Women’s Perceptions and Experiences of Sexual Violence in Marital Relationships and Its Effect on Reproductive Health

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In this article we explore women’s perceptions and experiences of sexual violence in marital relationships and its effects on reproductive health. We conducted a qualitative study composed of key informant interviews, focus group discussions, and in-depth interviews in two low- to middle-income areas of Karachi, Pakistan. Results show sexual coercion and nonconsensual sex were common and not limited to abusive relationships. Difficulties in negotiating safe sex resulted in unwanted pregnancies, some leading to unsafe abortions. The women reported escalation of violence during pregnancy to be common. Social norms prevented disclosure of sexual violence leading to limited support or intervention or both. The link between women’s social status, marital violence, and reproductive health is discussed.

INTRODUCTION

In recent years, there has been increasing attention and focus on violence against women, in particular, domestic violence and its impact on women’s health. The recent multicountry study by the World Health Organization on women’s health and domestic violence against women, which included 24000 women across 10 countries, showed that domestic violence is widespread. The reported prevalence of physical violence by intimate partners ranged from 23% to 49% and that of sexual violence between 10% and 50% (Garcia-Moreno, Jansen, Ellsberg, Heise, & Watts, 2005). The results of this large cross-cultural study corroborate those of a number of earlier studies revealing that in many countries domestic violence includes not only physical abuse, but in 30%–50% of the cases it includes sexual violence as
Sexual violence is directly linked to reproductive and sexual health outcomes including gynecological problems (Campbell et al., 2002; Golding, Taylor, Menard, & King, 2000), sexually transmitted infections (Augenbraun, Wilson, & Allister, 2001; Campbell et al., 2002; Maman, Campbell, Sweat, & Gielen, 2000), and unintended pregnancies (Kaye, Mirembe, Bantebya, Johansson, & Ekstrom, 2006; Martin, Killgallen et al., 1999; Raj, Liu, McCleary-Sills, & Silverman, 2005). Unplanned pregnancies are often the leading cause of induced abortion. In countries where induced abortions are still illegal, many women resort to unsafe abortion, which carries its own risk of ill-health and even death (Berer, 2000). Furthermore, for many women physical and sexual violence continues during pregnancy (Ahmed, Koenig, & Stephenson, 2006; Bacchus, Mezey, & Bewley, 2006; Bowen, Heron, Waylen, & Wolke, 2005; Campbell, Garcia-Moreno, & Sharps, 2004; Campbell, 2001; Nasir, & Hyder, 2003) and may affect the health of the woman as well as the child (Ahmed et al., 2006; Asling-Monemi, Pena, Ellsberg, & Persson, 2003; Diop-Sidibe, Campbell, & Becker, 2006; Janssen et al., 2003; Kaye, Mirembe, Bantebya, Johansson, & Ekstrom, 2006; Murphy, Schei, Myhr, & Du Mont, 2001).

In this article, we are concerned specifically with issues of violence against women, particularly wife abuse, and their link with reproductive health of women in Pakistan. Although there are no national-level data on domestic violence and its impact on women’s health, results of small-scale studies show that violence against women is widespread and that nonconsensual or forced sex is part of the different forms of violence that women experience (Fikree & Bhatti, 1999; Fikree, Razzak & Durocher, 2005; Human Rights Commission of Pakistan [HRCP], 2001; Shaikh, 2003). Authors of a large multisite study from neighboring India, with which Pakistan shares substantial social and cultural norms, found that 26% of married women had experienced physical violence in the preceding 12 months of the survey; and nearly 15% of the total sample reported one or more incidents of forced sex (International Clinical Epidemiology Network [INCLEN], 2000). Researchers in another large study (Martin, Tsui, Maitra & Marinshaw, 1999; Martin et al., 2002) that interviewed married men in northern India reported that the prevalence of physical violence varied from 18% to 45% across different districts; while estimates for sexual abuse ranged from 18% to 40% for non-consensual sex and 4% to 9% for physically forced sex.

Although the above studies are extremely useful for understanding the prevalence of sexual abuse, they provide little information on women’s experiences of sexual violence within marriage. This is a serious issue for Pakistani society, where women’s low social status and lack of autonomy make them vulnerable both to domestic violence and poor reproductive health (Mahbub-ul-Haq Human Development Centre [MHDC],
Moreover, social mores do not allow an open discussion about sexual violence, especially marital sexual violence. In this article we hope to provide information about women’s perceptions and experiences of sexual violence within marriage and their impact on reproductive health.

