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# Domestic Violence in Low-Income Communities in Mumbai, India

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# Domestic Violence in Low-Income Communities in Mumbai, India

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B.S., Messiah College, 2009

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# APPROVAL PAGE

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## Abstract

Domestic violence is a public health problem globally and in India because of its physical and mental health consequences for victims and families. It has been shown to have an increased prevalence in populations with low socioeconomic status and strong patriarchal attitudes. This study examines qualitative (n=39) and quantitative data (n=1125) to find characteristics of women, men, and couples that are associated with violence in a low-income, patriarchal society on the outskirts of Mumbai, India. Associations were found between several variables and any violence, physical violence, sexual violence, emotional violence, and marital control. Risk factors include financial struggles, alcohol use, men's unemployment, women's employment, extramarital sex, pain with sexual intercourse, presence of extended family members, religious institutions, and unsupportive neighbors. Protective factors included interactions with NGOs or religious groups discussing women's issues, responding calmly to arguments, and women's empowerment to make purchasing or family size decisions. Overall, interventions that involve re-defining traditional gender norms are most promising for decreasing domestic violence, as deviation from strict family roles are often associated with increased violence.

## Chapter 1: Introduction and Literature Review

### Nature of Investigation

Domestic violence has been a long-standing and ubiquitous public health and human rights concern, an important component of women's oppression and inequality. "Domestic" or "intimate partner" violence (IPV) occurs most frequently from husband to wife. This thesis examines the factors associated with domestic violence in an economically marginal community of 700,000 in Mumbai, India. The data on which the thesis is based is drawn includes qualitative in-depth interviews with married women and a baseline survey instrument conducted from 2009-2012 with married women seeking care for gynecological problems in the community's urban primary care center and recruited into the study, "The Prevention of HIV/STI among Married Women in Urban India." This study involved US and Indian anthropologists, demographers, public health and medical professionals, social workers and psychologists interested in interventions that would address sexual health concerns, sexually transmitted diseases, and HIV in Indian communities. Domestic violence plays an intimate role in sexual health and transmission of HIV/STI; the secondary analysis of project data presented in this thesis seeks to identify the factors that contribute as well as ameliorate domestic violence in households in the study community.

### Global Perspectives on Domestic Violence

The United Nations defines 'violence against women' in its 1993 Declaration on the Elimination of Violence Against Women as "any act of gender-based violence that results in, or is likely to result in physical, sexual, or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life" (Patrikar et al., 2012, p. 136). The International Clinical Epidemiologists Network (INCLEN) defines domestic violence in a similar way but includes humiliation and acts that

“perpetuate female subordination” (Mitra, 2013, p. 1287). The World Health Organization (WHO) reports that 35% of women have experienced some form of violence from an intimate partner (World Health Organization, 2014). Similar results were found in a 2010 meta-analysis, which reported that globally 30.0% of women over age 15 have experienced physical or sexual violence from an intimate partner (Devries et al., 2013).

Domestic violence can be classified as physical, sexual, and emotional in nature. The WHO also includes “marital control” as a fourth category of domestic violence. The Conflict Tactics Scale (CTS) is a tool developed in 1990 that is considered the gold standard for screening for domestic violence when used in one-on-one, private interview sessions and defines the types of violence as described below.

Physical violence includes actions that can cause bodily harm to another person. The CTS defines physical violence as a husband doing any of the following to his wife: slapping, twisting arms, pulling hair, pushing, shaking, throwing objects, punching, kicking, dragging, beating up, attempting to choke or burn, or threatening with a weapon (International, 2007). In a 10-country study, the WHO found 13-61% of ever-partnered women reported physical violence (Aygül et al., 2012) based on this definition. Of the 10 countries studied (Bangladesh, Brazil, Ethiopia, Japan, Peru, Namibia, Samoa, Serbia and Montenegro, Thailand and the United Republic of Tanzania), urban Japan had the lowest rates, and rural Peru had the highest rates of physical violence (Garcia-Moreno et al., 2005). A meta-analysis of 48 studies from 1982-1999 showed similar results, estimating 10-69% of women worldwide experienced physical abuse from an intimate partner sometime during their life (Heise et al., 1999).

