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Correlation between Domestic Violence and Family Planning Attitude among Migrant Women in Turkey

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Authors' contributions

This work was carried out in collaboration among all authors. Authors NB and SS designed the study, performed the statistical analysis, wrote the protocol and wrote the first draft of the manuscript. Author YCO managed the analyses of the study. Author YCO managed the literature searches. All authors read and approved the final manuscript.

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ABSTRACT

Background: This study was conducted for the purpose of determining the effect of violence against women upon the attitudes of immigrant women toward family planning.
Methods: It is a cross-sectional and descriptive study. The smallest number of study sample was determined as 383. Four hundred fifteen married women aged 15-49, who applied to the aforementioned FHCs and accepted to participate in the study, were included in the study. The research data were collected by using a "Women's Information Form", "Scale for Domestic Violence against Women (SDVW)" and "Family Planning Attitude Scale".
Results: It was determined that 46.7% of women were in the age group of 21-30, 44.1% were primary school graduates, 46.5% had migrated at least eleven years before, 63.1% had migrated from the Eastern Anatolia Region and 37.3% had migrated due to family and relatives. The score averages of women were determined as 74.87±10.01 in the Scale for Domestic Violence against Women and 108.96±17.92 in the Family Planning Attitude Scale. As a result of the correlation analysis that was performed between the score averages of the Scale for Domestic Violence against Women and the Family Planning Attitude Scale; a negative, moderate and significant relationship was determined ($r=-0.329$, $p<0.001$).
Conclusion: It could be suggested that as violence against immigrant women increases, their

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attitudes toward family planning are affected negatively. As a result of this study; it was determined that violence against immigrant women negatively affected the attitudes of women toward family planning and their state of using reproductive healthcare services.

Keywords: Migration; violence against women; family planning; attitude.

1. INTRODUCTION

People are drawn apart from their habitats and moved to different regions and countries all over the world for different reasons that call as migration. Migration fact that coeval with Humanity is a situation that leaving of people their habitat for certain and perennial or temporary period because of different reasons [1]. According to the statistics, its estimate that international migrants were 75 million in 1965, 105 million in 1985 and 150 million in 2000; and for now are 215 million [2]. Especially after 1950's, expeditious urbanization period has started in Turkey as a result of migration from rural areas to urban areas. Whereas urban population share was 25% in 1950's, it is rose to 76% in 2010. Urbanization rate was 33 per thousand in 1990 – 2000 periods. This urbanization process has caused problems for provision of urban services, environmental concerns, occurring of non-planned wide-spread shanty districts and also problems related with healthcare [3].

People are trained culturally by their habitat and carry the main principles of this culture in themselves lifelong. People who migrated from rural area to a city or from a city to an another city would bring their traditional culture with them and this culture would be accepted as accorded as with the urban culture, but would cause marginalization of the culture of migrant, also marginalization of migrant and have problems on self-identity, feel alienated and excluded. This aimless and hopeless life style which is a result of this "marginalization" would cause indifference, apathy and aggression. This conflict between traditional culture of migrant and urban culture that unknown by him would cause increasing on violence against women [4,5].

Violence against women cause economic, sexual, social and medical harms, unwanted marriages, disabilities even deaths besides being a serious social problem. Domestic violence against women includes forced sterilization and miscarriage, forced / by pressure applying contraceptives, murdering of baby girls and prenatal sex choice [6,7,8]. Migrated women experience inequality on results of pregnancy and delivery besides of difficulties on migration. There can a need for new researches on how to decrease this inequalities [9].

It is seen that migrant individuals do not have benefit from mother-child health and family planning services which are part of basic health services when receiving of these services by them is evaluated [5,7]. Giving birth is considerable for sustainability of their statute in migrated women. Utilization from family planning services is rare because of conservativeness [7]. Therefore it is well known truth those women who have lower education level in migrated ones have more children and do not have adequate knowledge on family planning methods. It is determined that receiving prenatal healthcare is not common and rate of delivery in hospitals of migrated women is sparse and high incidence of delivery at home for some factors rooted in socio – cultural and psychological aspects as economic situation, environment, fear [5,7].

Nurses and Midwives have important role as an important part of primary health care service and as itself of service for progressive keep up of health condition of migrated individuals. Nurses and Midwives should accept migrated individuals as privilege group besides the other members of the society and evaluate their promotion of health behaviors to protect and develop their health [6].

