

Coerced Sexual Intercourse Within Marriage: A Clinic-Based Study of Pregnant Palestinian Refugees in Lebanon

Marwan Khawaja, PhD, and Nadwa Hammoury, MSc

This study examines the correlates of forced sexual intercourse among pregnant refugee women attending an antenatal clinic in Sidon, Lebanon. A total of 349 pregnant women were interviewed during a clinic visit for a prenatal check-up during the months of June and July 2005. The Abuse Assessment Screen was used to identify cases of abuse. The outcome variable was whether the woman was forced to have sexual intercourse during the past year. One-quarter of women (26.2%) reported having forced sexual intercourse. Associations between forced sexual intercourse and sociodemographic risk factors were assessed using odds ratios from logistic regression models. Low educational levels and reported fear of husband were significant risk factors for sexual abuse, adjusting for other relevant variables. Age, parity, length of marriage, place of residence, undesired pregnancy, gestational age, consanguinity, and physical violence during last year were not associated with forced sexual intercourse. *J Midwifery Womens Health* 2008;53:150–154 © 2008 by the American College of Nurse-Midwives.

keywords: domestic violence, forced sex, intimate partner violence, Lebanon, Palestinian refugees, screening, sexual coercion, UNRWA

INTRODUCTION

There is a large and growing body of literature on domestic violence against women in developing countries, providing evidence on the prevalence and associated risk factors of abuse within and across countries.^{1–2} Although most available research on domestic violence has focused on physical abuse, other forms of abuse, including sexual coercion, have received increasing attention. The World Health Organization (WHO) defines domestic violence as “any behavior within an intimate relationship that causes physical, psychological or sexual harm.”¹ According to the WHO definition,¹ such behaviors include forced sexual intercourse. Previous studies indicate that sexual coercion is a prevalent behavior, and about 1 in 4 women around the globe experience sexual violence by a partner.¹ Recently, studies in developing countries have shown high rates of forced (or nonconsensual) intercourse during a woman’s lifetime; rates reach up to 50%.³

Forced sexual intercourse has numerous adverse reproductive health consequences,² including unintended pregnancy and various gynecologic problems.^{4–6} A recent study among adolescents in Uganda found significant associations between coerced first sexual intercourse and genital tract symptoms, including vaginal discharge, pain during intercourse, lower abdominal pain, and vaginal itching.⁷ In a series of studies from Goa, India, Patel et al.^{8–10} reported significant associations between sexual abuse and sexually transmitted infections, bacterial vaginosis,⁸ complaints of abnormal vaginal discharge,⁹ and common mental disorders.¹⁰

Little is known about the extent and determinants of

domestic violence, particularly sexual coercion, and its consequences in the Arab region. Available studies investigating the prevalence and determinants of abuse in the Arab family have focused on physical violence.^{11–13} They indicate that about one-third of women are beaten by their husbands,^{13,14} but a study of refugees living in Jordanian camps indicated that about 45% of women were beaten at least once during their marriage.¹⁵ To our knowledge, there has been no study on the determinants of coerced intercourse among pregnant women in the Arab region.

Pregnancy provides an opportunity to ask screening questions on domestic violence, including sexual coercion.¹⁶ This brief paper is based on a screening study of pregnant refugee women attending an antenatal clinic for Palestinian refugees in the city of Sidon, Lebanon. The design, methods, and preliminary findings from the screening study were previously published elsewhere.¹⁷ The findings from that study reveal that domestic violence against pregnant women is common. Fifty-nine percent of women had ever experienced physical abuse, 19.1% experienced physical violence in the previous year, 26.2% were subjected to sexual coercion, 16.8% experienced emotional violence, and 11.4% experienced physical violence during pregnancy.¹⁷ This paper is a fuller examination of a specific topic and research question, reporting findings on the correlates of sexual coercion among pregnant refugee women during the past year. Although sexual coercion includes a wide range of unwanted sexual acts, comments, or advances,¹ our study focuses on forced intercourse within marriage, a widely known and easily understood behavior on the part of study participants in this context.