Sexual domestic violence involves a woman’s loss of control over sexual activity. The CTS defines sexual violence as a husband physically forcing his wife to have sexual intercourse or perform any unwanted sexual acts (International, 2007). The WHO also includes the following in its definition: “Was forced to do something sexual that she found degrading or humiliating” (Garcia-Moreno et al., 2005, p.14). A 2014 meta-analysis of marital violence in India describes

sexual violence as “marital rape” (Bhat and Ullman, 2014, p.57). In the 2005 WHO 10-country study, 6-59% of ever-partnered women reported ever experiencing sexual violence, with the lowest rates in urban Japan, Serbia and Montenegro and the highest rates in rural Ethiopia. In all countries except Thailand, sexual violence was higher in provinces than in cities (Garcia-Moreno et al., 2005).

Emotional violence involves psychological harm to a woman by an intimate partner. The CTS defines emotional violence as a husband saying or doing something to humiliate his wife, threatening to hurt or harm her or someone close to her, insulting her, or making her feel bad about herself (International, 2007). The WHO also includes “being intimidated or scared on purpose (for example, by a partner yelling and smashing things)” (Garcia-Moreno et al., 2005, p.14) and found that 20-75% of ever-partnered women reported emotional abuse (Garcia-Moreno et al., 2005). Samoa has the lowest prevalence, and rural Ethiopia had the highest prevalence (Garcia-Moreno et al., 2005).

Finally, marital control is defined by the WHO as a fourth form of domestic violence in this way: “the partner commonly attempts to restrict a woman's contact with her family or friends, insists on knowing where she is at all times, ignores her or treats her indifferently, controls her access to health care (i.e. requires that she obtain his permission to seek health care), constantly accuses her of being unfaithful, and gets angry if she speaks with other men” (Garcia-Moreno et al., 2005, p.14). Prevalence varied from 21% in urban Japan to 90% in Tanzania and was highly correlated to rates of physical and sexual violence (Garcia-Moreno et al., 2005).

Asking women about violent actions they have experienced within marriage is the standard approach used in major national and international studies evaluating domestic violence. However, recent literature on domestic violence has explored ways to more sensitively detect domestic violence in homes where lower levels of violence is culturally accepted. In her work with focus groups in India, Mitra (2013) explains that the term “violence” conjures up ideas of heinous cruelty and brutality, leaving less severe forms of violence unrecognized. She observes:

“Women... may regularly experience these without holding themselves to be victims of violence, or may carry a notion of being violated even while they do not register or narrate any episodes of beating, kicking, or thrashing” (p. 1287). Women may experience violence as “sadness, rage, humiliation, or despair” (Mitra, 2013, p. 1290) instead of discrete abusive acts. A study from northern India concludes that victims may process violence as a toxic home environment rather than isolated incidents of rage (Sharma, 2005). The WHO also comments on the inadequacy of its definition of emotional violence since its manifestations are highly culture-dependent (Garcia-Moreno et al., 2005).

While a consensus exists in recent human rights literature that current definitions of domestic violence may need revision, there are variable opinions on the best approach. For example, more sensitive definitions of sexual violence vary greatly and may include forced sterilization, forced abortion or contraceptive use, female genital mutilation, getting an STD, or husband’s marital infidelity (Aygül et al., 2012). With such diversity of concepts of violence cross-culturally, it is difficult to agree on a global standard that is not only sensitive but also specific. Therefore, since much inconsistency exists regarding expanding definitions of violence, this thesis limits its analysis to validated measures of physical, sexual, emotional violence and marital control as described above in the CTS and WHO definitions.

### Consequences of Domestic Violence

In the United States, female victims of violence have 2.5 times greater health care expenses than their peers (Subaşı, 2001). The number of healthy years of life lost due to rape and domestic violence is similar to HIV/AIDS, 9.5% and 10.6% respectively of the global health burden for women 15-44 (McCaw et al., 2007). The act of violence can cause physical trauma. In a 10-country study of domestic violence, 42% of victims of physical violence reported resultant injuries (Garcia-Moreno, 2014). A Vietnamese study found that 50% of women exposed to violence suffered injuries, and 58% of those required health care attention (Vung et

al., 2009). Physical violence causes more injuries to the head, neck, face, thorax, breasts and abdomen in women than any other mechanism (Campbell, 2002). Violence can cause “broken bones, cuts, burns, hemorrhages and broken teeth” (Riecher-Rössler and Garcia-Moreno, 2013, p.6). Furthermore, among women seeking emergency shelter or care in the emergency room for intimate partner violence, 30-74% had traumatic brain injuries (Riecher-Rössler and Garcia-Moreno, 2013). Choking and loss of consciousness are other severe acute consequences of physical violence (Campbell, 2002). Physical abuse can also lead to murder, and 30% of murdered women are killed by intimate partners (Riecher-Rössler and Garcia-Moreno, 2013). Long term sequelae of trauma include headaches or back pain (Riecher-Rössler and Garcia-Moreno, 2013), and the same Vietnamese study showed women exposed to violence are 3.8 times more likely to suffer from pain (Vung et al., 2009).

