Sexual and reproductive ill health is a major cause of morbidity and mortality; however, calls to enhance these dimensions of health have been neglected (Glasier and Gülmezoglu, 2006). Research suggests that having the freedom to decide if, when and how often to reproduce is central to sexual health, implying that access to abortion services is important. However, 25 per cent of the world’s population lives in one of the 66 countries where abortion is either prohibited or allowed only where the pregnant woman’s life is at risk (Center for Reproductive Rights, 2017). In such countries, women do not have the capacity to decide if and when to reproduce and are structurally disadvantaged with regard to their reproductive rights. Indeed, given that they

Restricted reproductive rights and risky sexual behaviour: How political disenfranchisement relates to women’s sense of control, well-being and sexual health

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Abstract
Few studies have investigated the role of disenfranchisement and denial of agency in women’s sexual health. To address this, a cross-sectional study of disenfranchisement, control (general and reproductive control) and health was conducted in Ireland, where abortion is severely restricted. Multiple mediation models (N = 513 women) indicated that general but not reproductive control mediates the association between disenfranchisement and psychological well-being. Additionally, serial mediation shows disenfranchisement is associated with lower sense of control, which is linked to poorer well-being and risky sexual behaviour. Disenfranchisement arising from socio-political contexts may have important implications for women’s sexual health.

Keywords
abortion, control, disenfranchisement, health, well-being

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cannot obtain abortion services should they want or need them, we argue that such women are disenfranchised: stripped of the power to make personal health-related decisions that impact their lives and well-being. We propose that this disenfranchisement reduces women’s sense of control. In turn, we predict that this reduced sense of control has deleterious effects for their well-being and sexual behaviour (Kerrigan et al., 2013).

To date, few studies have investigated the role of disenfranchisement in women’s sexual health. We address this gap by investigating this issue in Ireland: one of the two European countries where abortion is permitted only where the pregnant woman’s life is at risk (Center for Reproductive Rights, 2017). In Ireland, the Eighth Amendment to the constitution legislates against access to abortion services, by recognising the right to life of an unborn child as equal to the right to life of a pregnant woman. The Irish constitution can be changed only by referendum (The All-Party Oireachtas Committee of the Constitution, 2005), and the last opportunity for Irish women to influence law was the referendum inserting the Eighth Amendment in 1983 (Irish Family Planning Association, n.d.). As such, at the time of writing, no Irish woman of childbearing age has had the opportunity to vote on Ireland’s current constitutional outlawing of abortion. Effectively, women in Ireland are politically disenfranchised with regard to their sexual health. In this study, we use the Irish setting to investigate the link between disenfranchisement, feelings of control, psychological well-being and risky sexual behaviour.

**Sexual health and well-being**

In a global review of mental health aspects of women’s sexual health, the World Health Organization (WHO) asserts that sexual and reproductive rights are important aspects of human rights and overall health (WHO et al., 2009). Sexual health goes beyond the absence of disease and infections, to include the ability to control fertility and enjoy relationships free from discrimination (WHO et al., 2009). It is inextricably linked to well-being; women’s mental health suffers when reproductive rights are compromised (WHO et al., 2009).

In countries where abortion is illegal, the social and political environment can contribute to poorer mental health, particularly where women access abortion through illicit means (Krug et al., 2002). Denying access to legal, safe, timely and affordable abortion means women in developed and developing countries may resort to unsafe, ‘backyard’ or self-inflicted procedures (WHO et al., 2009). Illegal and unsafe abortion is a source of stigma and a leading cause of preventable death in developing countries (Sedgh et al., 2007). In predominantly Catholic European countries such as Poland and Ireland, women often travel to nearby countries to access legal abortion services. Estimates suggest that between 2001 and 2008, 18 Irish women a day travelled to the United Kingdom for abortion services, a trip that is expensive and entails the emotional and psychological burden of secrecy and deception (Gilmartin and White, 2011). Moreover, longitudinal evidence indicates that women who are denied abortion in pregnancy are more likely to experience adverse emotional consequences than a matched cohort of mothers who desired their pregnancies (David et al., 2003). These findings support an association between denial of reproductive rights and impaired well-being. We propose that the association between disenfranchisement and impaired psychological well-being is not limited to women who need to access abortion, but rather extends to all women whose reproductive rights are restricted as a result of social or structural circumstances.