The effect of violence against women to receiving family planning services on migrated women is presented by this study. Especially considering of this situation by increasing the awareness of nurses and midwives who work in institutes and organizations giving family planning services, could contribute to provide appropriate consultation and healthcare service on violence and family planning whenever they need. This study is conducted to determine the effect of violence against migrated women on attitude of migrated women for family planning.

2. MATERIALS AND METHODS

2.1 Data Sources

This study is a cross-sectional and descriptive study. The study was conducted in the central

district of Manisa between 01 February 2015 and 1 February 2016. Target population of the study consisted of 99.917 immigrant women aged 15-49 in the city of Manisa. The minimum sample size of the study, which was exemplify of universe, which was calculated as 383 immigrant women by using the Epi info 7.0 software and taking the frequency of domestic violence against women in our society as 42%, confidence limit 95% and the margin of error 5%. The study involved Family Health Center Numbered 3 in the District of Yunus Emre, Nükhet Salim Yavas Family Health Center Numbered 4 in the District of Sehzadeler and Family Health Center Numbered 5, which have the highest rates of migration in the city of Manisa. 415 married women aged 15-49, who applied to the aforementioned FHCs and accepted to participate in the study, were included in the study.

2.2 Measures

In the study, the data were collected by using the "Women's Information Form" consisting of 32 items which was prepared by the researchers in accordance with literature, the "Scale of Domestic Violence Against Women (SDVAW)" and the "Family Planning Attitude Scale (FPAS)". All data collection tools were used in Turkish, in a way the participants could understand.

2.2.1 Women's information form

The women's information forms consisted of questions about their socio-demographic and marital features, income status, residence, family type (nuclear, extended etc.) and educational background.

2.2.1.1 Scale of Domestic Violence against Women (SDVAW)

Developed by Kılıc in 1999, Scale of Domestic Violence against Women determines domestic violence committed by the husband on the woman. The scale consists of 50 items and 5 sub-dimensions. Sub-dimensions are physical violence, emotional violence, verbal violence, economic violence and sexual violence. Each group can be used independently. Each sub-dimension consists of 10 items. Items related to physical violence are numbered 1, 6, 11, 16, 21, 26, 31, 36, 41, 46 while emotional violence are expressed in the items numbered 2, 7, 12, 17, 22, 27, 32, 37, 42, 47. Sub-dimension concerning verbal violence includes the items numbered 3, 8, 13, 18, 23, 28, 33, 38, 43, and 48 while sub-dimension concerning economic violence includes the items numbered 4, 9, 14, 19, 24, 29, 34, 39, 44, and 49. The sexual violence related items are numbered 5, 10, 15, 20, 25, 30, 35, 40, 45, and 50. The total score obtained from the scale shows the level of "domestic violence against women". The scale is a likert type scale from 1 to 3 with responses of "Never", "Sometimes" and "Always". Participants obtained scores from each statement in the scale as follows: Never (1), Sometimes (2), Always (3). Out of 50 items, 16 items numbered 2, 5, 7, 8, 9, 12, 14, 22, 28, 30, 32, 33, 38, 44, 47 and 49 were reversely coded. The lowest score to be obtained from the scale is 50 while the highest score to be obtained from the scale is 150. The lowest and highest scores to be obtained from each sub-dimension are 10 and 30, respectively. High scores that women get from the scale show high level of exposure to violence while low scores indicate low level of exposure to violence. Cronbach alpha coefficients of the scale and sub-dimensions were determined to range between 0.73 and 0.94 [10]. In this study, Cronbach alpha coefficient of the scale was calculated as 0.71.

2.2.1.2 Family Planning Attitude Scale (FPAS)

This scale was developed by Orsal in order to assess individuals' attitudes toward family planning. The scale consists of 34 items and is a 5-point Likert-type self-assessment scale. After completing the scale, participants were asked to rate the items, with an aim to assess their attitudes toward family planning, from 1 (strongly disagree) to 5 (strongly agree). The possible total score on the scale ranges between 34 and 170. The scale's reliability and validity were evaluated in a study with 1142 participants, and Cronbach's alpha was reported as 0.90. Its construct validity was evaluated through a confirmatory factor analysis, and it was found that the scale consisted of three sub-dimensions that influenced their attitudes toward the society (items between 1 and 15), family planning methods (items between 16 and 24), and pregnancy (items between 25 and 34). The scale evaluation involves considering that "individuals with higher scores have more positive attitudes toward family planning." This scale has already been used in another study conducted in Turkey [11]. In this study, the Cronbach's alpha for the Family Planning Attitude Scale was calculated as 0.90, a value which was very close to the original scale.