METHODS

We conducted the study across two study sites in Karachi, the largest city of Pakistan. Study sites were selected for their multiethnic population mix and are representative of low- to middle-income neighborhoods of Karachi. To enable us to give voice to women’s perceptions and experiences, we chose a qualitative study design and included a range of data collection methods to obtain a more comprehensive picture of domestic violence (Liamputtong & Ezzy, 2005; Patton, 2002).

For the first stage we interviewed key informants, who were women considered knowledgeable about community issues, especially those affecting women. The potential participants were identified through snowball sampling. Unstructured free flowing interviews were conducted with these informants to allow for greater exploration of the context, dynamics, and attitudes toward domestic violence. All the interviews were conducted in the homes of the informants and lasted between 90 minutes to 3 hours. In some cases we made more than one visit to allow for completion of the interviews. In all, eight key informant interviews were conducted with middle-aged to older married women with children. Many lived with extended family, which in many instances included adult married sons and their families living in the same house. All informants were long-term residents of the selected study sites and had lived there for a period ranging between 10 to 30 years. Most were actively involved in some form of formal or informal community welfare activities, many with a focus on women’s health. Their long-term residence in these communities and their involvement in welfare issues allowed them to provide not only detailed insights into the issues associated with violence against women, but they also played an important role in identifying and recruiting women who currently were experiencing domestic violence.

The key informant interviews were followed by focus group discussions with a wider cross section of married women. The group discussions were aimed at further exploration of the insights gained from the key informants. Although the groups were homogeneous in many respects (Kreuger & Casey, 2002), a heterogeneous age range was sought to explore intergenerational viewpoints. The group discussions were moderated by one of the authors in the local language. A semistructured interview guide containing questions on the role of women, their status in society and family, and contextual determinants of violence was used to guide the discussions. The issue of sexual violence was probed toward the end of the discussions to allow
participants to feel comfortable with voicing their concerns about physical and emotional violence before moving on to a more socially taboo subject. The number of participants varied from five in the first group discussion to seven in the second and 12 in the third. While only six participants were invited in each group, the dynamics of arranging a women’s group meeting in community setting often are complex, and rather than exclude the additional participants from data analyses, we decided to incorporate their views to more accurately reflect the dynamics and content of the discussions. The group discussions lasted between 2 to 3 hours and were audiotaped after seeking approval from the participants. Extensive notes were made following the discussions, and these notes later were incorporated into the transcripts. The demographic profile of the 24 participants showed a wide age range from 20 to 70 years. All were married and had children varying from 1–2 children in the younger age group to 7–8 children in the older age groups. Most of the younger participants lived in extended households either with their husband’s parents or one or more married brothers or both. The older participants were generally women who lived with married sons and their families.

The last component of the study included in-depth interviews with women currently experiencing domestic violence. The identification and recruitment of these potential participants was made by some of the key informants who approached the women to seek their agreement for an interview at a time and place of their choosing. In-depth interviews were conducted with 10 women who were identified as victims of recent or ongoing domestic abuse. The sampling was purposive and included women aged 20–40 years. The respondents had varying degrees of education ranging from one woman with no formal education to some who had secondary school education and two with college degrees. The socioeconomic status (based on household income) varied from being poor to lower middle class. The in-depth interviews averaged around 90 minutes, although some were much longer in duration. The interviews were audiotaped, barring one where the participant did not feel comfortable with tape recording of the interview.

In all, the study yielded approximately 40 hours of taped interview data, which included eight key informant interviews, three focus groups with 24 participants, and 10 in-depth interviews. Verbatim transcripts were prepared in the local language, with additional postinterview notes incorporated into the transcripts. These transcripts were reviewed for consistency by comparing them with the taped interviews and the notes. The transcripts were translated verbatim into English. The quality of translations was reviewed by comparing each with original taped data to ensure accuracy in translation and also through back translation of key phrases and quotes into the local language.

Since the focus of this article is on sexual violence within marriage and reproductive health, themes relevant to the topic were selected for more in-depth thematic analysis (Liamputttong & Ezzy, 2005). In undertaking
thematic analysis we were interested in the context in which violence took place and the form and expression given to it by our participants. Our analytic technique resembled those used in grounded theory analysis (Dey, 1999; Strauss & Corbin, 1998); however, the central purpose of thematic analysis is to develop themes, whereas the focus in grounded theory analysis is on questioning and comparing techniques, inductive identification of categories, and generation of substantive theory (Browne, 2004). Our coding was influenced largely by the qualitative data analysis techniques described by Miles and Huberman (1994, p. 148) of open coding involving noting of patterns, themes, and metaphors. The key themes emerging in relation to perceptions and experiences of sexual violence in marital relationships included the strong interrelationship between physical and sexual abuse; the reproductive health effects of nonconsensual sex, including unwanted pregnancy, induced abortions, and dynamics of contraceptive use; the impact of violence during pregnancy; and the role of familial support during women’s childbearing years.