**Disenfranchisement and risky sexual behaviour**

Denying women’s reproductive rights means that the state, rather than women themselves, makes decisions regarding women’s reproductive trajectories. One proposed reason for restricting reproductive rights is that providing women with more reproductive control (e.g. over-the-counter access
to contraception) increases their engagement in risky sexual behaviour. Yet, a prospective cohort study of 9256 women provided little evidence to support such concerns (Secura et al., 2014). However, the extent to which women’s disenfranchisement in the context of restricted reproductive control influences risky sexual behaviour is unknown, and this study aims to address this gap.

Due to ongoing political controversies, successive Irish governments have avoided a referendum that might allow abortion even in limited circumstances, leading to de facto disenfranchisement on this issue (Fletcher, 2001). Therefore, perceived disenfranchisement is likely to be high in an Irish female sample, allowing us to consider its impact on women’s health. To date, limited research has examined the role of disenfranchisement in women’s sexual health, or health in general. Far greater attention has been given to health outcomes associated with disempowerment. Given that disenfranchisement involves systematic exclusion from authoritative power, it is a form of disempowerment (Zimmerman, 2000). A substantial literature on disempowerment indicates that feelings of control are central to the empowerment process (Zimmerman, 1995). Most relevant to this study are three systematic reviews which link empowerment to sexual health and reduced risky sexual behaviour in female sex workers (Kerrigan et al., 2013, 2015) and in HIV and AIDS sufferers (Wiggins, 2011). By extension, we argue that disenfranchisement should be related to higher levels of risky sexual behaviour. This refers to behaviours that increase the risk of unwanted pregnancy and the transmission of sexually transmitted disease. This includes engaging in unprotected sex and substance use during dating or social activity (DeHart and Birkheimer, 2010). Specifically, we argue that disenfranchisement predicts sexual health behaviour through a reduced sense of control.

Control and sexual health

Extensive evidence demonstrates that perceptions of control are associated with health outcomes across a range of health domains (Bosma et al., 1997; Ell et al., 1989; Macrodimitris and Endler, 2001). Moreover, a sense of control has been found to mediate the negative health consequences of adverse conditions, such as lack of food, clothing and heating (Bobak et al., 2000). In examining the role of perceived control in sexual health, it is important to look beyond general control and examine reproductive control. Reproductive control is defined as a woman’s perception that she is able to make autonomous decisions with regard to her sexual health (Moore et al., 2010; Upadhyay et al., 2014). Control of women’s reproduction can be exerted by other sources, including partners, parents or peers, through economic, emotional and financial means (Moore et al., 2010). At a structural level, governmental legislation in relation to contraception, sex education, vulnerability to violence and access to abortion can also impact on women’s reproductive control. Each of these factors may exert independent effects on women’s mental health (WHO et al., 2009). This study aims to investigate the role of women’s perceptions of reproductive control, as well as more general perceptions of control, in explaining the link between disenfranchisement, well-being and risky sexual behaviour.

This study

This study aimed to explore women’s sexual health in a context where social, cultural and structural conditions restrict women’s reproductive rights. In Ireland, the outlawing of abortion was enshrined in the constitution more than two generations ago. In this setting, this cross-sectional study investigates the underexplored links between disenfranchisement, feelings of control (both general and reproductive), psychological well-being and risky sexual behaviour. Drawing on the evidence reviewed, the following hypotheses were generated. First, disenfranchisement will be negatively associated with psychological well-being, and this relationship will be mediated by both reduced general control and reduced reproductive
control (H1). Second, disenfranchisement will be associated with increased risky sexual behaviour, and this association will be mediated by reduced general control and reproductive control (H2). Finally, our third hypothesis draws these assumptions together and predicts that disenfranchisement will be associated with increased risky sexual behaviour, and this relationship will be serially mediated by reduced feelings of control (both general and reproductive) and poorer psychological well-being (H3).

**Method**

**Participants and procedure**

Women aged 18 years and over were recruited to a cross-sectional survey study via an email invitation to the student population at a university in the Republic of Ireland. Participants read the information sheet detailing the questionnaire content and indicated their consent before completing the questionnaire. Demographic items were presented first, followed by measures of religiosity, attitudes to abortion, well-being, disenfranchisement, risky sexual behaviour, general control and reproductive control. Upon completion, participants were directed to the debriefing page which provided details on the study aims and information on sexual health clinics. Ethical approval was obtained from the faculty Research Ethics Committee.

In total, 724 volunteers entered the survey, and 513 (71%, aged 18–54 years) completed all survey items and were included in the final sample. The majority identified as White Irish (80%) or other White background (13%); 4 per cent of the sample did not specify their ethnicity or nationality. The greatest proportion identified as heterosexual (85%), 12 per cent bisexual, 1 per cent gay/lesbian and 2 per cent as ‘other’. Most did not have children (n = 495, 97%) and had not had a pregnancy terminated (n = 496, 97%). Of them, 12 participants said they had had a pregnancy terminated (2%) and 5 preferred not to answer (1%).