2.3 Application Procedure and Material

In the study, the research was applied that Women's Information Form, Scale of Domestic Violence against Women and Family Planning Attitude Scale by using the face-to-face interview technique after the necessary explanations were made by the researcher. The data were collected within 30-45 minutes in total (Women's Information Form 10-15 minutes on average, Scale of Domestic Violence against Women 10-15 minutes on average and Family Planning Attitude Scale 10-15 minutes on average).

2.4 Analysis

Descriptive data are presented as number, percentage and mean. The data gathered from the groups were compared with the Pearson Correlation Test. All analyses were carried out using the SPSS for Windows, release 15 .0 (SPSS, Inc., Chicago, IL, USA). A p value of <0.05 was thought to be crucial for all analyses.

3. RESULTS

It is determined that 46.7% of women are 21 – 30 age group and average age of them is 30.90 ±7.98; 44.1% of them graduated from elementary school, 95.4% of them unemployed, 73.3% of them have middle income, 46.5% of them migrated eleven or more years ago and average period after migration is 12.52±9.07 years, 63.1% of them migrated from Eastern Anatolian Region, 37.3% of them migrated because of their family and relatives.

According to the obstetric history of these women it is determined that 29.9% of them have two delivery, and average delivery of them is 2.62±1.59, 92.5% of them has known any of birth control method, 17.3% of them do not use birth control method, 82.7% of them apply birth control method and 35.9% of women who apply birth control method use withdrawal method for preventing pregnancy.

3.1 Violence Against Migrant Women

When the distributions of the score averages women received from the scale of domestic violence against women are examined, it is seen that 43.4% of women have score averages above the score average of the scale (74.87±10.01) and they are exposed to violence more than the others (Table 1).

When the sub-dimension score averages of the women are examined, it is determined that physical violence sub-dimension score averages of 4.3% of the women are above the average of the sub-dimension (10.88±2.03) and they are exposed to physical violence more than the others; emotional violence sub-dimension score averages of 78.8% of the women are above the average of the sub-dimension (17.72±2.61) and they are exposed to emotional violence more than the others; verbal violence sub-dimension score averages of 45.1% of the women are above the average of the sub-dimension (15.72±3.05) and they are exposed to verbal violence more than the others; economic violence sub-dimension score averages of 72.5% of the women are above the average of the sub-dimension (17.26±3.23) and they are exposed to economic violence more than the others; and sexual violence sub-dimension score averages of 14.9% of the women are above the average of the sub-dimension (13.28±2.38) and they are exposed to sexual violence more than the others (Table 1).

3.2 Family Planning Attitudes of Migrant Women

When the distributions of the score averages women received from the scale of women family planning are examined, it is seen that 8.9% of women have score averages above the score average of the scale (108.96±17.92) and migrant women's family planning attitude scores were low more than the others (Table 2).

When the sub-dimension score averages of the women are examined, it is determined that attitude of the society about family planning sub-dimension score averages of 23.4% of the women are above the average of the sub-dimension (44.80±9.62) and migrant women's society family planning attitude scores were low more than the others; attitude of the family planning methods sub-dimension score averages of 3.9% of the women are above the average of the sub-dimension (38.15±6.27) and migrant women's family planning methods attitude scores were low more than the others; attitude about the labor sub-dimension score averages of 11.8% of the women are above the average of the sub-dimension (15.72±3.05) and migrant women's attitude about the labor scores were low more than the others (Table 2).

It is determined that the correlation analysis between FPAS total point averages of immigrant

women and SDVAW a moderate, significant and negative correlation. (r = -0.329, p <0.001). It can be said that migrant women were exposed more violence and the attitudes of family planning of migrant women are affected negatively (Table 3).

