Silent Failings: Sexual Violence and Female Reproductive Health

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Introduction

Sexual violence is a global problem, which often causes significant harm to victims' health, including wide-ranging reproductive health harms. The umbrella term encompasses sexual harassment, rape, sexual abuse, sexual exploitation, and any other sexual acts carried out without the active informed consent of all involved parties. (Rape Crisis England & Wales, n.d.-a; Rape Crisis England & Wales, n.d.-b). Current research suggests pregnant women, disabled women, adolescent girls, and black women are at an escalated risk of experiencing sexual violence. (García-Moreno and Stöckl, 2013; Office for National Statistics, 2021).

Exact prevalence is impossible to ascertain for various reasons, such as, women not understanding their experience is sexual violence, distrust of the police, and a culture of victim-blaming leaving women too ashamed to speak up. Recently, UN Women reported that 97% of young women in the United Kingdom (UK) have experienced at least one incident of sexual harassment in a public space. (UN Women UK, 2021). Not all women will experience sexual violence, but given it is so common women view it as an inevitable and expected part of their life, the impact of sexual violence on female reproductive health warrants exploration.

Existing research has focussed largely on victimisation occurring in war zones and developing countries, exploring the accuracy of prevalence estimates in greater detail than the adverse health effects for victims. Where health effects are researched, there is a pattern of focus on the psychological effects, ignoring the reality that profound reproductive consequences can be present for a victim's entire life.

This essay will focus exclusively on female sexual violence victims, including women who were victimised as children. The full reproductive consequences are too extensive for this essay's capacity, thus this essay will explore three specific areas of women's reproductive health to assess the impact of sexual violence: pregnancy, breastfeeding, and gynaecological cancers. Then, it will explore how the impact can be ameliorated.

Medical Consequences

All forms of sexual violence can result in serious harm to the short and long-term physical health of victims. (García-Moreno and Stöckl, 2013; Sardinha *et al.*, 2022). Short-term consequences include unwanted pregnancies, swollen non-pelvic bruising, hymen ecchymosis, labia abrasions, STDs, chlamydia, bacterial vaginosis, and trichomoniasis. (Jenny *et al.,* 1990; Parrish, Ryan and Farone, 1996; Slaughter *et al.,* 1997; Schliep *et al.,* 2016; St. Pierre, 2019).

A clear association with dyspareunia, dysmenorrhea, menorrhagia, PID, genital herpes, HIV, immune system problems, asthma, diabetes, IBS, and arthritis also exists. (Waigandt *et al.,*1990; Golding, Wilsnack and Learman,1998; Stein and Barrett-Connor, 2000; Harne, 2002; Schliep *et al.,* 2016; Amin *et al,* 2017; Mengeling *et al.,* 2019; Rajeev *et al.,* 2019; Anderson *et al.,* 2021).

Sexual violence is associated with risk factors too. For example, sexual violence victimisation has been linked to smoking cigarettes, obesity, high cholesterol, hypertension, and social isolation. (Cloutier, Martin and Poole, 2002; Schliep *et al.,* 2016).

It is essential to thoroughly understand the health effects related to sexual violence in order to improve care for sexual violence victims.

Reproductive Cancers

Sexual violence increases the risk of women developing some reproductive cancers, including breast and cervical cancers. (Stein and Barrett-Connor, 2000; Gordinier *et al.*, 2021). In addition, victims are more likely to be diagnosed when their cancer is at a more advanced stage than women with no sexual violence history, leaving fewer treatment options available. (Modesitt *et al.,* 2006). If patients are fortunate enough to have access to viable treatment options, their sexual violence history can make the innately invasive treatments feel traumatic.

According to Cancer Research UK, breast cancer is the second most common cause of cancer death for women in the UK. (Cancer Research UK, n.d.). Although breast screening cannot prevent cancer it saves lives through early diagnosis, with some estimates stating that over 1,000 lives are saved annually by the UK's breast screening programme. (Macmillan Cancer Support, 2022a). Breast screening is performed by completing a low dose x-ray of both breasts, known as a mammogram. (Macmillan Cancer Support, 2022b). However, sexual violence victims are less likely to participate in screening as advised. This is understandable when one considers that mammograms squeeze the breasts, which may be distressing if breasts were exposed and/or abused during the event(s) of sexual violence. (Gesink and Nattel, 2015). Understandably, re-traumatisation contributes to the poor attendance because screening requires women to undress, surrender control of their body to their mammographer, and can cause breast pain; all of which can trigger unpleasant memories of their sexual trauma. (Schnur *et al.*, 2017). Victims may be reluctant to attend due to concerns about radiation exposure, which could be easily overcome through the use of public health campaigns. (Gesink and Nattel, 2015).

