographic and health data from Columbia, Pallitto and O'Campo (2004) found elevated risks of unintended pregnancy for women who had been physically or sexually abused by their current or most recent sexual partners. In some cultures, women are less likely to discuss the use of contraception with their husbands because it may lead to accusations of infidelity and may lead to physical violence and/or abandonment, because some men believe that the use of contraception is associated with infidelity on the woman's side. Violence during pregnancy can also cause maternal mortality. Many of the maternal deaths related to traumas are caused by head traumas or intra-abdominal bleeding. Abdominal injury may cause a secondary bleeding risk due to the separation of the placenta and maternal and fetal deaths may be seen because of this (Öztürk & Sevil, 2005).

Among married women, reproductive coercion is common; although it is common, it is also an understudied form of gender-based violence. The National Sexual and Intimate Partner Violence Survey (NISVS), first conducted in the United States in 2010, found that nearly 1 in 10 women reported having partners who refused to use condoms and/or were trying to get them pregnant when they did not want to be (Black et al., 2011). In Boston, women reported that partners had limited their ability

to choose whether to have children; they often described that their partners used tactics to get them pregnant or forced them to undergo abortion and sterilization (Hathaway et al., 2005).

Silverman and Raj (2014) posited that violent men could control the reproductive behavior of their partners, preventing them from accessing important family planning and reproductive health services. Reproductive coercion often includes the prevention of a woman from obtaining birth control, as well as the manipulation of a woman to get pregnant. Nikolajski and colleagues (2015) further divided pregnancy coercion into pregnancy pressure and control of pregnancy outcomes; direct interference with a woman's contraceptive efforts (birth control sabotage), pressuring a female sexual partner to become pregnant when she does not want to be (pregnancy pressure), and using pressure or threats to coerce women to either continue or terminate a pregnancy (control of pregnancy outcomes). Miller et al. (2010) measure includes items under the "pregnancy coercion" section, which focused on removing or sabotaging condoms during sexual activity. For instance, if a woman consented to sexual activity with a condom, but would not have consented without a condom, this partner behavior could be both sexual assault and reproductive coercion. Indeed, survivors of stealthing describe stealthing as "a disempowering, demeaning violation of a sexual agreement" (Brodsky, 2017).

Domestic violence affects women's reproductive health as conceptualizations of reproductive coercion, typically including birth control sabotage, or active attempts to prevent women from using birth control, and pregnancy coercion, or attempts to pressure them into becoming pregnant and/or to control the outcome of a pregnancy. Batterers who are sabotaging or preventing birth control use are coercing pregnancy. Over the last decade, reproductive coercion has emerged as a widespread but understudied form of gender-based violence. Some studies do not separate out physical assault from sexual assault when examining their relationship to reproductive health.

Studies from the United States and Norway have linked battering during pregnancy to increased risk of pregnancy complications, miscarriage, and to delivering a low birth weight infant. Studies from the United States also suggest varying patterns of abuse during pregnancy with some women at higher risk of assault during pregnancy and others being abused less often while pregnant. Studies of women presenting to prenatal care clinics in the United States suggest that between 3.9% and 15.2% are being beaten during their present pregnancies. Women's anxiety following emotionally violent experiences (e.g., intimidation, fear, and ridicule) could limit their ability to control their fertility and may be harmful to their experiences in pregnancy (Tiwari et al., 2008). Demographic and health data from Columbia, Pallitto and O'Campo (2004) found elevated risks of unintended pregnancy for women who had been physically or sexually abused by their current or most recent sexual partners. According to WHO, intimate partner violence is one of many barriers to accessing sexual reproductive health services in both developed and developing countries. In Kenya, family planning workers reported that women regularly forge their partners' signature on spousal consent forms for contraception rather than ask their partners' permission. When family planning clinics in Ethiopia

removed their requirement for spousal consent, clinic use rose to 26% in a few months. Violence not only causes physical injury, but it also undermines the social, economic, psychological, spiritual, and emotional well-being of the victim, the perpetrator, and the society as a whole. Domestic violence is a major contributor to the ill health of women.

However, Katz et al. (2017) pointed out and explored the co-occurrence of sexual assault and reproductive health. For instance, forced sexual activity without contraception could be considered sexual assault. That is, if a woman consented to sexual activity with a condom, but would not have consented without a condom, but her partner went ahead without a condom, the partner's behavior could be translated as sexual assault. Different forms of intimate partner physical violence are linked to different risks and outcomes for survivors. For instance, weapon threats, sexual assaults, and strangulation are, not surprisingly, more strongly linked to higher future lethality risks.