MATERIALS AND METHODS

An adapted version of the Abuse Assessment Screen (AAS),^{18,19} a widely validated screening instrument, was

Address correspondence to Marwan Khawaja, PhD, 3 Dag Hammarskjöld Plaza, 8th Floor, New York, NY 10017-2303. E-mail: mk36@aub.edu.lb

used to identify cases of intimate partner abuse among all women attending the primary health care clinic of the United Nations Relief Works Agency in the city of Sidon, Lebanon, during the months of June and July 2005. The agency is the main provider of prenatal health care services to Palestinian refugees in Lebanon. The AAS tool is a 5-item screening instrument with “yes” or “no” answers to questions about physical, emotional, and sexual violence, and it takes 45 seconds on average to complete if all answers are negative. Women are first asked if they have experienced any physical violence during their marital life, during the last year, and during the current pregnancy. In addition, they are asked whether or not they were forced by their husbands to have sexual intercourse, and if they fear their husband or someone else in the household. While the original AAS instrument asks about “sexual activities against your will” more generally, we revised this question to ask about “sexual intercourse against your will” after a pilot test. The modified AAS instrument was translated into spoken Arabic, pretested, and modified before administering it to the women participating in the study. Data on some demographic and socioeconomic background factors were retrieved from the women’s health records available in the clinic. Additional questions about background variables not found in their medical records, such as years of education completed, were added to the instrument.

The study was reviewed and approved by a local ethics committee, and WHO ethical guidelines were followed with particular attention to privacy and safety of respondents.²⁰ The sample consisted of all women visiting the Sidon clinic during their first, or a follow-up, prenatal check-up. After obtaining verbal informed consent, the final instrument was completed by face-to-face interviews by the second author (N.H.), who is a trained midwife.

The outcome variable in this study is sexual coercion, measured by a binary response to a single question asking each woman if she experienced forced sexual intercourse during the past year or not. Predictors for forced sex explored in the analysis included age of women (15–24, 25–29, 30–34, or 35+ years), length of marriage (1 year or less, or more than 1 year), education (elementary level or less, intermediate and secondary, or more than secondary), area of residence (refugee camp or non-camp area), fear of husband or someone else in the

house (yes or no), physical abuse during last year (yes or no), parity (primipara or multipara), desire for the pregnancy by either the husband or the wife (yes or no), gestational age (first, second, or third trimester), and consanguinity (married to relative or a non-relative).

For the analysis, descriptive statistics and chi-square tests of association between the outcome variables and predictors were first calculated. Multivariate analysis was then carried out using logistic regression models, including all variables reaching statistical significance at the bivariate level. The program SPSS for Windows (SPSS, Inc, Chicago, IL) was used to perform the statistical analysis.

RESULTS

There were 351 patients who visited the clinic during the target timeframe. A total of 349 pregnant women were interviewed in private, with a response rate of 99.4%. One woman declined to participate, and another woman stopped the interview before completion. Table 1 describes the demographics of the sample. Women interviewed were on average 28 years of age, and 75% had been married for longer than 1 year. Consanguinity was not common; 12% of the women interviewed were married to relatives. They had relatively low levels of education, having completed an average of 9.3 years of schooling. Most (71%) resided outside the refugee camp, largely in the area surrounding the clinic. Almost half (47.6%) were primiparas; one-fourth (25.4%) were in their first trimester of pregnancy, 41.3% in the second, and 32.8% in the third trimester. Nearly one-third (31.9%) of the women (but just 16% of their husbands) did not desire the current pregnancy.

Overall, more than one quarter of the women (26.2%) had experienced forced sexual intercourse in the past year. As shown in Table 1, smaller proportions reported physical abuse during last year (19.1%) or fear of husband (16.8%).

Forced sexual intercourse was significantly associated with educational level ($P < .009$), parity ($P < .003$), fear of husband ($P < .001$), length of marriage ($P < .035$), and pregnancy undesired by the respondent ($P < .035$). Age, place of residence, gestational age, undesired pregnancy by the husband, consanguinity, and physical violence during last year were not associated with forced sexual intercourse.

The five variables showing significant associations with abuse at the bivariate levels were entered into the logistic regression. Table 2 shows the unadjusted and adjusted odds ratios from the logistic regression models. Only education and fear of husband were significant predictors of sexual coercion when adjusting for other variables. Women with elementary education were 2.41 times more likely to have forced intercourse than women with higher than secondary education. Women fearing

Marwan Khawaja, PhD, is Professor of Population Health, Department of Epidemiology and Population Health, and Director of the Center for Research on Population and Health, Faculty of Health Sciences, American University of Beirut.

Nadwa Hammoury, MSc, is a midwife specialist at UNRWA’s polyclinic in Sidon, Lebanon. She has MSc degree in Population Health from the American University of Beirut, and was a researcher at the Center for Research on Population and Health, Faculty of Health Sciences, American University of Beirut while completing this study.