Physical violence is also linked to chronic illnesses. Stress from abuse can suppress immune, endocrine, cardiovascular, and metabolic organ systems (Eberhard Gran, 2007) and manifest itself as physical symptoms. For example, victims of domestic abuse have higher rates of gastrointestinal symptoms, such as loss of appetite, eating disorders, and irritable bowel syndrome, than non-abused women (Campbell, 2002). Abuse has been linked to “hypertension, irritability, gastrointestinal disorders, asthma, and headaches” (Wednt and Zannettinno, 2012, p. 5). An Australian study suggests that abused women are more likely to report allergies, breathing problems, pain, fatigue, bowel problems, vaginal discharge, vision and hearing problems, anemia and cervical cancer (Riecher-Rössler and Garcia-Moreno, 2013). Stress from abuse can result in somatoform disorders (Aygul et al., 2012) and affect women’s sensitivity to pain (Eberhard, 2007).

Victims of sexual abuse are more likely to have sexually transmitted diseases, genital irritation, infection, bleeding, fibroids, decreased libido, dyspareunia, pelvic pain, and urinary tract infections (Campbell, 2002). Male promiscuity is associated with abuse, and globally, sexual abuse victims are 1.5 times more likely to have sexually transmitted diseases (García-

Moreno, 2014). Women also have less control of their fertility as perpetrators of sexual abuse often refuse to use condoms or other contraception. Victims of abuse are twice as likely to have an abortion (García-Moreno, 2014), and they have higher rates of unintended pregnancies (Patel and Khan, 2014, Campbell, 2002). In Bangladesh, victims of sexual and physical abuse respectively are 1.64 and 1.35 times more likely to have unintended pregnancies (Rahman et al., 2012). Among victims of sexual abuse, 30.9% of births in the last 5 years were unplanned. Studies in the USA, South Africa and India also show that women who are sexually abused are more likely to use contraception secretly (Patel and Khan, 2014).

In addition to physical symptoms, domestic abuse is strongly associated with poor mental health. Poor mental health can come from the abuse itself as well as other life stressors that accompany violence, such as unwanted pregnancies or children, marital separations, and child behavior problems (Campbell, 2002). Most of the long-term increase in health care costs for domestic violence victims in the United States is for mental health services (Campbell, 2002), and there is evidence that physical violence causes more mental health symptoms than other types of violence (Ratner, 1993). Women who are abused have higher rates of depression, post-traumatic stress disorder (PTSD; Campbell, 2002), anxiety, insomnia, social dysfunction (Ratner, 1993), psychosomatic disorders (Riecher-Rössler and Garcia-Moreno, 2013), and eating disorders (Garcia-Moreno and Riecher-Rössler, 2013). Women exposed to intimate partner violence have a 2 to 3 fold increased risk of major depressive disorder, and 1.5 to 2 fold increased risk of symptoms of depression or post-partum depression. In fact, 9-28% of major depressive disorders, depression symptoms and post-partum depression can be attributed to intimate partner violence (Riecher-Rössler and Garcia-Moreno, 2013). Abused women are also more likely to abuse substances, with 18.5% abusing alcohol and 8.9% abusing other drugs (Riecher-Rössler and Garcia-Moreno, 2013).

Abuse can exacerbate symptoms in women with underlying psychotic disorders (Garcia-Moreno and Riecher-Rössler, 2013), and women with mental disorders, such as bipolar disorder

and schizophrenia are also more at risk for intimate partner violence (Riecher-Rössler and Garcia-Moreno, 2013). Therefore, the relationship between abuse and psychotic symptoms is bidirectional. Studies of intimate partner violence in the USA, Scandinavia and Papua New Guinea also show increased suicidal tendencies among women victims (Campbell, 2002).