Women may have problems like unwanted pregnancies and serious pregnancies related complications as a result of different kinds of violence. Taft and Watson (2008) reported that women exposed to violence from their partners have many more unwanted pregnancies, abortions, and pregnancy-related complications. Akyüz et al. (2008) showed that women who experienced more violence did not plan their most recent pregnancies and, therefore, terminated those pregnancies by means of abortion. Unwanted pregnancies among women experiencing violence have a higher rate of being terminated through induced abortion. Furthermore, these unwanted pregnancies can lead to unsafe abortions in countries where abortion is illegal. This situation causes many risks of serious health complications and even death for women exposed to violence. In addition, physical and sexual violence continues during pregnancy for many women if the pregnancy continues. This may affect both the health of the woman and the baby (Khan & Hussain, 2008). Some complications, such as prenatal bleeding, fetal fractures, maternal infections, uterus, lung, or spleen rupture, abortion, stillbirth, and premature birth, may appear due to exposure to violence or due to being beaten during pregnancy. Violence during pregnancy can also cause maternal mortality. Many of the maternal deaths related to traumas are caused by head traumas or intra-abdominal bleeding. Abdominal injury may cause a secondary bleeding risk due to the separation of the placenta, and maternal and fetal deaths may be seen because of this.

Risk factors for domestic violence in pregnancy have been identified from various studies. These are: teenagers, late bookers and women with unwanted pregnancies, unmarried or divorced women, and of greater parity, low socioeconomic class, together with high consumption of tobacco and alcohol (Khan & Hussain, 2008). Domestic violence in pregnant women is well recognized as an important health issue and has been associated with increased rates of adverse pregnancy outcome or fetal risk, although the magnitude of this risk is not well established. By detecting domestic violence during pregnancy, there would be an opportunity to intervene and protect two lives from a dangerous environment.

Physical Violence, Low Birth Weight, Unwanted Pregnancy, Abortion, and Malnutrition

Physical violence between intimate partners contributes as an independent risk factor for gestational weight gain deficit during pregnancy (Moraes et al., 2006). Pool et al. (2014) argued that violence has a detrimental effect on the health of unborn babies, including contributing to disabilities, body disfiguring, and pregnancy loss. These health difficulties are more pronounced among pregnant women with low educational and socioeconomic status (Koppensteiner & Manacorda, 2013). About 15% of women who reported low birth weight (LBW), live birth, or late fetal death in Houston indicated that an intimate partner was violent or abusive towards them during pregnancy. Domestic violence during pregnancy has been associated with adverse pregnancy outcomes for infants (Ntaganira et al., 2008), including low birth weight, preterm delivery, and neonatal death (Sarkar, 2008). Another indirect health consequence of domestic violence for the woman and child is the effect on nutritional status, with a high prevalence of anemia reported among pregnant women who face domestic violence (Ackerson & Subramanian, 2008). The consequences of DV and the low antenatal care-seeking behavior among victims of DV are likely to increase infant and maternal morbidity and mortality rates (Sarkar, 2013). Greater abuse frequency was associated with increased risk for these outcomes (Coker et al., 2006). Taft and Watson (2008) reported that women exposed to violence from their partners have many more unwanted pregnancies, abortions, and pregnancy-related complications. Akyüz et al. (2008) showed that Turkish women who experienced more violence did not plan their most recent pregnancies and, therefore, terminated those pregnancies by means of abortion. Women who reported IPV in the year prior to or during pregnancy, and women reporting IPV across both periods were significantly less likely to breastfeed the infant born subsequent to present pregnancy in the United States. Similarly, women reporting IPV around the time of pregnancy tried breastfeeding but were more likely to cease breastfeeding by 4 weeks postpartum (Silverman et al., 2006). Chinese women who had no experience of IPV during pregnancy in Hong Kong were significantly more likely to initiate breastfeeding than women exposed to IPV. Apparently, because of neglect in care, children of mothers who were victims of domestic violence were less likely to receive complete vaccinations against childhood diseases (Kishor & Johnson, 2004). It could also be expected that children in this category could become malnourished and suffer from the attendant health complications of malnutrition.

Physical Violence and Premature Birth and Loss of Pregnancy

It is reported in recent studies that being subjected to domestic violence during pregnancy leads to adverse effects in terms of women's reproductive health, to miscarriage, low infant birth weight, premature birth, loss of pregnancy which

may eventually lead to obstetric complications, bleeding in the vagina, and reproductive system infections.

Domestic violence during pregnancy poses significant risks to both the pregnant woman and her unborn child. This demonstrates that victims of domestic violence are prone to increased rates of sexually transmitted infections, unintended pregnancies, premature births, preeclampsia, miscarriages, stillbirth, vaginal bleeding, and low birth weight. In addition, mental health conditions such as homicide and suicidal thoughts, postpartum depression, anxiety, trauma, and eating disorders were reported among women who were victims of abuse either before or during pregnancy.

Furthermore, women abused during pregnancy were three times more likely to become an attempted/completed feticide victim than their nonpregnant abused counterparts. Violence against pregnant women is also of particular concern because of the additional risk to the unborn child. Violence can harm the fetus through direct injury, causing placental damage, premature contractions, membrane rupture, or fetal death, or through indirect mechanisms such as stress or abuse-related maternal health problems.

