

Review Article

Sexual violence among married women: an unspoken sting

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ABSTRACT

Sexual violence is not only a violation of human rights, but also a public health problem, with intimate partner violence and sexual violence among the most pervasive forms of violence against women. Worldwide, one in three women experience either physical or sexual partner violence or non-partner sexual violence. The lifetime prevalence of sexual partner violence reported by women, in age group of 15 to 49 years, in the WHO multi-country study ranged from 6% in Japan to 59% in Ethiopia, with rates in the majority of settings falling between 10% and 50%. The observed inter community; country and regional variation in the prevalence of violence imply that sexual violence within marriage can be addressed and preventable. The existing prevention programmes need to be tested and scaled up. The majority of women tend to avoid reporting these experiences due to associated shame, reprisal or gender inequity. Current review is an attempt to address the sexual violence among married women in a silent suffering. Various internet based popular search engines were used to explore data from literature, which includes PubMed, PubMed Central, Google Scholar and Medknow. Search was done using the key-word combinations 'sexual violence within marriage' and 'intimate partner violence'. A total of 51 publications were evaluated for this article.

Keywords: Intimate partner violence, Sexual violence, Married women

INTRODUCTION

There is one universal truth, applicable to all countries, cultures and communities: violence against women is never acceptable, never excusable and never tolerable.

- United Nations Secretary-General, Ban Ki-Moon

Sexual violence is not only a violation of human rights, but also a public health problem. Although there is a growing research examining the burning issue among adolescent girls, only a small number of studies address intimate partner sexual violence in settings where early marriage is common culture, and/or sex that may not be seeming as forced, but unwanted.¹ To judge the facts associated with sexual violence among married women is unfeasible to achieve by analysing the victim alone, but requires a deep understanding of perpetrator characteristics, kind of relation shared by couples, their past experience, beliefs and customs they share, family and community contexts they belong. The majority of

women tend to avoid reporting these experiences due to one or the other reasons like shame, reprisal or deep rooted gender inequity.²

One in three women worldwide has experienced either intimate partner or non-partner sexual violence. The WHO multi-country study among women, in age group of 15 to 49 years, reported lifetime prevalence of sexual violence by partner ranged from 6% in Japan to 59% in Ethiopia, with rates in the majority of settings falling between 10% and 50%.³ It ranges from 23.2% in high income countries to 37.7% in south East Asian region.⁴ The prevalence of sexual violence within marriage [SVWM] is 75% in Bangladesh, 52% in Bolivia, and 42% in Zambia.⁵ In India, sexual violence takes place for the most part among adolescent girls and young women within the context of marriage, about 25% of adolescent girls aged 15-19 years are married and less than 10% of unmarried young women presumably sexually active.^{6,7} It is not essential the sex after marriage becomes voluntary,

pleasurable or safe. Despite the fact that, 10-15% of adolescent marriages are consummate by force. Evidence regarding the patterns and dynamics of sexual violence within marriage remains sparse.¹ Few studies on the husbands perspectives on partner violence highlight the fact that younger men are more likely responsible for such incidences than older men.⁸ Current review is an attempt to address the sexual violence among married women in a silent suffering.

METHODS OF LITERATURE SEARCH

The materials for this review were obtained from an extensive search using Medical Subject Headings (MeSH) of electronic databases which included PubMed, PubMed Central, Google Scholar, Medknow, Science Direct and Textbooks were searched until year 2013. Literature on the sexual violence within marriage (SVWM) in WHO publication on reproductive health was retrieved. The key words were used for the literature search included ‘sexual violence within marriage’, ‘violence against women’ and ‘intimate partner violence’. The search was limited to reviews, meta-analyses and multi country study reports were retrieved and evaluated from year 1999 - 2013. A total of 51 articles were identified. After examining the titles and abstracts, this number was finally reduced to 41 articles.

Definition of sexual violence

The World Health Organization defines sexual violence as “any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person’s sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work”.⁹

During 2006-07, a study was conducted in Nepal on sexual violence among young couples. The following were the 10 most frequently list acts and behaviours of their partners defined as sexual violence by the respondents.¹⁰

- Sex against partner’s wishes
- Sex during illness
- Forced sex after consuming alcohol
- Sex during menstruation
- Physical or verbal abuse or threats following refusal of sex
- Sex after delivery/when baby is small
- Sex in spite of being tired
- Unwanted sexual touch
- Extramarital sexual relationship
- Forced sex.