Table 1. Distribution of average score of scale for domestic violence against migrant women

Scale for Domestic Violence against Women*	n	%	Mean± SD
Total score average			74.87±10.01
Below Scale average scores 50-74	235	56.6	(Min:56.00
Above the average scale score 75-150	180	43.4	Max: 112.00)
Subscales			
Physical violence			10.88±2.03
Below Scale average scores (15↓)	397	95.7	
Above Scale average scores (15↑)	18	4.3	
Emotional violence			17.72±2.61
Below Scale average scores (15↓)	88	21.2	
Above Scale average scores (15↑)	327	78.8	
Verbal violence			15.72±3.05
Below Scale average scores (15↓)	228	54.9	
Above Scale average scores (15↑)	187	45.1	
Economic violence			17.26±3.23
Below Scale average scores (15↓)	114	27.5	
Above Scale average scores (15↑)	301	72.5	
Sexual violence			13.28±2.38
Below Scale average scores (15↓)	353	85.1	
Above Scale average scores (15↑)	62	14.9	

Table 2. Women's family planning attitude scale total and subscale average score

Scale	n	%	Mean± SD
Total score average (1-34)			108.96±17.92
Below Scale average scores (85↓)	37	8.9	(Min:53.00
Above the average scale score (85↑)	378	91.1	Max: 164.00)
Subscales			
Attitude of the Society about Family Planning (1-14)			44.80±9.62
Below Scale average scores (37.5↓)	97	23.4	
Above the average scale score (37.5↑)	318	76.6	
Attitude of the Family Planning Methods (15-26)			38.15±6.27
Below Scale average scores (27.5↓)	16	3.9	
Above the average scale score (27.5↑)	399	96.1	
Attitude about the Labor (27-34)			26.01±5.30
Below Scale average scores (20↓)	49	11.8	
Above the average scale score (20↑)	366	88.2	

Table 3. Determination of the relationship between the mean scores of FPAS and the SDVAW

Family Planning Attitude Scale	Score of Scale for Domestic Violence against Women		
	n	*r	p
Attitude of the Society about Family Planning	415	-0.289	0.000
Attitude of the Family Planning Methods	415	-0.268	0.000
Attitude about the Labor	415	-0.271	0.000
Total FPAS Score	415	-0.329	0.000

4. DISCUSSION

Migration is a major problem in our country as it is in the whole world. Negative effects of migration to health have more influence on women's health than men's health [12]. The most common health problems that seen on migrated women in our country are summarized as contagious diseases, being unable to benefit from family planning services and prenatal healthcare services, low incidence of delivery in hospitals and higher incidence of delivery at home without attendance of any healthcare personnel, irregular heavy periods, spontaneous abortions, too many deliveries in short periods [7]. When the literature is examined that immigrant women are multipara and do not use contraceptives and have adolescence gestation and need to support and help for reproductive health [1,5,6,7,12].

It is determined that more than half of the women (63.1%) are migrated from Eastern Anatolian Region according to our study. 1 for 5 women (17.3%) do not use contraceptives. On the other hand, 1 out of every 3 women (35.9 %) that use a contraceptive method use the withdrawal method.

According to a study conducted countrywide of Turkey (HUIPS 2013) throughout the country, 74% of married women use contraceptive methods, 47% of them are modern methods and 26% of them are traditional methods. Currently 26% of women have reported using withdrawal method for preventing of pregnancy in the date of conduction of the study [3]. According to the study that conducted by Çalışkan et. al. (2014) it is determined that nearly half of women (41.2%) prefer withdrawal method and the other traditional methods for preventing pregnancy; age and education level of migrated women have influence on choosing of birth control method; elder and less educated migrant women prefer traditional family planning methods [13]. In a study conducted in 2017 with Syrian women in Turkey it is detected that however they didn't want children for near future, they hadn't use a modern method for birth control and most common used traditional method was withdrawal method in preventing pregnancy [14]. Withdrawal method is the common used traditional method as it could see from the conducted studies.

There is some special conditions lead up to violence against women in Turkey. One of them is migration fact. Migration fact could be an important determinant on sharp raise of violence against women and murder of women [15]. Migration diversifies and intensifies the violence types that women would be exposed addition to labor exploit of women [16]. Furthermore language barrier of migrant women who have different ethnical roots and can't speak the local language of migrated region both internal and international migration; socio economic difficulties as social isolation limit to receive healthcare and psychiatrically services [1], therefore statistical inventory of exposing to violence of migrant women could be inadequate for reflecting real situation. It is seen that average score for Scale of Domestic Violence against Women is 74.87 ±10.01 and nearly half of the women (43.4%) scored higher than the average score of scale and exposed more violence.