Additionally, women with experience of both physical and sexual violence were more likely to have reported an unwanted pregnancy and a pregnancy loss. However, only those experiencing sexual violence reported unwanted pregnancies. Similarly, community level IPV was associated with sexual health outcomes. Respondents in communities with higher levels of sexual violence were significantly more likely to have had unwanted pregnancies.

Violence against women could be physical, sexual, psychological, and economic. The magnitude of physical and sexual violence has been examined in several population-based surveys around the world. In these surveys, 10–50% of women reported having been hit, or otherwise physically harmed by a male partner and most women had experienced multiple acts of violence over time (Helweg-Larsen & Kruse, 2003). Studies based on clinical samples reported a higher frequency of partner violence than community studies. However, in recent years, a wide range of clinical studies has shown that women victimized by violence have a risk of subsequent health problems. Most of the studies have been based on limited clinical samples, e.g., patients in a gastrointestinal unit in gynecological departments, or in general practice. These studies often included experiences of abuse both in childhood and as an adult. Additionally, that a significant correlation was found between domestic violence and different health problems does not justify drawing definitive conclusions about a causal correlation between violence and ill health. Victims of violence may, at baseline, present other health problems from women not victimized by violence, which might present a serious bias. In a clinical study, one-third of adult female patients with neurological disorders reported previous domestic violence, and a higher frequency of violence was endured among patients with diagnoses of migraine, depression, or vertigo. Furthermore, health problems among victims of violence may be associated with risky health behavior.

Domestic Violence and Mental Health of Women

Psychological or emotional violence may result in depression, anxiety, stress, low self-esteem, and in the long run, may lead to risk-taking behaviors (WHO, 2005). Depression and anxiety, in turn, may lead to overeating and obesity, thus further increasing the risk of emotional verbal abuse (Afifi et al., 2011). Perceived poor health, somatic symptoms (body aches, weakness, etc.), increased body mass index (BMI), depression, and stress are some of the common outcomes of violence. According to Vandra (2013), various personal, familial, and sociocultural factors influence women's decision to continue in a relationship despite abuse. The process of terminating the relationship usually involves leaving and returning several times before the woman can end the relationship for good. Also, violence includes threats of dire consequences, verbal abuse, deprivation of food and social contact, being constantly thrown out of the house and physical isolation resulting from being locked inside the home.

Pregnant women who experience emotional violence and are further diagnosed with anxiety/depression more frequently complain of physical and psychosomatic symptoms (nausea, stomach pain, headaches, shortness of breath, gastrointestinal symptoms, heart-pounding, dizziness) than those who are not so emotionally violated and diagnosed. Emotional violence was found in every civilized society, irrespective of the country. Hence, emotional violence is a global phenomenon and a serious psychological and health problem.

Violence may cause emotional imbalance, depression, fear, anxiety, decreased self-respect, sexual function defects, eating disorders, post-traumatic stress disorders, and even suicide. Women exposed to violence often experience feelings of panic, have an expectation that something bad will happen and have sleep-related problems including sleeping and resting troubles, and waking up with violent nightmares. This chronic stress and anxiety results in some somatic disorders in women exposed to violence, such as hypertension, irritability, gastrointestinal disorders, asthma, and headaches. Taft and Watson (2008), in their study of 24,459 women in Australia, determined that depression was detected much more frequently among women exposed to violence (especially from their partners) than in other women.

Sexual Violence and Contraction of Sexually Transmitted Diseases

The United Nations and WHO identified violence against women as a main public health concern as victims may suffer from instant physical trauma, sexually transmitted diseases, unwanted pregnancies, unsafe abortions, and mental health issues (Anurudran et al., 2020). Domestic violence is a concern not only because of the

direct injury it may inflict but also because it may result in other health problems, such as sexually transmitted diseases (STDs). STDs comprise a significant public health threat to women in general, given the high prevalence of these infections and their potentially serious health consequences (for example, pelvic inflammatory disease, cancer of the genital tract, infertility, ectopic pregnancy, and poor birth outcomes).