Likewise, Public Health England estimates 83% of cervical cancer cases in England could be prevented if everyone eligible for cervical screening attended regularly. (Public Health England, 2019). However, there is an abundance of evidence suggesting victims of sexual violence, especially sexual abuse, are significantly less likely to attend regular cervical screening. (Oscarsson, Benzein and Wijma, 2008; Cadman *et al.,* 2012; Roberts, 2020; Madden *et al.,* 2022). Cervical screening, previously referred to as a smear test, detects high-risk HPV and abnormal cell changes in the cervix. (Jo's Cervical Cancer Trust, 2022). Sexual violence can create a seemingly insurmountable barrier to cervical screening, due to concerns about loss of control and the power disparity between patient and provider. Trauma-informed practices, such as allowing patients to insert specula, could alleviate this. Many victims fear physical pain during screening, which is a valid concern when one considers they are likely to suffer involuntary muscle tightening, or even vaginismus, due to their trauma, resulting in more pain. Further barriers identified by victims include embarrassment about scarring, feeling unworthy of healthcare, and concerns regarding the position required to carry out the test if it mimics the position sexual violence was carried out in. (Cadman *et al.,* 2012; Kelly, 2012; Victim Focus, 2022). It is crucial for healthcare providers to contemplate these barriers in order to deliver better quality care to victims, preventing avoidable cancer deaths. Self-testing should be explored as an alternative for victims. (Lofters and Vahabi, 2016; Gorfinkel, Perlow and Macdonald, 2021; Vrajlal, 2022).

Impacts During Pregnancy

Maternal morbidity and mortality rates may be higher for sexual violence victims, although conclusive evidence to support this is currently unavailable. Systemic racism may contribute to the under-researching of this hypothesis because black women are four times more likely to die during pregnancy and are more likely to experience sexual violence. (García-Moreno and Stöckl, 2013; Knight *et al.,* 2021; Office for National Statistics, 2021).

Norwegian research demonstrates that sexual violence is related to an increased requirement for antenatal hospitalisations. The complications reportedly causing these hospitalisations include bleeding, hyperemesis gravidarum, and preterm labour, suggesting a link between sexual violence victimisation and the listed complications. (Henriksen *et al.*, 2013). Additionally, research suggests women exposed to sexual violence, particularly if exposed between ages 12 - 19, are more likely to be at higher risk of some adverse obstetric outcomes, as well as being at an increased risk of bleeding and having a prolonged first stage of labour. (Gisladottir *et al.*, 2016). These findings are particularly concerning when one considers bleeding is one of four complications thought to be responsible for 75% of maternal deaths. (Say *et al.,* 2014). Similarly, pre-eclampsia is a sizeable concern for victims, with childhood sexual abuse (CSA) being associated with a 33% increased risk of pre-eclampsia during a woman's first pregnancy. (Stuart *et al.*, 2021). This is further supported by research in low to middle income countries, which established a correlation between sexual violence and increased risk of hypertensive obstetric complications, including pre-eclampsia. (Bellizzi *et al.*, 2019). Other obstetric complications related to sexual violence victimisation are less likely to be fatal, yet cause distress and severe pain for women, for example, cervical insufficiency and premature contractions, which are both associated with CSA. (Leeners *et al.*, 2010). A second Norwegian survey discovered victims were more likely to report pregnancy-related physical symptoms, which may sound minor to healthcare providers but cause remarkable discomfort for women. (Lukasse *et al.*, 2012).

As one may expect, many sexual violence victims avoid receiving antenatal care during their first pregnancy. (Edmonds *et al.*, 2021.) This could contribute to the adverse health effects experienced during their pregnancies, but there is limited evidence to substantiate this theory thus it is unethical to blame victims for pregnancy complications they endure.

Effects on Breastfeeding

Research has shown breastfeeding to have substantial health benefits for mother and infant, to the extent that the World Health Organisation has been recommending "exclusive breastfeeding for six months" since 2001. (World Health Organisation, 2001). The numerous benefits include a reduced cardiovascular disease risk in mothers, in addition to reducing the mother's risk of developing breast and ovarian cancers in the future. (NHS, 2020; American Heart Association, 2021).

Despite this, many women choose not to breastfeed, to respect women's' right to choose, efforts should focus on continuation of breastfeeding rather than initiation. The various barriers to breastfeeding identified include:

- cultural barriers,
- misinformation about infant feeding,
- employment-related barriers,
- lack of access to support. (UNICEF UK, n.d.).

Policies have been introduced to overcome some of the socially acceptable barriers, for example legislative changes to support breastfeeding mothers in the workplace. One further barrier to breastfeeding is sexual violence history but little has been done to address this.