RESULTS

Physical Violence, Sexual Coercion, and Non consensual Sex

Many participants who were in abusive relationships viewed sexual violence within marriage on a continuum of violent behavior that included repeated physical violence and gross verbal abuse. A woman’s refusal to have sex could lead to varied responses—resentment, suspicion, anger, physical violence, and forced sex. Participants felt that men had little interest in understanding the reasons and context in which sex was refused. For some women, the ongoing psychological trauma due to repeated physical violence made them want to avoid sexual contact. As one young participant put it, “My husband is often physically violent, never apologizes but expects me to have sex even though he may have beaten me up a few hours earlier. … How can he expect me to be intimate and loving?”

Many participants, irrespective of their own experience of marital violence, acknowledged that sexual coercion was common in marriage and that many women endured jismani ziyati (a metaphor for sexual assault). The strong social taboos of discussing sex and sexuality, however, also led to a certain degree of ambivalence amongst some participants in discussing issues specific to sexual violence in marriage. In group discussions, however, many of the participants spoke about the “hidden” nature of sexual violence especially in relationships where there was no outward sign of physical or psychological violence. In such relationships, sexual coercion rather than forced sex was seen as a problem, and participants described sexual coercion by husbands through verbal taunts such as “Why did you get married” or “You should have stayed in your parents’ house.” While some of the younger
women considered such behavior to border on verbal and psychological abuse, we found older participants to be more accepting, as illustrated by comments made by a 54-year-old woman in one of the focus groups: “This is part of marriage—many men behave like this, but young women these days think only of themselves.”

Young women, both in focus group discussions and in-depth interviews, talked about excessive fatigue related to long hours of work involving childrearing and doing household chores, which created a situation where sex on demand was seen as another task rather than as an intimate and pleasurable experience. For some of the older women, the reasons for declining sex were somewhat different—they wanted to avoid what they termed as “excessive sex” as they were concerned about privacy and embarrassment as their own daughters were becoming sexually mature:

The other issue is that women feel embarrassed, especially as their daughters are growing old. Not everyone has the space to have a separate bedroom, especially when they have a large number of children and other extended family members living under the same roof. It is hard to maintain privacy at times, but men do not understand these issues. (middle-aged participant in a focus group discussion)

For some middle-aged women, refusing sex led to desertion. One participant talked about her experience of physical and sexual abuse over several years. She had seven children, and over time her husband became more and more sexually demanding. When her daughters reached a “marriageable age,” the participant started feeling overtly embarrassed by her husband’s daily demand for sex, especially when it was in the middle of the day and the children were all at home. The refusal invariably led to physical violence and forced sex. When she tried to be more assertive and started saying no to sex on demand, her husband abandoned her for another woman and she was left with the responsibility of being a sole parent for their seven children.

Nonconsensual Sex, Unwanted Pregnancy, Abortion and Dynamics of Contraceptive Use

Another strong theme across different types of interviews was the link between nonconsensual sex and unwanted pregnancy. The difficulties in negotiating safe sex and avoiding yet another accidental pregnancy were not limited to women in violent relationships, but rather they were seen as part of a bigger problem of very restrictive social norms that prevented younger women from openly talking about family size and the need for contraception. Most young women felt that they could not openly discuss sexual health issues with their husbands, partly due to sex and sexuality
being a taboo and partly because of the fear that their motives may be misunderstood and they might even be accused of adultery. On the other hand, middle-aged women when they initiated such discussions, often felt frustrated as their views were ignored. Although the use of condoms was reported to be increasing, a common issue raised by many participants was irregular use, especially by men who were prone to violence:

My husband still wants to have more children and wants to keep on having unprotected sex. I told him, “When you are not providing for these children, then you should not want more children,” but the argument has little effect. I have no recourse but to stop having sex with him. This makes him very angry, and he resorts to insults and physical violence. (35-year-old informant, victim of domestic violence)