In Canada and the United States, many women reportedly experience sexual violence almost every day (Benoit et al., 2015). In a survey of women in rural Egypt, 80% of sampled participants said wife beatings were widespread and acceptable, especially if women resisted sexual relations with their husbands (United Nations Population Fund, 2005). Empirical studies suggest more than one-third of Ghanaian women experience forced sex and other forms of sexual violence from their husbands (Amoakohene, 2004; Adinkrah, 2011; Chirwa et al., 2018). In Ghana, married women were socialized to believe that marriage confers the right of sexual access, no matter how violent (Tenkorang et al., 2013). The consequences of sexual violence may be compounded as married women may be powerless and not seek help due to discrimination, stigma, and the fear of being mocked and ridiculed in public (Adinkrah, 2011; Adu-Gyamfi, 2014). Sexual violence within marriage, especially involving unprotected vaginal, anal, and oral penetration, increases the risk of spreading HIV and other sexually transmitted diseases (Raiford et al., 2013; Pederson et al., 2015; Nankinga et al., 2016). The Uganda AIDS Indicator Survey conducted in 2011 provided a higher estimate of women in union (married or cohabiting) with STIs, at 37%, a number that highlights the gravity of the situation in Uganda. Research from the United States indicated that untreated STDs could lead to pelvic inflammatory disease and eventually to infertility, an especially dire consequence in societies where a woman's worth derives largely from their ability to bear children. In a study in India, it was determined that one in three monogamous married women have been infected by their husbands (Türmen, 2003; Dunkle et al., 2004; Martin & Curtis, 2004). In Yılmaz's (2008) study, 59.5% of women that had one partner, but were human papillomavirus (HPV) positive, did not see themselves as being at risk of catching STDs. This shows that many women with STDs do not consider themselves or their partners at risk. Kishor and Kiersten (2004) found a higher rate of self-reported sexually transmitted diseases (STDs) among women who had experienced domestic violence compared to women who had not. This STD's consequence may stem from acts of sexual violence and unsafe sexual practices.

Sexual violence takes different forms such as knowing if husband/partner had ever physically forced to have sexual intercourse with their wives, when they did not want to; forced their wives to perform any sexual acts they did not want to; and respondent reported forced first sexual intercourse with their partner. Almost all women who reported experiencing sexual intimate partner violence also reported ever-experiencing physical intimate partner violence; this measure was combined into physical and/or sexual intimate partner violence because there was the use of force to achieve their sexual gains. Having limited control over their bodies and decisions related to sexual activities, such as the time of sex and use of contraceptive protection, these women were more likely to engage in unwanted and/or unprotected

sex, which can lead to the contraction of sexually transmitted diseases and/or unintended pregnancies (Ismayilova & El-Bassel, 2014). Women reported that they had experienced different forms of sexual violence by their husbands during the last 12 months. Among these women are those being physically forced to have sex when they did not want to have sexual intercourse, being intentionally denied sex, and being forced to do something sexual that was degrading or humiliating to their persons.

Violence sex ranges from beatings during sex, to sexual acts coerced by physical force or threat of force, to painful sexual acts which one participant has clearly indicated unwanted, which could eventually lead to STD contractions. Sexually abusive and controlling acts, such as refusing to use safe sex practices or contraception, or verbal sexual degradation could lead to disease contractions. Sexual violence within marriage, especially involving unprotected vaginal, anal, and oral penetration, increases the risk of spreading HIV and the contraction of other sexually transmitted diseases. Women victims may also experience shock, anxiety, intense fear, and self-blame (David-Ferdon et al., 2019). If relatives, friends, and neighbors isolate victims by casting shame and stigma upon them, such feelings may be aggravated, thus prolonging and compounding the original trauma.

Case Studies: Women Who Had Lived Experience of Domestic Violence in Lagos

Method

The research design selected for this study is descriptive and cross-sectional design. Study participants were married women in Ilaje, Bariga, and Shomolu local government areas, Lagos, Nigeria, who had experienced domestic violence and affected their reproductive health. The semi-structured interview guide was used to collect data from the participants. Twenty-five in-depth interviews were conducted among consenting women who reside at Ilaje, Bariga, and Shomolu areas who were either married, separated, or divorced, who have experienced or were experiencing domestic violence such as physical, sexual, emotional, and verbal violence among other forms of violence which have affected their health at the time of data collection. Participants were selected using purposive, accidental, and snowball sampling techniques. Participants were also accessed through the domestic sexual and violence response team (DSVRT) in Lagos, a government agency responsible for handling cases of reported domestic violence. Content analysis was used to analyze the qualitative data collected.

Case Studies

The following case studies are presented to illustrate how domestic violence could impact the reproductive health of women experiencing domestic violence.

Case One

Janet (real name withheld) was 32 years old, living in Lagos. She had a secondary school certificate as the highest educational qualification obtained. Trading was her main occupation, which served as her means of livelihood apart from being married and in a polygamous marriage. Janet had two children.

Janet had experienced physical violence from her husband resulting from misunderstandings including the timing of pregnancies, and this had led to loss of pregnancy. She has lost three pregnancies in the past, although she could not point out the main reasons on those three occasions, but she did not rule out the physical and verbal abuses she suffered or experienced at the hand of her husband. Specifically, she has had two stillbirths in the past.

Recalling her experiences on domestic violence from her husband, the heartbreak after each fight was hard to forget. The husband will apologize, and the next thing was still to have sexual intercourse with or without her consent, which continued to sadden her. Janet was always sad whenever she got pregnant as she was not able to afford attending antenatal clinics as her husband was not supporting in anyway, either emotionally or financially. She used traditional herbs, which was more affordable to her compared to orthodox medicines, whenever she was sick.

