Original Research Article

Socio-epidemiological study of marital violence among women's attending health care facility of Central Delhi

Abhishek Tibrewal*, Suneela Garg

Department of Community Medicine, Maulana Azad Medical College, New Delhi, India

*Correspondence:
Dr. Abhishek Tibrewal,
E-mail: dr.abhishek08@hotmail.com

ABSTRACT

Background: Marital or domestic violence (DV) is endemic in communities and countries around the world, cutting across class, race, age, religions and national boundaries. It is defined as a pattern of coercive / controlling behaviors and tactics used by one person over another to gain power and control. The study's objectives were to understand DV prevalence, factors associated with DV, and health and social outcomes of DV among married women.
Methods: This was a healthcare facility based cross-sectional study conducted from Jan-Dec 2011among married women attending antenatal clinic and chest / ICTC clinic. The presence of DV was evaluated using a semi-structured interview designed based on the NHFS-3screening tool. The data collected was analyzed using SPSS version 22.
Results: A total of 700 subjects were included. 36% of married women reported the presence of DV. The independent risk factors for DV were belonging to non-Hindu religion (OR=1.95, CI:1.02-3.72), belonging to joint family (OR=1.52, CI: 1.08-2.14), having no daughter (OR=1.7, CI: 1.19-2.44), and ever contraceptive use (OR=1.50, CI: 1.06-2.11) in a multivariate logistic regression model. DV's main cause was misunderstanding (46%) between the victim's and the perpetrator. The main perpetrator was husband (81%); main support system for victim's were parents or parental relatives (63%), while the main type of support received was emotional (92%). Headache (78%) was the most common symptom; 70% subjects were unable to carry out household activities, and 24% victim's relationship with relatives were affected because of DV.
Conclusions: The proportion of DV among the married women is high and is a common problem irrespective of the socio-economic and demographic factors. Hence there is no time for complacency and an urgent need for multisectoral coordination for its quick redressal.

Keywords: Delhi, Epidemiology, Factors, Healthcare facility, Marital violence

INTRODUCTION

Marital or domestic violence (DV) is widely recognized as a serious human rights violation that affects millions of women worldwide. DV, in its various forms, is endemic in communities and countries around the world, cutting across class, race, age, religions and national boundaries.[1] DV is defined as a pattern of coercive and controlling behaviors and tactics used by one person over another to gain power and control. This may include economic, emotional, sexual, and physical abuse.[2] Awareness, perception and documentation of DV varies across countries. Globally, as per the data from 1997 WHO Multi-centric study, proportion of women who had ever experienced physical or sexual violence or both by an intimate partner in their lifetime, ranged from 15% to 71%,whereas per NFHS-3 around 37% of ever-married women in India have ever experienced DV.[3,4]

DV occurs across the world, in various cultures, and affects people across society, irrespective of economic status.[5] Its most common causes are dissatisfaction with

the dowry, arguing with the partner, refusing to have sex, neglecting children or in-laws, not cooking properly or on time.[6] DV is observed to increase the risk of poor health from a growing number of studies exploring violence and health which consistently showed reports of negative effects.[7]

Moreover, DV not only causes physical injury, it also undermines the social, economic, psychological, spiritual and emotional well-being of the victim.[8] DV has long-term negative consequences for survivors, even after the abuse has ended.[9]

Abused women is also found to interfere with their efforts to obtain employment, education or training.[10] Moreover, survivors of family violence often experience difficulty in future relationships, which affects not only the stability of home and family, but also professional relationships in the course of employment.[11] In Indian culture, DV is tolerated and considered as a means of discipline or punishment. It is a common thing for most men to speak rudely and act aggressively.

Most probably, women do not protest or retaliate against the harassments, out of their concerns for social prestige, lack of economic and social support and for the sake of their children. Lack of education and economic independence often make them less confident to disclose their problems freely without any hesitation.

Mostly abused women do not seek help due to varied reasons like it is of no use, it is not necessary, embarrassment about the abuse, out of fear for further beatings, lack of knowledge about where or to whom to go.[12] Also, most of the victims, in case they seek help, do so only from their parents, neighbors, friends etc. while only few reports to the police or judiciary.