Few men take the responsibility for the number of children. Even in this age, some men are happy to have large families even though they cannot afford them. It is usually a woman who has to think about contraception and family size. Yes, some men do use condoms but not as regularly as they should. Eventually a wife may decide to get sterilization rather than keep on having accidental pregnancies. (30-year-old participant in a focus group discussion)

While key informants spoke openly about women seeking an induced abortion as a common practice to deal with an unwanted pregnancy, participants in focus groups showed some ambivalence in discussing abortions other than to acknowledge that abortions are commonplace and could lead to complications when “a dai [traditional midwife] and even a ‘lady doctor’ may not handle them properly, resulting in bigger problems.” Some of the women in abusive relationships pointed out that the decision to abort or continue with an unwanted pregnancy involved consideration of many factors including religious beliefs, opportunity costs, the opinion of the mother-in-law, and, most importantly, the sex composition of the children. Since the status of women was inextricably linked to their ability to bear sons, a pregnancy despite being a product of nonconsensual sex could be seen as another opportunity to have a son. On the other hand, women who already had a large number of children including sons viewed an unwanted pregnancy as an additional burden:

I have had sterilization. My husband opposed it and did not want me to stop having children. I told him we have four sons and four daughters—how am I supposed to take care of them? When he went to Lahore for 2 weeks, I got the operation done. He came back and said,” You have done this without my permission, I will not forgive you. “I told him at one point he had agreed; even his sisters had given him the same advice. So irrespective of what he says now, I did seek his permission earlier. (38-year-old informant, victim of domestic violence)
Even in situations where a husband agreed to sterilization, the responsibility of getting the procedure rested primarily with the woman. Vasectomy remains an extremely uncommon form of permanent contraception in Pakistan, and the national figures for vasectomy are around 2% compared with 36% for women’s sterilization. In our study we found only one couple where the husband underwent a vasectomy to limit family size. While vasectomy provided a reprieve from further unwanted pregnancies, however, the participant experienced an escalation in both physical and sexual violence due to her husband’s increased demands for sex:

Now that my husband has had a vasectomy, he has become more aggressive in his demands for sex—almost on a daily basis and sometimes more than once… Often he forces me to have sex, and if I refuse, he at times hits me badly and at other times he rips off my clothes and forces himself…. At times this has happened in front of the children, who get very upset. (34-year-old informant, victim of domestic violence)

Violence During Pregnancy. Another strong theme emerging from the interviews and group discussions was violence during pregnancy. While some participants in focus groups felt that many men tend to become more caring during pregnancy, the experiences of women in abusive relationships were mixed. For some women, physical and sexual violence started a few years after their marriage, and their earlier pregnancies were free from physical violence. Once the relationship turned violent, however, there was little difference in patterns of violence before and during a pregnancy. For other women, especially some of the younger participants who experienced frequent violence from early days of their marriage, violence intensified during pregnancy. In one in-depth interview, a young woman described how she lost her 6-month-old unborn child when her husband repeatedly kicked her in the stomach. She developed severe bruising and pain but did not receive any medical help for 3 days. Upon seeing a doctor only after a concerned neighbor called for one, the woman was told her unborn child had died and she needed immediate hospitalization. Her husband agreed to hospitalization, but he threatened her with divorce if she divulged any information about his violent behavior to the hospital staff. A year after this terrible ordeal, the participant was pregnant again as her husband had refused to use contraception and forbade her to use it on “religious grounds.” She held grave concerns about her own safety and the health of her unborn child, as the violence had escalated over time and now involved other members of her husband’s family. She also expressed considerable ambivalence about leaving her husband, however, as she was unsure of the degree of family support. Moreover, she felt that she would be judged
harshly by society and later by her own children for “walking out on her husband.”

Another young participant who also was a victim of marital violence spoke about excessive sexual violence during pregnancies. “At one point it was so bad that the doctor told him (her husband) he needed to be more careful, if not for my sake, then for the sake of his children, as who would look after them if I died?” The participant, however, would not be discuss the kinds of sexual violence she experienced. A third participant, a young woman with a 3-year-old son, narrated how she was subjected to physical and sexual violence repeatedly during the past four years of marriage:

I tried to put up with things the way they were [i.e., beatings, sexual abuse, etc.] but close to the birth of my first child my husband abandoned me. I had no choice but to come back to my parents’ house. All the expenses for childbirth were borne by my aging parents. After my son was born, my husband’s attitude changed suddenly and dramatically and he took me home. But a few months later he became violent again. I was repeatedly beaten and sexually assaulted and often deprived of food and money. Soon I was pregnant again and my husband asked me to leave. I am back at my parents’ house. My in-laws have now started saying that they will take me back and also pay part of the childbirth expenses provided I have the baby at a clinic of their choice. I fear that I may be murdered and the killing disguised as a medical problem. (22-year-old informant, victim of domestic violence)