Narrating her experience, Janet hardly used modern contraceptives; but rather she used traditional contraceptives each time she had sexual intercourse with her husband to prevent pregnancy. She did not discuss the timing of sexual intercourse with her husband but rather the husband will "come on her" anytime he felt like having sexual intercourse with her, not minding her own feelings or consent. Closely related, Janet had experienced forceful sexual intercourse with her husband on several occasions and had equally contracted sexually transmitted infections from him because he was having sexual intercourse with other women without using a condom.

Case Two

Bose (not real name) was a 28-year-old woman, living in Lagos. Married and with a National Certificate of Education (NCE), Bose worked as a primary school teacher. She and her husband frequently had quarrels because none of them wanted to listen to what the other person was saying. Telling her experience, the arguments between Bose and her husband always ended up in physical fights and she was constantly thoroughly beaten by her husband. Bose had two children, said they would have been three but she lost one pregnancy as a result of an argument with her husband which ended up in a physical fight and beating. During the fight, she fell on her face and hit her tummy on the floor. Although she was rushed to the hospital for attention, she lost the pregnancy. Bose remained grateful that she did not die during the fight with her husband but still sad that she lost the pregnancy.

Bose was a victim of not just the physical violence but she also suffered from emotional or verbal abuse because her husband did abuse her with harsh words such

that she regretted ever meeting and marrying him. She felt pained and that often made her to cry. Bose said she was lucky that she has not experienced sexual violence and did take part in joint fertility decision. She had never been infected with sexually transmitted infections.

Case Three

Chidinma (not real name) was a 32-year-old woman in a monogamous marriage living in Lagos. She was a B.Sc. holder and self-employed. According to Chidinma, she felt unlucky as she described her husband as an abusive man with a severe drinking problem. The drinking problem always created misunderstandings between the two of them. According to Chidinma, her husband always treated her harshly including physically beating her during pregnancy, which led to her losing her first pregnancy. Her husband kicked her down, will shake and push her to the wall and beat her, irrespective of whether she was pregnant or not. Chidinma said that at the end of the whole episode, the husband would not apologize but rather blame it on his alcoholic behavior. Chidinma was always heartbroken and sad as the husband from time to time denied the paternity of the children just to continue to oppress and suppress her, and keep her in a sad mood. Although, Chidinma's husband allowed her to use contraceptives, there were times that her husband forcefully had sexual intercourse with her, and did not take a joint decision when it came to the issue of fertility and sexual intercourse.

Conclusion

The universality of domestic violence against women makes it an urgent social problem that must be addressed holistically as it affects not just the health of the woman but also that of the unborn child, for those who might be pregnant and those who are nursing children, the family relationships, the community, and the society. Advocacy, continuing education, and research should be the engine room for addressing domestic violence against women and the effects on their reproductive health.

References

Ackerson, L. K., & Subramanian, S. (2008). Domestic violence and chronic malnutrition among women and children in India. *American Journal of Epidemiology, 167*(10), 1188–1196.

Adinkrah, M. (2011). Criminalizing rape within marriage: Perspectives of Ghanaian university students. *International Journal of Offender Therapy and Comparative Criminology, 55*(6), 982–1010.

Adu-Gyamfi, E. (2014). Challenges undermining domestic violence victims' access to justice in Mampong municipality of Ghana. *Health Care, 27*, 75–90.

Afifi, Z. E., Al-Muhaideb, N. S., Hadish, N. F., Ismail, F. I., & Al-Qeamy, F. M. (2011). Domestic violence and its impact on married women's health in Eastern Saudi Arabia. *Saudi Medical Journal, 32*(6), 612–620.

Akyüz, A., Şahiner, G., & Bakir, B. (2008). Marital violence: Is it a factor affecting the reproductive health status of women? *Journal of Family Violence, 23*(6), 437–445.

Amoakohene, M. I. (2004). Violence against women in Ghana: A look at women's perceptions and review of policy and social responses. *Social Science & Medicine, 59*(11), 2373–2385.

Anurudran, A., Yared, L., Comrie, C., Harrison, K., & Burke, T. (2020). Domestic violence amid COVID-19. *International Journal of Gynecology & Obstetrics, 150*(2), 255–256. https://doi.org/10.1002/ijgo.13247. PMID: 32472696; PMCID: PMC9087628.

Beck, C. J., Anderson, E. R., O'Hara, K. L., & Benjamin, G. A. H. (2013). Patterns of intimate partner violence in a large, epidemiological sample of divorcing couples. *Journal of Family Psychology, 27*(5), 743.

Benoit, C., Bill M., & Mikael, J. (2015). Stigma, sex work, and substance use: A comparative analysis. *Sociology of Health & Illness, 37*, 437–51.