The current study was undertaken with the following objectives: to study the proportion of DV among married women attending the health care facility of central Delhi, to study the relationship of socio-economic and demographic factors with DV and to find out the health and social outcomes of DV among these women.

METHODS

This was a healthcare facility based cross-sectional study conducted from January 2011 to December 2011 at two study sites under New Delhi Municipal Corporation (NDMC): Pallika Maternity Hospital (PMH) and NDMC polyclinic. The institutional ethical committee reviewed the research protocol and cleared it before the start of study.

The inclusion criteria were married women attending antenatal clinic (ANC) of PMH (representative of general population) and married women attending Chest/Tuberculosis clinic &Integrated Counselling and

Testing Centre (ICTC) of NDMC polyclinic (represented the high-risk group).

The exclusion criterion was the study subjects not giving consent and unmarried women. The study subjects after their initial work up by the respective departments were interviewed about DV in the presence of a female counselor and evaluated using a semi-structured pretested interview schedule developed based on the National Family Health Survey-3 (NHFS-3) screening tool.[4]

The study subjects having a history of any of the following mentioned violence episode were considered as victims of DV-A) Emotional violence (including verbal violence): husband or family members humiliated in front of others, threatened, harassed for dowry, pressurized for pregnancy, taunted for not bearing a male child; B) Economic violence: husband did not give money to the spouse or the subjects who were not able to spend the money according to their wish; C)Physical violence: husband or family members ever slapped, twisted arm, pulled hair or used any physical force; D) Sexual violence: not able to avoid sex during certain periods of life like illness, menstruation, or were forced to have sex when unwilling.

The study subjects who were found to be victims of DV were referred to a female counselor in ICTC department for further work up.The sample size was calculated using the following formula: $N=(4pq)/l^2=681$, where p=prevalence of 37% (based on NFHS-3 survey), q=1-p=63%, l=allowable error 10% of p i.e. 3.7. The study subjects attending ANC clinic of PMH were interviewed by selecting every 5th new subject.

Similarly, every 2nd new suspected case of pulmonary TB subject attending chest/TB laboratory of NDMC polyclinic for sputum examination was interviewed and every new subject attending ICTC for HIV testing and counseling was interviewed.

To avoid duplication of study subjects a mark was put on the outpatient card. A total of 750 subjects were enrolled, of which 50 subjects did not give consent, and so were excluded. Hence data was collected from 700 subjects.

The data collected was analyzed using SPSS version 22. The qualitative data is expressed as proportion and the difference between the two groups was analyzed by chi-square test or Fisher's exact test. The association of different risk factors with DV was assessed using a univariate analysis and reported as odds ratio (OR) along with its 95% confidence interval (CI).

The factors with $p \leq 0.1$ in a univariate analysis was analyzed further in a multivariate logistic regression model. A two-sided $p<0.05$ was considered as a statistically significant.

RESULTS

A total of 700 study subjects (500 attending ANC of PMH; and 120 attending chest/TB clinic and 80 attending ICTC for HIV testing and counseling of NDMC polyclinic) were included. Table 1 shows the distribution of socio-demographic characteristics of the study subjects.

Table 1: Socio-demographic characteristics of the study subjects (N=700).

Variables		N (%)
Age (in years)	19-24	340 (48.6%)
	25-29	285 (40.7%)
	30-34	66 (9.4%)
	35-44	9 (1.3%)
Religion	Hindu	661 (94.4%)
	Others (Muslim, Sikh and Christian)	39 (5.6%)
Education	Illiterate	52 (7.4%)
	Below Primary	48 (6.9%)
	Primary	38 (5.4%)
	High School	113 (16.1%)
	Secondary	129 (18.4%)
	Senior Secondary	152 (21.9%)
	Graduate	160 (22.9%)
	Professional	8 (1.1%)
Occupation	Housewife	626 (89.4%)
	Unskilled	7 (1.0%)
	Semi-skilled	37 (5.3%)
	Skilled	2 (0.3%)
	Semi-professional	10 (1.4%)
	Professional	2 (0.3%)
	Un-employed	16 (2.3%)
Type of family	Joint	477 (68.1%)
	Nuclear	223 (31.9%)
Years of marriage	Upto 1 year	233 (33.3%)
	>1-3 year	166 (23.7%)
	>3-5 year	139 (19.9%)
	>5-7 year	86 (12.3%)
	>7 year	76 (10.9%)
No of children	None	397 (56.7%)
	1	233 (33.1%)
	2	56 (8.0%)
	≥3	14 (1.9%)