**Measures**

Where necessary, scores were recoded so that higher scores represented higher levels of each construct measured.

**Political disenfranchisement.** Political disenfranchisement was assessed using the Political Efficacy Scale (Schulz, 2005), containing nine items rated on a 4-point Likert scale from strongly agree to strongly disagree (e.g. ‘I know more about politics than most people my age’).

**Health measures**

**Psychological well-being.** The 12-item version of the General Health Questionnaire (GHQ; Goldberg, 1992) includes items used to measure psychological well-being (e.g. ‘Have you recently lost much sleep over worry?’), rated using a 4-point Likert scale, as in previous research (e.g. Schmid and Muldoon, 2015).

**Risky sexual behaviour.** The Student Sexual Risks Scale (self-assessment version; DeHart and Birkheimer, 2010) consists of 38 items with responses obtained using a 3-point scale—agree, undecided or disagree (e.g. ‘If my partner wanted me to have unprotected sex, I would probably give in’). This scale includes six sub-scales, and here, we used all items to create an overall measure of risk.

**Mediating variables: control**

**General control.** General sense of control was measured using a total score from the short version of the Sense of Control Measure (Lachman and Weaver, 1998). This comprises five items scored on a 4-point scale from a lot to not at all (e.g. ‘I can do just about anything I put my mind to’).

**Reproductive control.** This construct was measured using six items based on the conceptual framework on reproductive control outlined by Moore et al. (2010). Each participant responded to six items related to reproductive control and contraception on a 5-point scale from completely agree to completely disagree.
(e.g. ‘I cannot control the effectiveness of my contraception’).

Covariates

Religiosity. The Duke University Religion Index (Koenig and Büssing, 2010) is a 5-item measure commonly used to measure religiosity, containing items related to frequency of public and private religious behaviours rated on a 6-point scale from never to once a week or more (e.g. ‘How often do you attend church or other religious meetings?’), and items on religious belief and experience rated on a 5-point scale from rarely or never to more than once a week (e.g. ‘My religious beliefs are what really lie behind my whole approach to life’).

Attitudes to abortion. The Abortion Attitude Scale (Smith and Son, 2013) contains seven items about different situations a woman could have access to a legal abortion, with a 5-point Likert scale ranging from strongly agree to strongly disagree (e.g. ‘Please indicate whether or not you think it should be possible for a pregnant woman to obtain a legal abortion if the woman’s own health is seriously endangered by the pregnancy?’).

Results

Relationships between disenfranchisement, control and health

Descriptive statistics and correlations for our study variables are displayed in Table 1. Disenfranchisement was inversely correlated with psychological well-being ($r = -0.13$, $p = .003$), as expected, but not with risky sexual behaviour ($r = 0.02$, $p = .66$). Psychological well-being and risky sexual behaviour were negatively related ($r = -0.12$, $p = .007$). Religiosity was negatively correlated with attitudes to abortion ($r = -0.42$, $p < .001$).

Predicting well-being and risky sexual behaviour

Figure 1(a) and (b) displays multiple mediation models using PROCESS (Hayes, 2013), for
disenfranchisement and our health variables, controlling for religiosity and attitudes to abortion. Contrary to our H1 prediction, disenfranchisement had no significant direct effect on psychological well-being (Figure 1(a); $\beta = -.05$, standard error (SE) = .07, $t = -.65$, $p = .51$, 95% confidence interval (CI) (−.18, −.09)). However, there was a significant indirect effect, such that the association between disenfranchisement and psychological well-being was mediated via general control ($\beta = -.17$, SE = .04, 95% CI (−.26, −.09)). Disenfranchisement was positively associated with well-being ($\beta = .94$, SE = .07, $t = 13.17$, $p < .001$, 95% CI (.81, 1.08)). Disenfranchisement did not predict reproductive control ($\beta = -.04$, SE = .05, $t = -.80$, $p = .41$, 95% CI (−.14, .06)), but reproductive control was directly associated with well-being ($\beta = .25$, SE = .46, $t = 4.26$, $p < .001$, 95% CI (.13, .36)). As such, H1 was partly supported.

Figure 1(b) summarises our findings relative to risky sexual behaviour (H2). Disenfranchisement showed no direct association with risky sexual behaviour ($\beta = .05$, SE = .16, $t = .32$, $p = .74$, 95% CI (−.28, .39)). Neither the indirect effect for general control nor reproductive control were significant (results not shown), meaning H2 was not supported. Reproductive control significantly predicted risky sexual behaviour ($\beta = -.39$, SE = .74, $t = -2.72$, $p = .006$, 95% CI (−.67, −.011)).