Sexual Violence and Familial Support. Many women said that they felt powerless to stop sexual violence. Also the strong taboos on discussing sexual matters with family members led to this aspect of abuse being largely hidden from their own families. So while family members did intervene when they became aware of physical violence and sought assurances of better treatment for their daughters or sisters, the issue of sexual violence remained unresolved. Furthermore, we found little support for the common perception that when a woman’s own family lives in the same town, the level of support for her is much greater and the likelihood of violence against her is far lower. Generally, familial support was constrained not only by social and cultural norms, but also by concerns that intervention could lead to more retaliatory violence or, worse still, desertion. The strong social stigma associated with divorce made many families nervous, and many women themselves felt that they could do little except endure the abuse quietly. Many participants talked about the changing cultural norms, which made women perhaps more vulnerable to frequent violence during pregnancy. Traditionally, most women used to return to their natal home to deliver their first-born and sometimes the second child and often would not return to their husband until 3–6 months after the birth or at times even longer. While
many women still went back to their parents' house, especially if it was in
the same city, the stay was now much shorter—immediately before birth and
1 to 2 weeks thereafter. Thus, for younger women in abusive relationships,
the reprieve from violence by being physically away was much shorter than
that experienced by older participants.

DISCUSSION

In this study we have identified several interrelated issues associated with
physical and sexual violence and women's reproductive health. These
include the contexts in which sexual coercion and violence take place,
the powerlessness of women to stop nonconsensual sex or unintended
pregnancies or both, the impact of violence on their own and their child's
health during pregnancy, and the reasons for apparent lack of familial
support to prevent and stop such violence.

Although our participants talked about forced or nonconsensual sex and
alluded to sexual assault, by and large the concept of marital rape does not
exist in Pakistan. This is not limited to this particular study setting, but rather
it is seen right across all levels of the society. In fact, there is no term that
appropriately fits the concept of marital rape in the local language. The term
used for rape of women is *zina-bil-jabbr* (sex by force), but even among the
most educated sections of the society the term hardly ever would be used for
marital rape. Many men and also women believe that “sex is a man's right in
marriage.” This perception is not limited to only men with limited education
or low income, and in one study nearly 25% of high-income earners did not
agree with or were unsure about the acceptability of wife's refusal to have sex
(Qidwai, 2000). Religious interpretations often lend weight to the concept
that women’s existence is to fulfill the sexual needs of men and to bear
children (Mernissi, 1987; Moghadam, 2004). From a legal standpoint, there is
no direct law that gives a woman the right to refuse sex with her husband.
Even forced sex or marital rape is not a crime under the *Zina* ordinance
(Patel, 2003).1 The issue of nonconsensual sex in marriage is not unique to
social norms in Pakistan, however, but is part of the larger cultural landscape
of the Indian subcontinent where sex in marriage is used as another medium
of control (Bates, Schuler, Islam, & Islam, 2004; Koenig, Stephenson, Ahmed,
Jejeebhoy, & Campbell, 2006). Ganesh (1999) in discussing the link between
sexuality and violence, argued that “the sexual power plays experienced by
women in marriage mean that they are expected to be constantly sexually
willing, are unable to control reproduction and cannot expect pleasure as
an inherent part of any sexual exchange” (p. 52).

1 According to the Zina Ordinance, demonstration of being validly married is complete defense to
the crime of *zina-bil-jabbar* or marital rape (HRCP, 2001, p. 36).
Women’s economic dependency often has been perceived as an important factor in increasing the risk of marital violence. The link between domestic violence and women’s economic activity, however, reveals a mixed picture across South Asia, and women’s earnings are not necessarily linked to a reduced likelihood of experiencing domestic violence (Bates et al., 2004; Koenig, Ahmed, Hussain, & Mozumder 2003; Koenig et al., 2006). Similar results have been reported from analysis of regional data for Pakistan (Ghuman, 2002). Estimation of direct or indirect economic costs of domestic violence for Pakistan is problematic, however, as only 16% of the women are employed in the formal economy, whereas nearly two-thirds are involved in economic activities in the informal sector United Nations Development Program [UNDP], 2005). What is clearer is that the health costs of domestic violence are likely to be considerable. The health of Pakistani women is compromised at all stages of life, especially during their reproductive years (Fikree & Pasha, 2004; Winkvist & Akhtar, 1997). Relational problems including domestic violence further contribute to their poor health (Ali et al., 2002; Fikree & Bhatti, 1999; Mumford, Mihhas, Akhtar, Akhter, & Mubbashar, 2000).