Black, M., Basile, K., Breiding, M., Smith, S., Walters, M., Merrick, M., et al. (2011). *National intimate partner and sexual violence survey: 2010 summary report.*

Brodsky, A. (2017). Rape-adjacent: Imagining legal responses to nonconsensual condom removal. *Columbia Journal of Gender & Law, 32*, 183–210.

Chirwa, E. D., Sikweyiya, Y., Addo-Lartey, A. A., Alangea, D. O., Coker-Appiah, D., & Adanu, R. M. et al. (2018). Prevalence and risk factors of physical or sexual intimate violence perpetration amongst men in four districts in the central region of Ghana: baseline findings from a cluster randomised controlled trial. *PLoS One, 13*(3), e0191663.

Coker, A. L., Smith, P. H., Flerx, V. C., Whitaker, D. J., Fadden, M. K,. & Williams, M. (2006). Design and implementation of the domestic violence services in rural clinics intervention. CRVAW Faculty Book Chapters. 49. https://uknowledge.uky.edu/crvaw_chapters/49

David-Ferdon, C., Clayton, H. B., Dahlberg, L. L., Simon, T. R., Holland, K. M., Brener, N., Matjasko, J. L., D'Inverno, A. S., Robin, L., Gervin, D. (2019). Vital signs: Prevalence of multiple forms of violence and increased health risk behaviors and conditions among youths – United States, 2019. *MMWR Morb Mortal Wkly Rep, 70*(5), 167–173. https://doi.org/10.15585/mmwr.mm7005a4. PMID: 33539331; PMCID: PMC7861486.

Dunkle, K. L., Jewkes, R. K., Brown, H. C., Gray, G. E., McIntryre, J. A., & Harlow, S. D. (2004). Gender-based violence, relationship power, and risk of HIV infection in women attending antenatal clinics in South Africa. *The Lancet, 363*(9419), 1415–1421.

Fageeh, W. M. K. (2014). Factors associated with domestic violence: A cross-sectional survey among women in Jeddah, Saudi Arabia. *BMJ Open, 4*, Article e004242.

Fawole, O. I., Ajuwon, A. J., & Osungbade, K. O. (2005). Evaluation of interventions to prevent gender-based violence among young female apprentices in Ibadan, Nigeria. *Health Education, 105*, 186–203.

Fawole, A. O., Hunyinbo, K. I., & Fawole, O. I. (2008). Prevalence of violence against pregnant women in Abeokuta, Nigeria. *Australian and New Zealand Journal of Obstetrics and Gynaecology, 48*(4), 405–414.

Fikree, F. F., Jafarey, S. N., Korejo, R., Afshan, A., & Durocher, J. M. (2006). Intimate partner violence before and during pregnancy: Experiences of postpartum women in Karachi, Pakistan. *The Journal of the Pakistan Medical Association, 56*(6), 252–257.

Garcia-Linares, M. I., Pico-Alfonso, M. A., Sanchez-Lorente, S., Savall-Rodriguez, F., Celda-Navarro, N., Blasco-Ros, C., & Martinez, M. (2005). Assessing physical, sexual, and psychological violence perpetrated by intimate male partners toward women: A Spanish cross-sectional study. *Violence and Victims, 20*(1), 99–123.

García-Moreno, C., Jansen, H. A., Ellsberg, M., Heise, L., & Watts, C. (2005). *WHO multi-country study on women's health and domestic violence against women*. World Health Organization.

Garcia-Moreno, C., Jansen, H. A., Ellsberg, M., Heise, L., & Watts, C. H. (2006). Prevalence of intimate partner violence: Findings from the WHO multi-country study on women's health and domestic violence. *The Lancet, 368*(9543), 1260–1269.

Gyuse, A. M. I., & Ushie, A. P. (2009). Pattern of domestic violence among pregnant women in Jos. *Nigeria. South African Family Practice, 51*(4).

Hathaway, J. E., Willis, G., Zimmer, B., & Silverman, J. G. (2005). Impact of partner abuse on women's reproductive lives. *Journal of the American Medical Women's Association (1972), 60*(1), 42–45.

Helweg-Larsen, K., & Kruse, M. (2003). Violence against women and consequent health problems: A register-based study. *Scandinavian Journal of Public Health, 31*(1), 51–57. https://doi.org/10.1080/14034940210133708. PMID: 12623525.

Hussain, R., & Khan, A. (2008). Women's perceptions and experiences of sexual violence in marital relationships and its effect on reproductive health. *Health Care for Women International, 29*(5), 468–483.

Ismayilova, L., & El-Bassel, N. (2014). Intimate partner physical and sexual violence and outcomes of unintended pregnancy among national samples of women from three former Soviet Union countries. *Violence Against Women, 20*(6), 633–652. https://doi.org/10.1177/1077801214540538

Jeremiah, I. G. B. K., Kalio, G. B., & Oriji, V. K. (2011). Domestic violence in pregnancy among antenatal attendees at the University of Port Harcourt Teaching Hospital, Port Harcourt. *Nigerian Journal of Medicine, 3*, 355–359.