**Predicting risky sexual behaviour: a role for disenfranchisement, control and well-being**

To test H3, that disenfranchisement was indirectly linked with risky sexual behaviour via psychological well-being, we conducted a final analysis. In search of a more parsimonious
explanation of the relationships between our variables, we conducted a serial mediation model, including general control and psychological well-being as serial mediators of the relationship between disenfranchisement and risky sexual behaviour. Reproductive control was not included here as it was unrelated to disenfranchisement in our earlier models. We again controlled for abortion attitudes and religiosity. This model was a good fit to the data; political disenfranchisement had an indirect effect on risky sexual behaviour because of shared associations of these two variables with general control and psychological well-being ($\beta = .05$, SE = .03, 95% CI (.02, .11)).

As illustrated in Figure 1(c), higher levels of disenfranchisement significantly predicted lower general control ($\beta = -.18$, SE = .04, $t = -4.30$, $p < .001$, 95% CI (−.26, −.10)). General control predicted lower psychological well-being ($\beta = -.17$, SE = .04, 95% CI (−.26, −.09)), which in turn predicted higher levels of risky sexual behaviour ($\beta = -.99$, SE = .07, $t = 13.88$, $p < .001$, 95% CI (.85, 1.14)). In a model reversing the order of our health variables (psychological well-being and risky sexual behaviour), the indirect effect was no longer observed, offering support for the proposed direction of these relationships.

**Discussion**

This study aimed to investigate the underexplored role of disenfranchisement in women’s psychological well-being and sexual health. Specifically, in a setting where women are excluded from abortion services, we investigated whether perceived disenfranchisement was associated with a reduced sense of general control, impaired psychological well-being and more risky sexual behaviours. Our study has three key findings. First, political disenfranchisement was indirectly associated with impaired psychological well-being, via a reduced sense of control. Second, the link between political disenfranchisement and risky sexual behaviour, although not apparent when examined directly, was evident via reduced general control and impaired psychological well-being. Finally, although reproductive control was not a significant mediator, it predicted better psychological well-being and reduced risky sexual behaviour.

Based on previous evidence that women’s mental health is negatively affected where their reproductive rights are restricted (WHO et al., 2009) and wider epidemiological research associating structural disenfranchisement with poorer health (Marmot, 2004; Wilkinson and Pickett, 2009), we predicted that women’s perceived political disenfranchisement would directly relate to decreased psychological well-being. The absence of this direct relationship was unexpected. However, it is important to note that the existing research in this area tends to focus on women who are trying to access abortion. In our study, we aimed to investigate the effect of disenfranchisement on all women. As such, although prior research has shown negative mental health implications for women seeking an abortion when they live in a country where it is illegal (Krug et al., 2002), it may be that such effects are evident only in those denied access to abortion. That is, disenfranchisement has immediate consequences for mental health when it blocks access to healthcare.

However, it is important that the indirect path via general control was observed. This indicates that regardless of whether women have needed abortion services, feelings of disenfranchisement are associated with a reduced sense of control, which links to impaired psychological well-being. This provides empirical support for a link between empowerment and control over health decisions (Andreassen and Trondsen, 2010) and is consistent with epidemiological research relating structural disenfranchisement to concepts such as control over one’s health and well-being (Marmot, 2004; Wilkinson and Pickett, 2009). Moreover, by focusing on the perception of disenfranchisement and how this relates to psychological well-being via perceptions of control, our findings extend previous knowledge about the links between disenfranchisement and general control (Andreassen and Trondsen, 2010), psychological well-being
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(Marmot, 2004; WHO et al., 2009; Wilkinson and Pickett, 2009) and risky sexual behaviour (Kerrigan et al., 2013, 2015), as well as links between each of these variables (e.g. Bobak et al., 2000; Ell et al., 1989; Macrodimitris and Endler, 2001). We provide a more nuanced understanding of how political disenfranchisement relates to reduced feelings of control, and the way it connects to psychological well-being and risky sexual behaviours. This represents an important addition to the existing literature.