Forms and contexts of sexual violence¹¹

A wide range of sexually violent acts can take place in different circumstances and settings. These include:-

- Rape in marriage, dating relationships or during armed conflict or by strangers
- Any undue sexual advances or harassment, or demanding sex in return for favours
- Child marriage or forced marriage
- Refutation of the right to adopt contraception or other measures to protect against sexually transmitted diseases;
- Vicious acts like female genital mutilation, obligatory inspections for virginity or forced abortion etc. against the sexual integrity of women.

Table 1: Showing examples of health consequences of sexual violence and coercion for women.³

Reproductive health	<ul style="list-style-type: none"> • Gynaecological trauma • Unintended pregnancy • Unsafe abortion • Sexual dysfunction • Sexually transmitted infections including HIV • Traumatic fistulae
Mental health	<ul style="list-style-type: none"> • Depression • Post-traumatic stress disorder • Anxiety • Sleep difficulties • Somatic complaints • Suicidal behaviour • Panic disorder
Behavioural	<ul style="list-style-type: none"> • High-risk behaviour (e.g. unprotected sexual intercourse, early consensual sexual initiation, multiple partners, alcohol and drug abuse) • Higher risk of perpetrating (for men) or of experiencing subsequent sexual violence (for women)
Fatal outcomes	Death from:- <ul style="list-style-type: none"> • suicide • pregnancy complications • unsafe abortion • AIDS • murder during rape or for ‘honour’ • infanticide of a child born of rape

Health consequences of sexual violence on women¹²

Clinically women with intimate partner violence may present with, range of symptoms for example they may range from psychological symptoms like depression, suicidal tendency, anxiety, sleep disorders, or substance abuse including alcohol, or irrefutable frequent infections of genitourinary tract or chronic gastrointestinal or gynaecological symptoms includes pelvic pain, sexual dysfunction, chronic pain, repeated traumatic injury with vague explanations or vaginal bleeding, adverse pregnancy outcomes, including repeated unintended pregnancies or terminations and delay in pregnancy care or may present with central nervous system problems with symptoms like

headaches, cognitive problems, hearing loss or repeated consultation to health facility with irrelevant signs and symptoms or repeated interferes of intimate partner in consultations.

Physically or sexually abused women within marriage report a higher rate of various important health problems. For example, women with sexual violence within marriage are likely to experience 16% more low-birth-weight baby, more than twice abortion and depression, in some regions, they are 1.5 times more likely to acquire HIV, as compared to their counterpart.¹³ Evidence shows that sexual violence is associated with detrimental emotional, psychological, social, and physical outcomes, both immediate and latent.¹⁴ The repatriating effect of sexual violence on women's reproductive and sexual health has been indicated as a growing concern from a range of studies.^{9,15-20} Sexual violence is coupled directly with both gynaecological and reproductive consequences like unwanted pregnancy, diminish sexual desire, genital irritation, vaginal bleeding or infection, urinary tract infections, fibroids, pelvic inflammatory diseases, dyspareunia, HIV and sexually transmitted infections (STIs) and indirectly to a variety of mental health problems, such as psychological stress, substance abuse, and lack of fertility control and self autonomy.^{10,21-23}

Factors increasing women's vulnerability

Women's lack of autonomy, young age at marriage, low educational attainment, economic dependency, and lack of education and knowledge of sexuality, supplemented by women's inability to negotiate sexual matters; inadequate awareness of rights and opportunities for recourse, power imbalances and lack of supportive environments due to patriarchal society may increase young women's vulnerability to sexual violence within marriage.^{9,24-28} Variety of the husband's characteristics like level of husbands education, age at marriage, occupation, household economic pressure, use drugs or alcohol consumption, have multiple casual partners also play a significant role in intimate partner sexual violence among married women.²⁹⁻³¹