The mean (SD) age of the subjects was 25.1 (8.3) years with almost half (49%) aged between 19-24 years; 94% of the study subjects were following Hindu religion, 93% had some extent of formal education (below primary to professional), 89% were housewives, 69% were living in a joint family, 77% had <5 years of marriage, and 57% were without any children.

Prevalence of DV

A total of 36% (n=252) of the study subjects reported that they have experienced DV in their married life. The most common type of DV was sexual violence (reported by 20% of the study subjects), followed by economic violence (17%), emotional violence (8%), and physical violence (5%).

Also, among those with DV (n=252), sexual violence was the most predominant DV reported by 56% subjects, followed by economic violence (46%), emotional violence (22%), and physical violence (14%). Moreover, almost half (48%) had experienced at-least 2 types of DV, 6% had at-least three types of DV, and 2% had experienced all the four types of DV.

The proportion of DV did not differ significantly among those attending ANC of PMH as compared to those attending the chest /TB clinic/ICTC department of NDMC polyclinic (34%(171/500) vs. 41% (81/200); unadjusted odds ratio: 0.764 (0.545-1.070); p=0.117).

Socio-demographic factors associated with DV

In the univariate analyses, subjects age <25 years (OR: 1.368 (1.004-1.864); p=0.047)), husband's age <30 years (OR: 1.682 (1.204-2.351); p=0.002), non-Hindu religion (OR: 1.946 (1.018-3.721); p=0.041), husband's income <Rs 5,000 (OR: 1.729 (1.187-2.517); p=0.004), joint family status (OR: 1.520 (1.081-2.139); p=0.016), and no daughters (OR: 1.702 (1.186-2.441); p=0.004) were significantly associated with the presence of DV (Table 2).

In a multivariate logistic regression analysis, non-Hindu religion (OR: 2.034 (1.056-3.919); p=0.034), joint family status (OR: 1.489 (1.050-2.114); p=0.016), no daughters (OR: 1.818 (1.248-2.650); p=0.002) and history of contraceptive use (OR: 1.504 (1.057-2.114); p=0.023) were observed to be independently associated with the presence of DV among the study subjects (Table 3).

Cause, perpetrator, and support system of DV as reported by the victims

Misunderstanding between the victim and the perpetrator (45.6% of cases) was the most common cause of DV; followed by dowry (36.5%), alcohol addiction (19.4%), no male child (15.1%), wife's mistake (11.5%), and male dominance (8.7%) as perceived by the victims.

In majority (81%) of the DV cases, husband was reported to be the perpetrator followed by mother/father in-law (54%), other in-laws family members (21%).The most important support system as informed by the victims were parents and parental relatives in almost (63%) of cases, followed by friends and neighbours (52.4%), NGOs/Mahila Samaj (29%), medical facilities (13%), police/legal system (10%).

Most of the victims (92%) received emotional support (in form of counseling like everything will become alright, this is part of married women's life etc.), followed by

monetary help (30%), medical help or treatment (21%), shelter (15%), while only 11% victims took help or support from police or legal system.

Table 2: Univariate analysis of different socio-demographic factors associated with the presence of DV among the study subjects.