Table 1. Sample Characteristics (N = 349) and Proportions of Pregnant Women Who Experienced Sexual Coercion by Vulnerability Factors

Variable	n (%)	Sexual Coercion	
		%	P*
Fear of husband or someone else			
Yes	56 (16.8)	44.6	.001
No	292 (83.2)	22.9	
Physically abused (in last yr)			
Yes	67 (19.1)	35.8	.051
No	282 (80.3)	24.1	
Age			
15–24	119 (33.9)	26.9	.991
25–29	96 (24.4)	27.1	
30–34	65 (18.5)	26.2	
35+	69 (19.7)	25.0	
Educational level			
Elementary or less	64 (18.2)	34.4	.009
Intermediate and secondary	202 (57.6)	29.0	
More than secondary	85 (24.2)	14.1	
Length of marriage (yrs)			
≤1	85 (24.2)	17.6	.035
>1	264 (75.2)	29.3	
Consanguinity			
Yes	42 (12.0)	14.3	.058
No	308 (87.7)	28.0	
Place of residence			
Inside camp	101 (28.8)	24.8	.663
Outside camp	249 (70.9)	27.0	
Parity			
Primipara	167 (47.6)	19.2	.003
Multipara	183 (52.3)	33.0	
Gestational age			
First trimester	89 (25.4)	25.8	.489
Second trimester	145 (41.3)	29.2	
Third trimester	115 (32.8)	22.6	
Desired pregnancy (respondent)			
Yes	239 (68.1)	23.1	.043
No	112 (31.9)	33.3	
Desired pregnancy (husband)			
Yes	295 (84.0)	25.9	.682
No	56 (16.0)	28.6	

*Two-tailed Pearson's χ^2 test.

their husbands were 2.63 times more likely to be sexually coerced than those who did not report fear of their husbands.

DISCUSSION

Forced intercourse and other forms of sexual coercion against women occur throughout the world, with profound consequences on their physical and mental health.^{1,21} It is particularly common in contexts characterized by patriarchy and gender inequities,² such as the Arab region. In such contexts, the persistence of violence against women is perhaps reinforced by legal traditions and religious legacies, which do not normally criminalize such behav-

iors.¹⁵ In fact, violence against women by their intimate partners is a widely justified behavior by both men and women, and considered a private matter (not a criminal act) in many Arab countries.^{13,15}

In this study, we found that more than one-fourth of refugee women experienced forced sex during the past year, which is rather high compared to rates reported in other developing countries' populations.^{1,21–22} A multi-country study based on secondary data from the Demographic and Health Survey (DHS) Program found ever reporting of forced sexual intercourse to range from 3.4% in Cambodia to 16.7% in Haiti among ever-married women aged 15 to 49 years.²² Recent studies from Africa found between one-fourth and one-fifth of women experiencing coerced sexual intercourse,^{3,23–24} and one study from Sierra Leone found a much higher rate of 50.7%.²⁵ Comparable findings from the WHO multi-country study show a wide range of prevalence rates, from 3.6% in Serbia and Montenegro to 46% in Ethiopian and Bangladesh provinces.²¹ Prevalence rates of forced intercourse during the past year among ever-pregnant women were generally lower, ranging from 1.2% in a Japanese city to 32.6% in an Ethiopian province.²¹ In fact, of the 15 sites included in the WHO multi-country study, only one site (Ethiopia) had a prevalence rate of forced sex during the past year higher than the one reported in our study. There are many possible reasons that could account for the wide range of these rates. For one thing, some findings are derived from population-based surveys, while others are from facility-based studies. Second, the instruments used to measure abuse as well as data collection methods differ among studies. Third,

Table 2. Odds Ratios from Logistic Regression of Sexual Coercion Against Pregnant Women (N = 349)

Variable	Unadjusted		Adjusted*	
	OR	95% CI	OR	95% CI
Educational level				
Elementary or less	3.19	1.43–7.09	2.41	1.06–5.51
Intermediate and secondary	2.49	1.26–4.92	2.08	1.03–4.19
More than secondary	1.00		1.00	
Fear of husband or someone else				
Yes	2.71	1.41–4.90	2.63	1.42–4.88
No	1.00		1.00	
Parity				
Multipara	2.08	1.27–3.40	1.84	0.96–3.51
Primipara	1.00		1.00	
Length of marriage (yrs)				
>1	1.82	1.00–3.34	1.12	0.52–2.41
≤1	1.00		1.00	
Desired pregnancy (respondent)				
No	1.66	1.01–2.73	1.23	0.72–2.10
Yes	1.00		1.00	

CI = confidence interval; OR = odds ratio.