Existing support in society and culture and perpetuate beliefs that disregard violence like traditional gender and social norms related to male superiority (e.g. sexual intercourse is a man's right in marriage, its responsibility of women and girls for keeping men's sexual urges at bay or that rape is a sign of masculinity); added by weak community and legal sanctions against violence.³ A study conducted in Punjab, Rajasthan and Tamil Nadu of India, revealed that about two-third of men aged 15-24 years and 43% of men aged 36-50 years had agreed perpetrate intimate partner violence within 12 months preceding the study.⁸ The world scenario indicate that 10 countries around the world consider the women are legally bound to obey their husbands. Legislation addressing domestic violence exists only in 76 countries and just 57 of them embrace sexual abuse.³² Women facing harassment over a

period of time internalize male perceptions and blame themselves, doubt their own the validity of experiences and begin to justify themselves worth for the violence that comes their way.³³

Women's autonomy significantly decreases her risk of intimate partner sexual violence. Women autonomy in decision making and resources control, improve her overall mobility may aid in reinforcement of gender relationship and governing rules on women's behaviours roofed in the family and the community wildy. These changes bring with them changes in perpetuate men's behaviour towards women, and may revert sexually violence against their spouse as right. A statistically significant association was found with Husband's education and inter-spousal communication. This implies that sexual violence within marriage can be curtailed by sensitizing men about women's value and rights and also importance of communication with them. It is important to educate men on these issues in order to maintain women's status in society and thus reduce sexual violence within marriage.³⁴

Health care policy and provision

The observed inter community; country and regional variation in the prevalence of violence imply that sexual violence within marriage can be addressed and preventable. The evidence based documentation on factors influencing the violence is identified globally. They throw challenges on existing deep rooted culturally biased male supremacy and rights of control or perpetuate violence over women, reframing discriminatory family laws, abolition of gender inequalities and uplift of women's status economically, socially and culturally. This also indicates an effective enforcement of laws and scale up of existing programs that can protect women from this socio-cultural and economic circumstance that foster the violence against women.¹³

While approaches in the past to sexual violence have largely focused on the criminal justice system, there is a general movement towards a public health approach, which recognizes that violence is not the result of any single factor, but is caused by multiple risk factors that interact at individual relationship and community/societal levels. Thus, addressing sexual violence requires cooperation from diverse sectors, including health, education, welfare and criminal justice. The public health approach aims to extend care and safety to entire populations and focuses primarily on prevention, while ensuring that people who experience violence have access to appropriate services and support.³

CONCLUSION

The substantial level of sexual violence among women especially young recently married clearly indicates the necessity to strengthen the existing programs, to recognize this deprived sector of women facing sexual

atrocities at home. With an objective to assist women, protect and address sexual coercion within marriage independently by providing educational and counselling services. This can be further scaled up by programmatic along with community based efforts towards behavioural change between men and society in addition to the cultural norms to elevate autonomy or status of women in society.

Recommendations

Responding to intimate partner violence and sexual violence against women the following recommendations were developed by WHO in association with the centres for disease control and prevention [CDC], during a meeting at the WHO office in Geneva between 12 and 14 September 2011. The recommendations take into account the evidence, as well as considerations of the balance between benefits and harms, women's preferences and their human rights, and the cost implications in different countries and communities worldwide. Where there was a need for guidance, but no relevant research evidence, recommendations were decided using the expertise of the CDC.³⁵⁻⁴¹

1. Establishment of women-centred care which can offer immediate support to women experienced violence by an intimate partner.
2. Identification by universal screening or routine enquiry and care for the survivors of intimate partner violence by health-care professionals as per the evidence based guidelines.
3. Clinical care for survivors of sexual assault like first line support for first few days and or offering emergency contraceptive services, post-exposure prophylaxis against HIV and STDs and post-trauma psychological /mental health interventions using the mental health GAP intervention guide.
4. Capacity building of health-care providers on intimate partner violence and sexual assault by implementing training programs at various levels.
5. Advocate a multi model governing health-care policy to be integrated into existing health services.
6. Mandatory reporting of intimate partner violence

Other interventions that aim to prevent sexual violence in women in general need to be designed to be delivered in schools, colleges and universities, while interventions aimed at young people in schools are vital, there are other potential venues for intervention. These include homes, community mobilization strategies to promote changes in gender norms and behaviours, and community-based efforts to improve the social and economic status of women.

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