Variables		DV present N (%)	DV absent N (%)	Odds ratio (95% CI)	P value
Subject's age	<25 year	135 (53.6%)	205 (45.8%)	1.368 (1.004-1.864)	0.047
	≥25 year	117 (46.4%)	243 (54.2%)	Reference	
Husband's age	<30 year	182 (72.2%)	272 (60.7%)	1.682 (1.204-2.351)	0.002
	≥30 year	70 (27.8%)	176 (39.3%)	Reference	
Religion	Hindu	232 (92.1%)	429 (95.8%)	Reference	0.041
	Others*	20 (7.9%)	19 (4.2%)	1.946 (1.018-3.721)	
Husband income (Rs.)	<5,000	65 (25.8%)	75 (16.7%)	1.729 (1.187-2.517)	0.004
	≥5,000	187 (74.2%)	373 (83.3%)	Reference	
total family income (Rs.)	<20,000	37 (14.7%)	117 (26.1%)	1.360 (0.995-1.860)	0.054
	≥20,000	215 (85.3%)	331 (73.9%)	Reference	
Type of family	Joint	186 (73.8%)	291 (65%)	1.520 (1.081-2.139)	0.016
	Nuclear	66 (26.2%)	157 (35%)	Reference	
Education	Illiterate	12 (4.8%)	40 (8.9%)	1.365 (0.992-1.878)	0.056
	Literate	240 (95.2%)	408 (91.1%)	Reference	
No of children	Nil	152 (58.9%)	245 (55.4%)	1.122 (0.822-1.531)	0.469
	≥1	106 (41.1%)	197 (44.6%)	Reference	
No of sons	Nil	195 (75.6%)	366 (82.8%)	0.643 (0.441-0.937)	0.378
	≥1	63 (24.4%)	76 (17.2%)	Reference	
No of daughters	Nil	198 (78.6%)	306 (68.3%)	1.702 (1.186-2.441)	0.004
	≥1	54 (21.4%)	142 (31.7%)	Reference	
Contraceptive use	Present	81 (32.1%)	116 (25.9%)	1.356 (0.966-1.902)	0.076
	Absent	171 (67.9%)	332 (74.1%)	Reference	

Table 3: Multiple logistic regression analysis showing independent predictors of DV among the study subjects.

Variables		Adjusted OR (95%CI)	P value
Religion	Hindu	Reference	0.034
	Other	2.034 (1.056-3.919)	
Type of family	Joint	1.489 (1.050-2.114)	0.016
	Nuclear	Reference	
No of daughter	Nil	1.818 (1.248-2.650)	0.002
	≥1	Reference	
Contraceptive use	Present	1.504 (1.057-2.114)	0.023
	Absent	Reference	

Health and social impact of DV as reported by the victims

Headache (78%) was reported to be the most common health problem by the DV victims, followed by gastro-intestinal symptoms (abdominal pain, nausea etc.; 42%), restless and unable to sleep (34%), chronic body pain (25%), difficulty in remembering things (22%) or low back pain or genital soreness (9%). Almost two third

(70%) were unable to carry out routine household activities like cooking, washing, cleaning because of DV. Almost 40% of the DV victims were not able to carry out job obligations expected due to DV which indirectly affected their promotion, increment or working status like extra sick leave etc. In about 24% (n=60) of the DV victims, relationship have been affected which included separation of joint family (62%), relatives stopped coming (40%) and separation from husband (5%).

DISCUSSION

The present study was conducted to find out the proportion of DV among married women attending two health care facilities under NDMC. The study also aimed to assess the relationship of DV with various socio-economic and demographic factors, health and social outcomes of DV among the study subjects.

In the present study, the proportion of DV among the married women was observed to be 36%. Our finding is consistent to NFHS-34 data, which reported 37% (ranging from 5.8% in Himachal Pradesh to 41% in Tamil Nadu) of ever-married women in India have ever

experienced spousal violence. Similarly, an Indian based survey reported 21% to 48% of women from different socio-cultural settings experiencing DV.[13]

Globally, great variations have been shown by different studies; as per data from WHO Multi-country study, the proportion of DV among the women ranged from 15% to 71% with most sites reporting between 29% and 62%.[3] According to the review of studies by D Ghosh, women's religion affected the likelihood of experiencing DV.[13] In our study, the proportion of DV among non-Hindu religion subjects was observed to be significantly higher than those with Hindu religion, which might be due to lower sample size of non-Hindu subjects.