*Adjusted analysis included education, fear of husband, parity, length of marriage, and desired pregnancy in the model.

there are cultural differences among the countries studied, with clear variations in values and norms but also legal sanctions of domestic violence.

Findings from logistic regression showed that forced sexual intercourse was only significantly related to education and fear of husband after adjusting for other variables. The finding concerning education is consistent with the literature on sexual coercion elsewhere.^{7,12,19,25} In a study using a shorter version of the AAS instrument, fear of husband was found to correlate with sexual abuse.²⁶ The odds ratios for multiparity, length of marriage, and undesired pregnancy were not statistically significant. This is contrary to previous studies showing significant associations between sexual coercion and length of marriage,¹⁹ parity,¹⁹ and undesired pregnancy.^{7,19,24}

The lack of association between camp residence and sexual coercion demands explanation. Camp residence among Palestinian refugees is considered a marker of low socioeconomic status, and hence a determinant of many risky behaviors. However, this is not necessarily the case for refugees in Lebanon. Although they have been refugees for nearly 60 years, Palestinian refugees in Lebanon are a socially “excluded” group, regardless of camp residence. They face legal restrictions on participation in the formal labor market and they are permitted—when work permits are granted—to work mainly in a few low-skilled occupations. Furthermore, they are not allowed to own property or to use public social services such as education and health facilities. Although intermarriage between Palestinian refugees and Lebanese does occur, it is very uncommon in Lebanon. Thus, the context of Lebanon is quite different from that of Jordan or Syria, where refugees residing outside the camps tend to be better off than those in the camps; this is not the case in Lebanon. It should not be surprising that camp residence did not make a difference with regard to sexual coercion among pregnant women in our study.

Our study has some limitations. First, it was based on a cross-sectional design, enabling us to only ascertain associations but not causality. Second, the study suffers from possible under-reporting and response bias given the sensitivity of the topic. Third, the AAS instrument used here has not been formally validated in Arabic. However, the AAS instrument is widely validated, and an informal validation of the Arabic language instrument was undertaken in the form of a pilot study. Various versions of the translations were reviewed by two clinical experts. The original AAS instrument was slightly modified to ensure that the questions were understood as intended to be. For example, some terms in English, such as “having sex,” are not easily understood in Arabic when translated literally. We used the more explicit term “intercourse.” Fourth, the outcome variable (coerced sexual intercourse) may include physical force, but it was not possible to know how many of the victims were subjected to force during intercourse. Fifth, no back-

ground information about the husbands, such as education and age, was collected. Finally, the study was based on data from refugee women visiting one antenatal clinic, and the findings cannot therefore be generalized to the wider population in Lebanon or elsewhere.

The study findings should, however, be useful to health professionals and planners underscoring the acceptability and importance of screening for domestic violence, including sexual abuse, during pregnancy. Clinicians are frequently reluctant to screen for domestic violence because, in our context, they lack the necessary training to deal with identified cases of abuse. Once cases of abuse are identified, however, clinicians can easily refer patients to specialized agencies for counseling or other forms of appropriate interventions. If accompanied by appropriate referrals, screening for sexual abuse may lead to a reduction in the rate of abuse, appropriate treatment of the victims, and a reduction in the health burdens of abuse.^{16,18} The wide range of prevalence of abuse across cultures underscores the importance of screening for domestic violence in specific contexts. Further studies using longitudinal design are needed to understand the causal pathways leading to sexual coercion within marriage before implementing appropriate interventions to prevent and eradicate this form of violence.

We would like to thank the United Nation Relief and Work Agency for facilitating access to the women in the clinic. Thanks also are given to the pregnant women for their cooperation with the investigators during the course of this study.