If intimate partner violence occurs during pregnancy, it is associated with both pre- and perinatal complications for the mother and baby. Globally, 3-13% of pregnant women report abuse (World Health Organization, 2013). Financial and emotional stress that comes with having a baby may contribute to men's perpetrating abuse during pregnancy (McMahon et al., 2011), but there is conflicting evidence regarding violence increasing or decreasing during pregnancy (McMahon et al., 2011). Consequences of abuse during pregnancy include inadequate maternal weight gain, bleeding, preeclampsia, anemia, urinary tract infections, and preterm labor and delivery (Riecher-Rössler and Garcia-Moreno, 2013). Abused women are more likely to delay seeking prenatal care and have higher rates of sexually transmitted diseases, which are associated with poorer fetal outcomes (Patel and Khan, 2014). Pregnant women are also at increased risk for homicide, and this is the number one cause of death during pregnancy (McMahon et al., 2011).

Effects of violence on the fetus include an increased risk of low birth weight, miscarriage, and spontaneous abortion for children of abused women (Riecher-Rössler and Garcia-Moreno, 2013). The cause of poor fetal outcomes is often abdominal trauma or placental abruptions (McMahon et al., 2011). Abused women are also more likely to use alcohol and tobacco during pregnancy, which may also be a confounder for poor fetal outcomes (Campbell, 2002). After birth, victims of violence have more difficulty with breastfeeding (Riecher-Rössler and Garcia-Moreno, 2013), child attachment (McMahon et al., 2011) and postnatal mental disorders (Garcia-Moreno and Riecher-Rössler, 2013).

Violence affects children of victims as well. Studies in Kenya, Malawi and Honduras showed increased mortality of children under two whose mothers were victims of violence (Rico, 2011). Other studies from Haiti, Kenya, India and Brazil found associations between intimate

partner violence and childhood malnutrition (Riecher-Rössler and Garcia-Moreno, 2013). Many children of abused mothers are also mistreated, and children of victims are more likely to die before their fifth birthday (World Health Organization, 2010). Women who experience intimate partner violence are more likely to view their child's temperament as difficult and see themselves as less competent caregivers (McMahon et al., 2011). Witnessing violence among parents is distressing for children and increases their risk of becoming a perpetrator or victim, continuing the cycle of violence.

### Factors Associated with Domestic Violence

Globally, certain variables have been associated with increased rates of domestic or intimate partner violence. An 80 country study from the London School of Hygiene and Tropical Medicine, the Medical Research Council, and the WHO found that risk factors for domestic violence include low education levels, previous exposure to domestic violence, and cultural acceptance of domestic violence (World Health Organization, 2014). In a review of intimate partner violence in several countries, poverty, unemployment, and lower levels of education were associated with violence in several settings, whereas associations between domestic violence and age, rural versus urban residence, and marital status were more variable (Ismayilova and El-Bassel, 2013). In the U.S., domestic violence is more prevalent among the poor, less educated, non-married, young, and minority populations (McMahon et al., 2011) and less prevalent among the middle class and more educated women who have more resources to help escape violence (Campbell, 2002). However, domestic violence was more strongly predicted by male rather than female characteristics, such as history of arrest, substance abuse, low education levels, and unemployment (Campbell, 2002).

Patriarchal societies in which women have less empowerment can change women's risk of domestic violence. Globally, the term *empowerment* is difficult to define but often refers to the ability to make decisions and use resources. In the U.S., women with more empowerment

(education and resources) experience less violence (Campbell, 2002). However, in patriarchal societies, such as in India, participating in women's education and training programs is associated with increased domestic violence (Rocca et al., 2009). Living in a patriarchal society is also a separate risk factor for violence. In India, fetal death associated with violence is more prevalent in regions where patriarchal attitudes are stronger and women's empowerment is lower (Jejeebhoy, 1998). Where gender roles are more clearly defined, deviation from expected behavior may cause violence. For example, in Bangladesh, women cited not meeting husbands' expectations in daily chores are reasons for violence, and almost all felt that some violence is normal in marriage (Khan et al., 2014).

#### Domestic Violence in India

The rate of domestic violence in India is above the cited global prevalence of 35%. In a multi-site household survey in India in May 2000, INCLEN found 40.3% of women reported physical violence occurred at least once in their married life, and 43.5% of women experience emotional violence in their lifetime (Ellsberg et al., 2008). In 2005-2006, the National Family Health Survey-3 added questions regarding domestic violence and found that 39.7% of women had ever experienced any type of violence, ranging by state from 6.9% in Himachal Pradesh to 60.8% in Bihar (International, 2007). In Maharashtra, which includes Mumbai, 29.2% of women had ever experienced physical or sexual violence. The NHFS also assessed spousal violence specifically, finding that nationwide, 35.1% of women experienced physical violence, 10.0% sexual and 15.8% emotional violence (International, 2007).