Johnson, M. P. (2006). Conflict and control: Gender symmetry and asymmetry in domestic violence. *Violence Against Women, 12*, 1003–1018. https://doi.org/10.1177/1077801206293328

Josse, E. (2010). They came with two guns: The consequences of sexual violence for the mental health of women in armed conflicts. *International Review of the Red Cross, 92*(877), 177–195.

Katz, J., Poleshuck, E. L., Beach, B., & Olin, R. (2017). Reproductive coercion by male sexual partners: Associations with partner violence and college women's sexual health. *Journal of Interpersonal Violence, 32*(21), 3301–3320.

Kaye, D. K., Mirembe, F. M., Bantebya, G., Johansson, A., & Ekstrom, A. M. (2006). Domestic violence as risk factor for unwanted pregnancy and induced abortion in Mulago Hospital, Kampala, Uganda. *Tropical Medicine & International Health, 11*(1), 90–101.

Kelly, J. B., & Johnson, M. P. (2008). Differentiation among types of intimate partner violence: Research update and implications for interventions. *Family Court Review, 46*(3), 476–499.

Khan, A., & Hussain, R. (2008). Violence against women in Pakistan: Perceptions and experiences of domestic violence. *Asian Studies Review, 32*(2), 239–253.

Kishor, S., & Johnson, K. (2004). *Profiling domestic violence: A multi-country study.* measure DHS, ORC Macro 53–63.

Kök, G., Şenel, N., & Akyüz, A. (2006). Determination of the awareness level of the women over 20 years old who attended to GMMA Gynecology Outpatient Clinics in terms of urinary incontinence. *Gülhane Tip Dergisi, 48*(3), 132.

Koppensteiner, M. F., & Manacorda, M. (2013). The effect of violence on birth outcomes: Evidence from homicides in rural Brazil. IDB Working Paper No. IDB-WP-416, Available at SSRN: https://ssrn.com/abstract=2367689 or https://doi.org/10.2139/ssrn.2367689

Laanpere, M., Ringmets, I., Part, K., & Karro, H. (2013). Intimate partner violence and sexual health outcomes: A population-based study among 16–44-year-old women in Estonia. *The European Journal of Public Health, 23*(4), 688–693.

Luce, H., Schrager, S. B., & Gilchrist, V. (2010). Sexual assault of women. *American Family Physician, 81*(4), 489–495.

Martin, S. L., & Curtis, S. (2004). Gender-based violence and HIV/ AIDS: Recognising links and acting on evidence. *Lancet, 363*(9419), 1410–1411.

Miller, E., Decker, M. R., McCauley, H. L., Tancredi, D. J., Levenson, R. R., Waldman, J., Schoenwald, P., Silverman, J. G. (2010). Pregnancy coercion, intimate partner violence and

unintended pregnancy. Contraception, 81(4), 316–22. https://doi.org/10.1016/j.contraception.2009.12.004. PMID: 20227548; PMCID: PMC2896047.

Moosa, Z., Ahluwalia, K., Bishop, K., Derbyshire, H., Dolata, N., Donaldson, L., et al. (2012). *A theory of change for tackling violence against women and girls*. DFID: Gend Dev Netw.

Moraes, C. L., Amorim, A. R., & Reichenheim, M. E. (2006). Gestational weight gain differentials in the presence of intimate partner violence. *International Journal of Gynecology & Obstetrics, 95*(3), 254–260.

Morgan, A., & Chadwick, H. (2009). *Research in practice summary paper no. 7 key issues in domestic violence*. Australian Institute of Criminology.

Nankinga, O., Misinde, C., & Kwagala, B. (2016). Gender relations, sexual behaviour, and risk of contracting sexually transmitted infections among women in union in Uganda. *BMC Public Health, 16*(1), 1–11.

Nigeria. National Population Commission, ICF Macro (Firm), & MEASURE DHS (Program). (2009). *Nigeria demographic and health survey, 2008*. National Population Commission.

Nikolajski, C., Miller, E., McCauley, H. L., Akers, A., Schwarz, E. B., & Freedman, L., et al. (2015). Race and reproductive coercion: A qualitative assessment. *Women's Health Issues, 25*, 216–223

Ntaganira, J., Muula, A. S., Masaisa, F., Dusabeyezu, F., Siziya, S., & Rudatsikira, E. (2008). Intimate partner violence among pregnant women in Rwanda. *BMC Women's Health, 8*(1), 1–7.

Obi, S. N., & Ozumba, B. C. (2007). Factors associated with domestic violence in south-east Nigeria. *Journal of Obstetrics and Gynaecology, 27*(1), 75–78.

Ogbuji, C. Q. (2004). Violence against women: Impact on their reproductive health. *Tropical Journal of Obstetrics and Gynaecology, 21*(1), 61–64.