Although, an Indian study done in 2007 reported that DV was more common among Hindu families (19%) than Muslim or Christian families (8%), the significant difference was not explained.[14] Our study also reported that those living in a joint family were at a higher risk of DV than those in nuclear family. Some studies have indicated that when a woman lives with her in-laws she is at higher risk of subordination to her husband as well as other members of his family.[13] Some others associate joint family living arrangements with less empowerment for women and hence at a higher risk to experience DV. Other factors associated with DV in our study were no daughters in the family which might be due to relatively lower duration from marriage so lesser understanding between husband and wife and contraceptive use which could be due to husband's unwillingness for contraceptive use.

The main causes of DV as informed by the victims were misunderstanding between the victim and the perpetrators and non-payment or inadequate dowry. Our finding is supported by some of the Indian studies as reviewed by Ghoshet al., which mentioned that although inadequate and failure of timely payment of dowry has been focused as an important reason for DV in India, several other triggers such as negligence or failure in performing duties expected of women in the family also exist. These causes reflect deep-rooted gender inequalities and male patriarchy that persists across India.[13]

As expected, husbands were the main perpetrator of DV followed by mother- or father- in laws. This finding has been supported by several Indian studies that mentioned that women were at more risk of violence by their husband than any other perpetrator. However, these findings should be understood cautiously as some of the behaviors considered as violent behavior such as coerced sex by husband, or husband having sex with his wife when she is unwilling may not be perceived by either partners or people as being inappropriate or wrongful. In the present study, the main support system of the DV victims were their parents and parental relatives, while only few women 10% resorted to police or legal system for the support. Studies from most countries found that majority of women do not seek help.

Those not seeking help among women who have ever experienced violence ranges from 41% in Nicaragua to 78% in Cambodia.[12] The police/legal system are used by ~15% of abused women in Colombia, the Dominican Republic, Nicaragua, and Peru.[12]

In the present study, almost half of the DV victims (52%) complained to their friends and neighbors about the suffering. Similarly, in the Project AWARE study, 45% of the Asian women surveyed did "nothing" to protect themselves from abusive events, and 32% said they "kept quiet"; 34% sought help from their family, and 32% from friends; only 16% reported having called the police and 9% obtained help from an agency.[15]

The present study found that DV causes many health morbidities which indirectly affect the overall well-being of the study subjects. It should be noted that it can't be ascertained whether these problems were due to DV or any other underlying health problem.

Similarly, a Nicaragua study reported that abused women were six times more likely to experience mental distress than non-abused women, after controlling for other factors and the US study fund that DV tripled women's likelihood of suffering from severe menstrual problems, or a urinary tract infection.[16,17] Abused women are less likely to participate in the labor force or to choose full-year employment than women experiencing no abuse, including women experiencing abuse in past relationships.[18]

In the present study, almost 30% of the DV victims were unable to carry out normal household activities like cooking, cleaning etc. due to violence. As unsatisfactory household activities have been one of the causes for the occurrence of DV, this may again perpetuate more violence thus leading to a vicious cycle. Similarly, Canada's national survey on violence against women found that 30% of reported wife assault incidents led to time off from regular activities, and 50% of women who were injured took sick leave from work.[19]

DV not only affects health, it also undermines the social and emotional well-being of the victim. In the present study, almost 24% DV victims' relationships either with their spouse, children or relatives were affected. Similarly, it was found that divorce rates for women abused in first marriages (75%) were dramatically different than those for non-abused women (15%).20 Women who are abused are significantly more likely to divorce than women in non-violent marriages.[18]

The main limitations of the study were 1) self-reported DV, 2) DV being a very sensitive issue, it might be possible that the subjects were hesitant to acknowledge or speak about it, and 3) interviewer enquiring about the presence of DV and filling the questionnaire was a male, so it is possible that the study subjects were not comfortable answering some of the questions. However,

this aspect of the study was taken care by interviewing the subjects in the presence of a female counsellor.