(Repič Slavič and Gostečnik, 2015). The idea is underexplored but may be due to discomfort resulting from the intense physical contact created by breastfeeding. (Kendall-Tackett, n.d.). Women also suggest that breastfeeding means surrendering control of your body, as infant feeding patterns are unpredictable. (Simkin, 2018). Furthermore, midwifery support provided in hospitals oftentimes involves midwives handling the mothers' breasts, which can cause intense discomfort. (Garratt, 2008). Although, neither mother nor infant's health is harmed by choosing not to breastfeed, they are both missing multiple medical benefits due to a choice that victims may feel is the only option.

As Trickey explained in 2012, "the current climate of cost cutting in the public sector has meant that…the services and infrastructure to support breastfeeding have begun to be cut back." (Trickey and Newburn, 2012). It is not news that cuts have continued, undoubtedly contributing to thousands of women, including sexual violence victims, being left without the support systems required to help them in their breastfeeding journeys. Trickey later highlighted that the 2010 withdrawal of the UK Infant Feeding Survey and a "lack of funding and human resources, particularly for breastfeeding peer support" hampers progress further. (Brown, Chucha, and Trickey, 2022). Compounded with a societal unwillingness to listen to women's voices, a lack of research into sexual violence, and inadequate training for healthcare professionals, it is no wonder some women are struggling. (Jackson *et al.*, 2007). With the implementation of trauma informed midwifery, increased funding for peer support initiatives, and the reintroduction of the UK Infant Feeding Survey we can drastically reduce difficulties victimised women face breastfeeding.

Prevention of Sexual Violence

The NHS utilises the "prevention is better than cure" principle, attributed to Dutch philosopher Desiderius Erasmus. Prevention of all sexual violence is impossible, but reducing prevalence is possible and will save lives. Current approaches to preventing sexual violence range from the use of technology to improvements in education, to poverty alleviation. (Jewkes, 2002).

It has been theorised that education is the key to sexual violence prevention. Experts believe, for optimal efficacy, preventative education should begin as a young child, rather than at college or university age, which is normally when sexual violence prevention education programmes are first initiated. (Basile, 2015; Pearse, 2022). However, because sexual violence is upsettingly common within higher education, with estimates that 17.4% of female students experience sexual violence, educational programmes aimed at sexual violence prevention should continue to be used in universities. (Steele *et al.*, 2021).

Experts state comprehensive sexual violence prevention education should consist of teaching new skills, support to unlearn rape myths and bystander intervention, alongside the teaching of unambiguous definitions of consent. (Edwards, Shea and Barboza Barela, 2018). It could be argued that a lack of teaching about consent means young women are growing up unaware they have experienced sexual violence, contributing to low disclosure rates. However, it is unlikely that consent-based education would prevent sexual violence from occurring, as research demonstrates that rapes are committed due to sexual entitlement, anger, for entertainment, and as a punishment, none of which is preventable by teaching about consent. (Jewkes *et al.*, 2013).

Bystander intervention programmes are a common strategy used to prevent sexual violence. The programmes teach people witnessing "warning signs" of sexual violence or sexual violence to intervene. (College of Policing, 2022). These programmes could be criticised as bystander intervention cannot prevent all forms of sexual violence, or any if no bystanders are present. For example, it may prevent a rape, but in doing so causes an attempted rape,

which remains a serious form of sexual violence. Despite this, research supports the use of bystander intervention programmes to prevent sexual violence. (McMahon and Banyard, 2011). Studies show bystander intervention initiatives are effective in immediately reducing rape myth acceptance, but whether this continues in the long-term is unexplored, and evidence evaluating the impact of these programmes upon victim empathy are currently inconclusive. (College of Policing, 2022). Due to this, bystander intervention should be taught as part of a multi-layered educational strategy to prevent sexual violence against women.

Technology, such as rape alarms and barbed condoms, is a popular approach to prevention. These methods are only superficially helpful and when fully evaluated various problems come to light. For example, technology could fail women when we need it the most, either because the violence being perpetuated leaves us unable to activate the technology, a fault with the device renders it useless, or because the 'freeze' adrenal response leaves us unable to use it. (White and McMillan, 2020).

Furthermore, sharp items for internal wear, for example barbed condoms, have the potential to cause injuries to women, or dangerous delay to receiving emergency medical care. These devices are capable of helping in limited circumstances because sexual violence does not always include vaginal penetration and it is unlikely women would have enough time to insert a device ahead of an assault. Aside from these issues, such technology could be criticised for the way it represents sexual violence, implying it is an inevitable event in women's' lives by normalising sexual violence, generating acute anxiety for many women.

The technology also misplaces responsibility- it is not for women to prevent sexual violence- and this misplacing of responsibility could contribute to self-blame or victim-blaming if devices, or more accurately women, do not prevent sexual violence. Additionally, it is known that unemployed adults are more likely to be sexually assaulted, and poorer women are more likely to be sexually exploited. (Cornish-Spencer, 2018; Office for National Statistics, 2021). Preventative technology is often extortionately priced making it presumptively inaccessible for no or low-income women, who it could be argued need this technology the most as they are most likely to be victims of sexual violence. (Phipps, 2009).