In Turkey the proportion of married women who stated that they had been exposed to physical violence is 36%. In other words, approximately 4 of 10 women had experienced physical violence from their husbands or partners [17]. In the most of the studies carried out in Turkey, exposure to violence rates of women vary between 40% and 80% [17,18,19,20]. Migrated women (5.9%) have subjected violence more than settled and located women in the center of the city (4.2%) as stated in the study that conducted by Mevlana Development Agency (2012) [21]. Also in a study that conducted with women moved to Lebanon, it is determined that women were subjected to domestic violence and also exposed harassment and violence in the society [22]. Rees and Pease (2007) also indicated in their study which conducted with women and men from Iraq, Sudan, Ethiopia, Bosnia, Serbia and Croatia who were migrated to Australia that violence against women especially domestic violence increase with migration [23]. Our findings show a parallelism with the work done on similar groups.

When the migration is evaluated according to receiving mother-child health and family planning aspects which are the parts of basic health services, it is seen that migrants cannot reach these services sufficiently. Delivering a child is accepted an important aspect for keeping the statue, related with the culture that they have loyalty and therefore make use of the family planning services rates can become lower [24,25,26,27,28]. It is determined that every one of ten women have lower score for average score of Family Planning Attitude Scale (108.96±17.92) and have negative attitudes

against to family planning in our study too. In the studies conducted in different regions of Turkey for determining of attitudes to Family Planning respectively Average Score for Family Planning Attitude Score is found as 114.11+0.91, 124.20 ± 27.34, 117.632±11.12 and 120.11±13.8 [25,26, 27,28]. The scores seems lower in our study when compared with the other studies. It is supposed that the difference derives from the participants who were migrated women. When the studies which conducted in different regions of the world examined it is reported that perception of health situation of 65% migrant women is poor / bad; most common health problems are psychological and gynecological complains [29], they are multipara and make use less birth control methods [30] and have less using of contraceptives and higher rate for adolescence gestation [31]. According to the results of the studies, it can be said that using of family planning methods of migrant women is in low level and these women cannot benefit from the family planning services sufficiently.

It is emphasized that migrant women in the third world are in higher risk for unwanted gestation and domestic violence against women. Migrant women could be exposed to sexual harassment, rape and violence for both they are women and migrant [32]. Violence against women is deal as a risk factor which effects women health besides being of it is a health problem. Although violence against women causes physical and psychological damages, behavior detrimental to women's health are most common as substance abuse and unprotected sex [33]. It is determined that there is a significant, moderate, meaningful and negative relation with situation for exposing violence of women and attitudes for family planning in our study. Attitudes for family planning of migrant women are influenced negatively by increasing of exposing to violence. It is possible to state that exposing violence of migrated women have negative effect on attitudes for using of family planning which is the one of the most important part of women health. Aspects of migration, violence and quality of life are important variables those effect women health and their attitudes for family planning according to the results of the study conducted by Mevlana Development Agency (2012) [21]. Most of the women didn't want to have a child in near future and knew the most of the contraceptive methods and despite these it is determined that they didn't use the modern contraceptive methods according to a research which was conducted in our country [14].

Health conditions of migrants are affected negatively for lack of health institutes in migration receiving regions, low income of migrants, language barrier, not to have health insurance, having traditional living models. Migrant women of our country are mostly migrated from Eastern, Southeastern Anatolian Region and rural area to urban area. It is known that there is a need for support and help for productive health therefore the most of the women from these regions are multipara and not to prefer use contraceptive methods and have adolescence gestation so, healthcare staffs should supply support to migrant women in these aspects [3,17,21,34].

5. CONCLUSION

As a result; migration is experienced in our country too as it is in the whole world that is a big problem. Attitudes for family planning of migrant women are influenced negatively by increasing of exposing to violence. It is possible to state that exposing violence of migrated women have negative effect on attitudes for using of family planning which is the one of the most important part of women health. Health of the all of the migrants could be protected by improving the health of migrant women. Therefore migrant women should be helped that on fertility, using contraceptives and family planning education.

6. LIMITATIONS

Our study has several limitations. Although the first intention was to conduct the study throughout Turkey, it was carried out in a specific region due to financial difficulty and time constraints. During the study, data were collected via personal statements. Despite the similarities between the findings of the present study and results of the studies covering the whole country, the results of this study only belong to the region where it is carried out and cannot be generalized to Turkey. Finally, the cross-sectional and descriptive design of the study limits conclusions about causality for some findings.

CONSENT

As per international standard informed and written participant consent has been collected and preserved by the authors.

ETHICAL APPROVAL

As per international standard written ethical permission has been collected and preserved by the author(s).

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COMPETING INTERESTS

Authors have declared that no competing interests exist.

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