In the NHFS-3 study, physical violence is more prevalent in women in their 20's (23.5% of women 25-29 experience violence sometimes or often) compared to older or younger women (14.5% of women 15-19 and 15.5% of women 40-49 experience violence sometimes or often; International, 2007). However, the prevalence of ever experiencing spousal violence was greater in older cohorts, which could be explained by a greater number of years in which there is a possibility of violence (International, 2007). It was also seen that rural women experience more

physical violence than urban women (36.1% versus 28.3%), and the prevalence of violence decreases with more years of education (44.3% with no education versus 14.3% with 12 or more years) and more wealth (45% ever experienced violence in the lowest economic quintile versus 19% in the highest; International, 2007). Employed women experience more violence (39.6%) as compared to women not working for cash income (29.1%.; International, 2007).

Women were also asked if they would justify wife beating for any reason, and those that did were more prone to violence (International, 2007). Muslim women were also associated with increased violence (Kimuna et al., 2013). Most physical violence in the household is perpetrated by husbands, and it was found that husbands with less education were more violent, and husbands who drink are more violent (International, 2007). Spousal violence also increased with number of children: the prevalence among women with 5 or more children is 50% (International, 2007). Sexual violence followed the same trends (International, 2007).

The NFHS-3 also included questions about a partner's control of their wife, finding that 26% of women report their husband is jealous if they talk to other men, and 18% reported that their husband does not trust them with money (Bhat and Ullman, 2014). This study also found that younger women are more likely to have controlling husbands, but otherwise these data follow the same trends as physical violence described above. In addition, women with 1-2 children have less controlling husbands than those with none or more than three children. Again, similar patterns were seen, with more spousal control among rural, uneducated, poorer, employed women (International, 2007).

Other studies also provide insight regarding female factors associated with domestic violence in India. Multiple studies had similar findings to the NHFS-3 results, finding higher rates of domestic violence among women with low education, low socioeconomic status, childlessness or a greater number of children, and separated or divorced. (Dala, 2012, Kimuna et al., 2013, Sabri et al., 2014, Babu and Kar, 2010, Patel and Khan, 2014). Women who work are also more prone to violence; one study showed that working women have double the risk of

physical violence unless they provide the entire household income (Kimuna et al., 2013).

Education and higher socioeconomic status are protective for domestic violence (Babu and Kar, 2010). One study showed membership in groups that help women with self-promotion or finances are protective for violence in India, yet in most other literature, women's increased empowerment increases one's risk of violence (Babu and Kar, 2010).

Characteristics of the male perpetrator also put a woman at risk for domestic violence. Husbands who are unemployed (Patel and Khan, 2014), exhibit more controlling behaviors (Dalal and Lindqvist, 2012), have low education, are employed as drivers, drink alcohol, and have multiple sex partners are more likely to be physically and sexually violent (Kimuna et al., 2013). Job changes were also identified as triggers of domestic violence (Babu and Kar, 2010). In addition, husbands who are reported to be jealous, suspicious and controlling are more likely to cause physical injuries to their wives (Sabri et al., 2014). Men who witnessed violence in their parents are also more likely to perpetrate violence (Babu and Kar, 2010).

Social factors also increase a woman's risk of domestic violence in India. In India, a dowry system is in place, which involves a woman's family giving money and gifts to her husband's family at marriage. Dowry-related disagreements are often associated with or precipitate domestic violence; just over 50% of crimes against women reported to the police were perpetrated by husbands or related to dowries (Bhat and Ullman, 2014). Women of scheduled or low castes were more at risk of domestic violence (Dalal and Lindqvist, 2012, Kimuna et al., 2013), and communities with greater gender, caste and class inequalities have higher rates of violence (Babu and Kar, 2010). Exposure to violence in childhood and adherence to social norms that accept violence increase one's risk of experiencing it (Sabri et al., 2014). A study in Northern India also showed that high crime rates in the community were also associated with increased risk of domestic violence (Babu and Kar, 2010).

There is evidence that the most common forms of violence in India are marital rape, dowry-related violence, and wife battering (Bhat and Ullman, 2014). In a retrospective cohort

study of women victims, 79-90% reported that this violence happened daily (Bhat and Ullman, 2014). Data from focus groups also showed that when violence was reported it was most often daily, routine mistreatment from husbands and relatives (Mitra, 2013).