Öztürk Can, H. A. F. İ. Z. E., & Sevil, Ü. (2005). Gebelikte "şiddet". *Sağlık ve Toplum, 15*(1), 25–31.

Pallitto, C. C., & O'Campo, P. (2004). The relationship between intimate partner violence and unintended pregnancy: Analysis of a national sample from Colombia. *International Family Planning Perspectives*, 165–173.

Pool, M. S., Otupiri, E., Owusu-Dabo, E., De Jonge, A., & Agyemang, C. (2014). Physical violence during pregnancy and pregnancy outcomes in Ghana. *BMC Pregnancy and Childbirth, 14*(1), 1–8.

Raiford, J. L., Seth, P., & DiClemente, R. J. (2013). What girls won't do for love: Human immunodeficiency virus/sexually transmitted infections risk among young African-American women driven by a relationship imperative. *Journal of Adolescent Health, 52*(5), 566–571.

Ramirez-Baena, L., Ortega-Campos, E., Gomez-Urquiza, J. L., Cañadas-De la Fuente, G. R., De la Fuente-Solana, E. I., Cañadas-De la Fuente, G. A. (2019). A multicentre study of burnout prevalence and related psychological variables in medical area hospital nurses. *J Clin Med, 8*(1), 92. https://doi.org/10.3390/jcm8010092. PMID: 30650557; PMCID: PMC6351959.

Sarkar, N. N. (2008). The impact of intimate partner violence on women's reproductive health and pregnancy outcome. *Journal of Obstetrics and Gynaecology, 28*(3), 266–271.

Sarkar, N. N. (2013). The cause and consequence of domestic violence on pregnant women in India. *Journal of Obstetrics and Gynaecology, 33*(3), 250–253.

Silverman, J. G., Decker, M. R., Reed, E., & Raj, A. (2006). Intimate partner violence around the time of pregnancy: Association with breastfeeding behavior. *J Women's Health, 15*(2006), 934–940.

Silverman, J. G., & Raj, A. (2014). Intimate partner violence and reproductive coercion: Global barriers to women's reproductive control. *PLoS Medicine, 11*(9), e1001723.

Somach, D. S., & AbouZeid, G. (2009). Egypt violence against women study: Literature review of violence against women. *The National Council of Women in Egypt, 1*, 15–20. Retrieved from https://pdf.usaid.gov/pdf_docs/Pnadq891.pdf

Statistics, A. B. O. (2006). *Census of population and housing*. Australian Government.

Susmitha, B. (2016). Domestic violence: Causes, impact and remedial measures. *Social Change, 46*(4), 602–610.

Taft, A. J., & Watson, L. F. (2008). Depression and termination of pregnancy (induced abortion) in a national cohort of young Australian women: The confounding effect of women's experience of violence. *BMC Public Health, 8*(1), 1–8.

Tanha, M., Beck, C. J., Figueredo, A. J., & Raghavan, C. (2009). (2010) Sex differences in intimate partner violence and the use of coercive control as a motivational factor for intimate partner violence. *Journal of Interpersonal Violence, 25*(10), 1836–1854.

Tenkorang, E. Y., Owusu, A. Y., Yeboah, E. H., & Bannerman, R. (2013). Factors influencing domestic and marital violence against women in Ghana. *Journal of Family Violence, 28*(8), 771–781.

Tiwari, A., Chan, K. L., Fong, D., Leung, W. C., Brownridge, D. A., Lam, H., et al. (2008). The impact of psychological abuse by an intimate partner on the mental health of pregnant women. *BJOG: An International Journal of Obstetrics & Gynaecology, 115*(3), 377–384.

Tomasulo, G. C., & McNamara, J. R. (2007). The relationship of abuse to women's health status and health habits. *Journal of Family Violence, 22*(4), 231–235.

Turla, A., & Özkanli, Ç. (2006). Çocuğa yönelik istismarda farklı bir boyut: Çocuk pornografisi. *Polis Bilimleri Dergisi, 8*(1), 117–133.

Türmen, T. (2003). Gender and HIV/aids. *International Journal of Gynecology & Obstetrics, 82*(3), 411–418.

UN Women. (2021). *Measuring the shadow pandemic violence against women during COVID-19*. Retrieved from: https://data.unwomen.org/publications/vaw-rga. Accessed 28 Feb 2021.

UNFPA. (2018). *Measuring violence against women in the Asia Pacific*. Retrieved from: https://asiapacific.unfpa.org/en/knowvawdata. Accessed 28 Feb 2021.

United Nations Population Fund. (2005). *State of world population 2005: The promise of equality, gender equity, reproductive health and the millennium developments goals*. United Nations Publications.

Vandra, M. N. (2013). Exploring domestic violence in an Indian setting. *Indian Journal of Gender Studies, 20*(1), 135–146. https://doi.org/10.1177/0971521512465940

World Health Organization. (2005). WHO multi-country study on women's health and domestic violence against women. Geneva, 2005.