The associations among partner violence, problems with birth control, and abortion number and timing

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Executive Summary

More than two decades of research has shown associations among partner violence, reproductive control, and detrimental sexual and reproductive health outcomes including lower use of condoms and other contraceptives, higher rates of sexually transmitted infections (STIs), HIV, urinary tract infections, unintended and teen pregnancies, and poor birth outcomes as well as miscarriage due to physical assault. However, little is known about whether partner violence is related to abortion characteristics such as method, timing, number, and follow-up.

Nationally, 18% of all pregnancies are electively terminated. Among women having abortions, 44% have had at least one prior abortion. The vast majority of abortion procedures take place in the first trimester, but 8.5% are performed in the second trimester, which is a lengthier, more expensive, higher risk procedure with less availability of doctors performing the procedure and in fewer geographic areas. Both repeat and second trimester elective terminations carry social stigma and expense for the women needing them, but little is known about what characteristics distinguish them in a way that would be helpful for prevention of repeat unwanted pregnancies and/or delays in obtaining an abortion.

The study aim was to compare women reporting past and current partner violence compared to those who did not for differences in a variety of abortion characteristics, after adjusting for some demographic characteristics, including years of sexual activity, parity (live births), and problems with birth control. We reviewed the medical records of more than 12,000 women receiving abortion and family planning services at three large health centers in New York City between 2010 and 2011. First, we compared women reporting any lifetime history of partner violence to those with none for differences in lifetime pregnancy outcomes of live births, elective terminations, and miscarriages. Second, we analyzed a sub-sample of women obtaining current abortions to compare women reporting current partner violence to those with no current violence for differences in gestational age, and abortion method choice in the first trimester (medical vs. surgical).

Study results indicate that women reporting partner violence had greater parity and were more likely to have problems with birth control. Women with a history of partner violence were more likely to have had repeat abortions and two or more miscarriages than women reporting no partner violence. Women reporting current partner violence (in the past year) were more likely to have an abortion at the latter end of the second trimester, from 19-24 weeks gestational age. Women with partner violence were not more likely to choose a medical vs. surgical abortion procedure than women not reporting violence.

The influence of partner violence in a woman's decision to terminate a pregnancy and when should be further researched with samples from different settings, including reproductive health centers, domestic violence organizations, and the general population. More in-depth knowledge is needed about mechanisms of reproductive control and the influence of violent partners on wanted and unwanted pregnancy outcomes, as well as the strategies women use to manage their health in such contexts. For reproductive health care practice, this study adds to the growing literature supporting: (1) the need for universal partner violence screening, (2) provider training on partner violence as a form of power and control and the ways in which that can impact reproductive health, and (3) targeted follow-up

counseling protocols. Follow-up counseling should focus on reproductive health and provide community referrals for more comprehensive domestic violence services. Reproductive health counseling protocols for women experiencing partner violence should include an assessment of partner influences on sexual and health care practices, identification of risk reduction strategies including birth control methods useful for each woman's unique relationship context, and increasing preventive health care, such as more frequent testing for STIs and early pregnancy testing.