CONCLUSION

DV, widely recognized as a serious human rights violation, is endemic in communities and countries around the world, cutting across class, race, age, religions and national boundaries affecting millions of women worldwide. It affects physical, social, economic, psychological, spiritual and emotional well-being of the victim, the perpetrator and the society. The proportion of DV among the married women is high and is a common problem irrespective of the socio-economic and demographic factors. Hence there is no time for complacency and an urgent need for multisectoral coordination for its quick redressal. To take to logical conclusion of each DV case, a concerted effort between law enforcement, social services and health care must be made. The role of each authority must be defined. A proper linkage is to be made between the stakeholders. This can be started as multi–centric pilot project and later, depending upon the results, it can be amicably modified and implemented in the phased manner throughout the country. There is also a need to develop more rigorous, detailed, and sensitive recording formats within the health sector at all levels for proper documentation.

REFERENCES

1. Selic P, Pesjak K, Kersnik J. The prevalence of exposure to domestic violence and the factors associated with co-occurrence of psychological and physical violence exposure: a sample from primary care patients. BMC Public Health. 2011(4);11:621.
2. Definition of Domestic Violence. Overview of Domestic & Sexual Violence. Massachusetts. Public Safety & Security. 2012. Available at www. mass.gov/eopss/crime-prev-personal-sfty/personal-sfty/. Accessed on 12 September 2020.
3. World Health Organization. Multi-country study on Women's health and domestic violence against Women. WHO. 1997.
4. National Family Health Survey NFHS-III: Ministry of Health and Family Welfare, Govt. of India. Fact sheet: 2005-06.
5. Waits K. The criminal justice system's response to battering: understanding the problem, forging the solutions. Washington Law Review. 1985;60:267-330.
6. Domestic violence in India causes consequences and remedies. Available at: http:// www. You thkiawaaz.com/2010/02/domestic-violence-in-india-causes-consequences-and-remedies-2/. Accessed on 07 February 2010.
7. World Health Organization. Violence against women: Health consequences. July 1997.
8. Kaur R, Garg S. Addressing domestic violence against women: An unfinished agenda. Indian J Community Med. 2008;33:73-6.
9. Campbell J, Jones A. Dienemann S, Kub J, Schollenberger, J, O'Campo P, Gielen AC, Wynne C. Intimate partner violence and physical health consequences. Arc Internal Med. 2002;162(10):1157-63.
10. LaViolette A, Barnett OW. It can happen to anyone. why battered women stay. Thousand Oaks, California. Sage Publications; 2000.
11. Hagion-Rzepka C. Acknowledging the invisible: Integrating family violence into mental health services. 2000. Available at: www.theripple-effect.info/publications /Advocating Public Policy Changes. Accessed on 16 March 2012.
12. Johnson K. Profiling domestic violence. A multi-country study Calverton, Maryland: ORC Macro. USAID. 2004.
13. Ghosh D. Predicting vulnerability of Indian women to domestic violence incidents. Res and practice in social Sci. 2007;3(1):48-72.
14. Varma D, Chandra PS, Thomas T. Intimate partner violence and sexual coercion among pregnant women in India: relationship with depression and post-traumatic Stress Disorder. J Affect Disord. 2007;102(1-3);227-35.
15. McDonnell KA, Abdulla SE. Project AWARE: Research Project: Asian/Pacific Islander domestic violence resource project; Washington, DC.2001.
16. Ellsberg M. Domestic violence and emotional distress among Nicaraguan women:results from a population-based study. American Psychol. 2000;54(1):30-6.
17. Plichta SB, Abraham C. Violence and gynaecological health in women <50 years old. Am J Obstetrics and Gynaecology. 1996;174:903-7.
18. Bowlus AJ, Seitz SN. Domestic violence, employment and divorce, working papers 1007. Department of Economics. Queen's University, Ontario. 2002.
19. Koss M, Koss P, Woodruff J. Deleterious effects of criminal victimization on women's health and medical utilization. Archives Int Med. 1991;151:342-7.
20. Strauss MA, Gelles RJ. Physical violence in American families; risk factors and adaptations to violence in 8,145. Families. New Brunswick: transaction publishers. 1990.