Trauma-Informed Care

The final solution to be explored is the use of trauma-informed care. The concept, originally from the psychology field, has "the goal of creating a healthcare environment that is safe and healing by integrating an understanding of trauma and trauma related sequelae into routine practice." (Ward, 2020). Studies found high rates of patient satisfaction when trauma-informed care is used in physical health environments, including among ethnic minority patients. (Stevens *et al.*, 2017).

As universal trauma-informed care is currently an unrealistic aim, the first step to implementing trauma-informed care is screening. Research suggests screening patients for sexual violence improves health outcomes, reduces repeat victimisation, and reduces the likelihood of retraumatised when accessing healthcare. (Sutherland, Fantasia and Hutchinson, 2015). Despite recommendations, research demonstrates universal sexual violence screening is simply not happening. Reasons for the insufficient screening, and consequential lack of targeted trauma-informed care, include inadequate training, time, and funding. (Long *et al.*, 2022; Terrell *et al.*, 2022). However, the most recent figures estimate implementing trauma-informed care could save the NHS £16 billion annually, making it undeniably financially worthwhile. (Newland *et al.*, 2022). We should also acknowledge society's unwillingness to listen to women's voices, and the stigma surrounding female reproductive health, which contribute to the challenges improving services.

Research demonstrates common triggers for sexual violence victims include inadequately explained procedures and the presence of unfamiliar staff, on top of triggers explored earlier. (O'Rourke-Suchoff *et al.*, 2018). Research indicates victims value consistency of staff, clinic environment, and interactions with receptionists, tying in with trauma-informed care principles. (Elliott *et al*., 2005; Ross *et al.*, 2021). Therefore, receptionists should be trained to prevent them using language that would shame patients for not attending sooner or reacting harmfully to valid concerns arising from their trauma histories. Additionally, women should be invited to share their preferences for clinic design. Realistically, we cannot expect all clinical staff to become trauma-informed care experts. Research shows having one or two staff members who are trained and able to lead in victims' care is acceptable as a long-term strategy, or a feasible starting point for building an entirely trauma-informed service. (Sperlich et al., 2017). This would also make it easier to provide consistency in staff, which women want.

Implementation of trauma-informed care can be non-disruptive. (Gordinier et al., 2021). For example, many providers use paper forms in waiting rooms to establish a medical and social history, which feature domestic violence screening. Adding sexual violence screening to this would be inexpensive and non-disruptive.

Public health campaigns sharing information about gynaecological cancer screenings, and consent during these screenings could be helpful. A full list of recommendations is available in *Figure 1*.

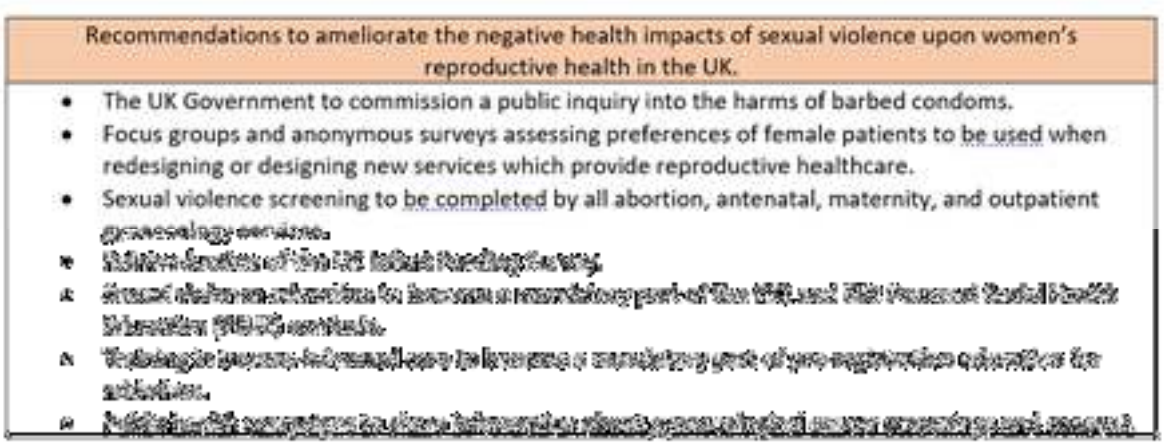

Figure 1

Conclusion

Sexual violence is a highly prevalent threat to women's reproductive health. There is no single solution to tackle this complex problem, but it is recommended that solutions take a multifaceted approach, including strategies to prevent sexual violence and improvements to healthcare systems, as demonstrated in *Figure 1*, to better support female sexual violence victims.

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