With regard to the link between sexual violence and reproductive health, we found the focus to be mainly on the connection between unsafe sex and pregnancy and also on violence during pregnancy. Although the use of contraceptives has increased manyfold, particularly in many urban areas of Pakistan, the inability to control their reproduction forces many women to have a larger number of children than their desired family size (Sathar, Jain, Rao, Haque, & Kim, 2005; Westoff & Bankole, 2000). In a recent large-scale survey, the investigators found that the two main barriers to using contraception were women’s perception that such behavior would conflict with their husbands’ views on fertility preferences and family planning, and women’s perception of social or cultural unacceptability of contraception (Casterline, Sathar & Haque, 2001). Additionally, women’s status in Pakistan is closely linked with having sons, and the entrenched son preference forces women with no sons to continue to have more children regardless of the impact on their health (Hussain, Fikree & Berendes, 2000; Winkvist & Akhtar, 2000). Few researchers investigating the dynamics of contraceptive use, however, have considered the issue of sexual violence as a factor that leads to unsafe sex and unplanned pregnancies (whether mistimed or unwanted). While many women opt to continue with unplanned pregnancies, as pointed out by our key informants, a sizeable proportion of pregnancies are terminated. These abortions often take place in an unsafe environment, thereby increasing the risk to women’s health through postabortion complications.² Investigators from major public hospitals as

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² Abortions are illegal in Pakistan unless they are conducted to save the life of the mother.
well as community-based studies report considerable morbidity in women admitted for complications of induced abortion (Fikree, Saleem, & Sami, 2002; Korejo, Noorani, & Bhutta, 2003; Rehan, Inayatullah & Chaudhary, 2001). Furthermore, in a study conducted in 32 clinics across three capital cities, Mahmud and Mushtaq (2001) found that only 22% of the clinics met the safety standards set by the World Health Organization for pregnancy termination.

The continuation and in some instances increase in violence during pregnancy is of considerable concern. While our study was not designed to quantify the degree of violence, the findings from in-depth interviews are in line with a number of other studies from South Asia that report continuation of violence during pregnancy (Fikree & Bhatti, 1999; Fikree et al., 2005; INCLEN, 2000). Although some of our participants alluded to the risk of grievous body harm and even murder, with the killing being disguised as a medical problem, it remains unknown to what extent domestic violence contributes to the very high maternal mortality rate in Pakistan (UNDP, 2005). Recent studies from other developing countries have shown a link reported on limited use of antenatal care and increased obstetric complications in women who were victims of domestic violence (Ahmed et al., 2006; Diop-Sidibe et al., 2006; Kaye et al., 2006b), and it is unlikely that the situation would be any different in Pakistan. Furthermore, although there are no studies from Pakistan, on the impact of violence on pregnancy outcome and child survival, research studies from India have reported that violence during pregnancy is associated with adverse birth outcomes and higher infant mortality (Ahmed et al., 2006; Jejeebhoy, 1998).

The present study does have some limitations. In common with many other qualitative research, our study is based on a small sample size. The use of random sampling was deemed inappropriate given the social sensitivities associated with the topic in general and identifying and recruiting women who currently were experiencing sexual violence in particular. We cannot claim, therefore, that our selected sample is representative of the larger population. We have confidence in the validity of our study results, however, as there is considerable concurrence between the issues identified by our respondents and findings of studies that have used large-scale survey designs (Ahmed et al., 2006; Bates et al., 2004; Diop-Sidibe et al., 2006; Garcia-Moreno et al., 2005; Koenig et al., 2006; Martin, Killgallen et al., 1999).

**CONCLUSION**

Physical and sexual violence against women is increasingly recognized as an important public health issue (Garcia-Moreno et al., 2005; Kishor & Johnson, 2004). While there is considerable emphasis on improving women’s reproductive health in Pakistan, both at the policy and with varying extent
at the programmatic level, there has been little attention paid to the link between violence and women’s health and the impact of sexual violence on maternal and child health. Women’s control over their sexuality should be central not only for health concerns but also from a human rights perspective. To better understand these issues within the sociocultural milieu of Pakistan, it is imperative that researchers examining women’s reproductive health in Pakistan include a focus on domestic violence and its links with the low status of women.

REFERENCES