REFERENCES

1. Krug EG, Dahlberg LL, Mercy JA, Zwi AB, Lozano R, editors. World report on violence and health. Geneva, Switzerland: World Health Organization, 2002.
2. Elsberg M. Violence against women and the Millennium development goals: Facilitating women’s access to support. *Int J Gynecol Obstet* 2006;94:325–32.
3. Koenig MA, Lutalo T, Zhao F, Nalugoda F, Kiwanuka N, Wabwire-Mangen F, et al. Coercive sex in rural Uganda: Prevalence and associated risk factors. *Soc Sci Med* 2004;58:787–98.
4. Heise L, Moore K, Toubia N. Sexual coercion and reproductive health: A focus on research. New York: The Population Council, 1995.
5. Eby KK, Campbell JC, Sullivan CM, Davidson 2nd. WS Health effects of experiences of sexual violence for women with abusive partners. *Health Care Women Int* 1995;16:563–75.
6. Schei B, Bakketeig LS. Gynaecological impact of sexual and physical abuse by spouse: A study of a random sample of Norwegian women. *BJOG* 1989;96:1379–83.
7. Koenig MA, Zablotska I, Lutalo T, Nalugoda F, Wagman J, Gray R. Coerced first intercourse and reproductive health among adolescent women in Rakai, Uganda. *Int Fam Plann Perspect* 2004;30:156–63.

8. Patel V, Weiss, HA, Mabey D. The burden and determinants of reproductive tract infections in India: A population based study in Goa, India. *Sex Trans Infect* 2006;82:243–9.
9. Patel V, Weiss HA, Kirkwood BR, Pednekar S, Nevrekar P, Gupte S, et al. Common genital complaints in women: The contribution of psychosocial and infectious factors in a population-based cohort study in Goa, India. *Int J Epidemiol* 2006;35:1478–85.
10. Patel V, Betty R, Kirkwood BR. Gender disadvantage and reproductive health risk factors for common mental disorders in women. *Arch Gen Psychiatry* 2006;63:404–13.
11. Diop-Sidibé N, Campbell JC, Becker S. Domestic violence against women in Egypt: Wife-beating and health outcomes. *Soc Sci Med* 2006;62:1260–77.
12. Haj-Yahia MM, Ben-Arieh A. The incidence of Arab adolescents' exposure to violence in their families of origin and its socio-demographic correlates. *Child Abuse Negl* 2000;24:1299–1315.
13. Khawaja M, Tewtel-Salem M. Agreement between husband and wife reports of domestic violence: Evidence from poor refugee communities in Lebanon. *Int J Epidemiol* 2004;33:526–33.
14. Douki S, Nacef F, Belhadj A, Bouasker A, Ghachem R. Violence against women in Arab and Islamic countries. *Arch Womens Ment Health* 2003;6:165–71.
15. Khawaja M. Prevalence of wife beating in Jordanian refugee camps: Reports by men and women. *J Epidemiol Community Health* 2005;59:840–1.
16. Anderson B, Marshak HH, Hebbeler DL. Identifying intimate partner violence at entry to prenatal care: Clustering routine clinical information. *J Midwifery Womens Health* 2002;47:353–9.
17. Hammoury N, Khawaja M. Screening for domestic violence during pregnancy in an antenatal clinic in Lebanon. *Eur J Public Health* 2007 Epub March 25 doi:1093/eurpub/ckm009.
18. Higgins LP, Hawkins JW. Screening abuse during pregnancy: Implementing a multisite program. *MCN Am J Matern Child Nurs* 2005;30:109–14.
19. Dunn LL, Oths KS. Prenatal predictors of intimate partner abuse. *J Obstet Gynecol Neonatal Nurs* 2004;33:54–63.
20. World Health Organization. Ethical and safety recommendations for research on violence against women. Geneva, Switzerland: World Health Organization, 1999.
21. World Health Organization, Gender and Women's Health. The WHO multi-country study on women's health and domestic violence against women. Geneva, Switzerland: World Health Organization, 2003.
22. Kishor S, Johnson K. Profiling domestic violence—A multi-country study. Clavertons, MD: ORC Macro, 2004.
23. Erulkar AS. The experience of sexual coercion among young people in Kenya. *Int Fam Plann Perspect* 2004;30:182–9.
24. Brown L, Thurman T, Bloem J, Kendall C. Sexual violence in Lesotho. *Stud Fam Plann* 2006;37:269–80.
25. Coker AL, Richter DL. Violence against women in Sierra Leone: Frequency and correlates of intimate partner violence and forced sexual intercourse. *Afr J Reprod Health* 1998;2:61–72.
26. Coker AL, Smith PH, McKeown RE, King MJ. Frequency and correlates of intimate partner violence by type: Physical, sexual and psychological battering. *Am J Public Health* 2000;90:553–9.