Although predictions relating to reproductive control were not supported, this construct is worthy of future research. In particular, reproductive control predicted both outcomes – higher reproductive control was associated with greater psychological well-being and lower risky sexual behaviour. Put another way, limited reproductive control is associated with reduced psychological well-being and more risky sexual behaviour. This is important because while it is known that a lower level of reproductive control (as such reproductive coercion) is associated with higher rates of unwanted pregnancy (Upadhyay et al., 2014), there was previously limited evidence that reproductive control is associated with measures of well-being. Our results also build on studies that focus on interpersonal control and how this relates to the use of contraceptives, or not (Tschann et al., 2002), by showing how social structural conditions impacting sense of control may also impact risky sexual behaviour.

The study’s implications go beyond theoretical advances in our understanding of the links between disenfranchisement, control, psychological well-being and risky sexual behaviour. There are clear practical implications for societies that limit women’s access to reproductive and sexual healthcare. The social and political context in which people make their health decisions, or are prevented from doing so, has an impact on sexual and reproductive health. Where women feel they have no political influence on an issue, this has clear everyday relevance for their sense of general control. Often in psychology, we think of people as operating in an ‘intrapsychic’ way; however, this finding suggests that the broader social and political landscape has consequences for how we feel about our ability to control our own lives and well-being.

A second broader implication of our findings is the paradoxical consequence of political positions that limit women’s reproductive autonomy to protect the right to life of ‘the unborn’, as in the Irish constitution. Ironically, legislation seeking to protect the life of the unborn has led to a situation where women feel they have no control, and this lack of control is related to risky sexual behaviour, effectively increasing the likelihood of unwanted pregnancies. As such, we have a status quo where legislation designed to protect the unborn may have the opposite effect. This highlights that restrictions on reproductive rights are unlikely to protect anyone’s health and may have far-reaching unforeseen negative consequences.

Limitations and future directions

Our findings are limited by the cross-sectional nature of our design, which precludes making causal inferences. Experimental and longitudinal research designs could usefully be employed in future research. In addition, qualitative methods could complement our current approach, providing insight into the nuances of the survey findings.

It would also be useful to investigate the role of another important dimension of perceived control: collective control or efficacy. While each woman is an individual, with personal characteristics and indeed personal identity, they also share a social category: women. Stollberg et al. (2015) argue that shared group memberships can satisfy the human need for control, a recognised human motive (Fritsche et al., 2013). Stollberg et al. (2015) argue that when personal control is threatened, group-based control can bolster people’s sense of general control. As such, we suggest that future research should include a measure of collective efficacy related to the group ‘women’ or perhaps ‘feminists’, to see how this fits with
disenfranchisement and the other aspects of control included in this study. In this study, we measured participants’ perceptions of reproductive control using a measure originally devised to determine the control that someone else or social structures have over a woman’s sexual health (Moore et al., 2010). Reproductive control is a complex concept related to reproductive autonomy (a women’s ability to make autonomous decisions with regard to her reproductive health) and reproductive coercion (the direct and deliberate interference on a woman’s attempts to either avoid or become pregnant; Grace and Anderson, 2016). Literature on these constructs is in the early stages of development (Upadhyay et al., 2014), tending to focus on women’s personal control over their contraceptive use (Tschann et al., 2002) rather than perceived restriction in accessing contraception, or control over other elements of reproduction and sexual health (e.g. pregnancy itself and sexual health screening), or control related to wider structural forces. Therefore, clearer conceptualisation of control, autonomy and coercion in relation to sexual and reproductive health is important to advance research in this area.

Our sample of university students also limits the study, as women at different life stages may experience reproductive health and autonomy differently. Additionally, attitudes to abortion were rather positive in this sample, and the pattern of results may differ where attitudes are less positive. We also have limited knowledge of the personal relevance of this issue for our sample; while we know that the majority have not accessed abortion before, we do not know about other experiences they may have of abortion (e.g. close friends or family members having abortions), whether they were sexually active or what they would do if they became pregnant. Such measures would further advance research in this area.

Conclusion

Overall, this study advances our understanding of how social and structural factors impact on sexual and reproductive health. In particular, perceptions of political disenfranchisement contribute to lower perceptions of general control, which are associated with poorer psychological well-being and more risky sexual behaviours. Additionally, reproductive control is directly associated with psychological well-being and risky sexual behaviour. Taken together, these findings suggest that limiting women’s access to reproductive healthcare may damage their health in terms of their psychological well-being and sexual health. Ironically, the findings point to the fact that banning abortion may serve to make unwanted pregnancy more likely, by facilitating disenfranchisement, and thus negatively impacting women’s psychological well-being and sexual health.

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Note

1. After data collection, but prior to publication of this article, a Citizen’s Assembly considered the issue of the Eighth Amendment and recommended it be replaced by legislation allowing access to abortion in a variety of circumstances that are yet to be defined (Irish Examiner, 2017).

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