In Indian households, family violence is often accepted. Gender norms dictate that women are household maintainers and men are providers, and marriage is structured to support these gender role definitions. Sitawa Kimuna, a sociologist analyzing domestic violence data in the 2005-2006 NFHS states, “violence against wives is deeply rooted in cultural norms of patriarchy, hierarchy, and multigenerational families where female obedience and modesty is controlled through abusive behaviours and accepted not only by men, but also by women” (2013, p. 774). The tradition of dowry between families reflects the cultural belief that women are an economic burden that are only valued for how quickly they can be married and what they contribute to their husbands’ households (Mitra, 2013).

A “culture of silence” (Bhat and Ullman, 2014, p.66) and acceptance has resulted in violence remaining under-reported by women and community leaders. Padma Deosthali, director of the Center for the Enquiry into Health and Allied Themes (CEHAT), a non-governmental organization in Mumbai says medical professionals frequently turn a blind eye when women present to government health care facilities who are obvious victims of violence: “Everyone knows that a woman doesn't accidentally drink half a bottle of pesticide...it's a conspiracy of silence” (Yee, 2013, p.1443). In a study of pregnant women in Mumbai, less than 5% reported being screened for domestic violence in a health care setting, and only 2/3 said they would report it, if asked (Decker et al., 2013). However, one in seven women experienced violence while pregnant in Mumbai (Das et al., 2013).

Domestic violence gained some awareness in the 1980's when an Indian feminist movement adopted domestic violence as its campaign issue (Deo, 2012). In 1983 the Indian Penal Code criminalized cruelty to women, defining behaviors that are likely to drive a woman to suicide or cause grave injury, or harassing a woman or her family for property. In 1986, a law

about dowry deaths was added to prosecute the husband or his family members, “if she died as a result of burns or any other injury within seven years of marriage, under suspicious circumstances and if it could be shown that she was subjected to cruelty or harassment by the husband and/or in-laws in relation to demand of dowry” (Kimuna et al., 2013, p.775). In 2000 the Lawyer’s Collective petitioned Parliament to expand domestic violence laws, but Parliament’s proposed amendment gave no protection to women at home. Keeping marriages together was valued above women’s safety. Finally, in 2005 India passed a Domestic Violence Act that protects women from physical, sexual, verbal, emotional, and economic violence. However, there remains a “massive gap between legal clauses and reality of pervasive domestic violence” (Kimuna et al., 2013, p 802). This law has been poorly enforced and therefore has not changed daily life for Indian women.

While awareness and recognition of domestic violence has been increasing, many women accept domestic violence in India is because they depend on their marriage for social status, care for their children, and economic support. Women’s value and status is based on their roles as mother and wife, and established gender roles are valued above human rights since they provide the cultural and normative framework for many Indian communities. Therefore, violence is often seen as justified if it is connected to maintenance of traditional family roles and values. Even advocates for victims of abuse at the Centre for Vulnerable Women and Children in Dharavi, Mumbai (Asia’s largest slum) admit that “there is a premium on keeping families intact, avoiding parental shame and the emotional, social, and financial consequences of separation” (Daruwalla et al., 2009, p. 3). As a result, many women tacitly accept violence believing appropriately that the concept of separation or divorce is beyond their means.

It is well established that domestic violence is common in India and carries multiple health consequences; therefore, interventions that target domestic violence would improve women’s health. Although the data used in this study was initially collected to study HIV and

STI prevention, use of this data set to study domestic violence in India is appropriate for several reasons. First, the study community in which the data for this thesis is drawn has the potential for high rates of domestic violence since it is characterized by several risk factors for abuse, such as poverty, low levels of education, patriarchy, and cultural acceptance of abuse. Second, both qualitative and quantitative data are available, allowing for both types of analysis. Lastly, the quantitative measures used to assess violence in this survey were the same as were used in India's National Family Health Survey, so data could be compared to national statistics. Therefore, this study aimed to identify specific risk and protective factors that may guide targeted domestic violence interventions in this and other similar areas of India with low socioeconomic status and patriarchal communities accept abuse.

## Chapter 2: Methodology

### Study Communities

The data used in this study comes from an officially designated slum community on the outskirts of Mumbai with a total population of 600,000. Most are long-term migrants, coming from the states of Uttar Pradesh (51.2%), rural Maharashtra (22.2%), and Tamil Nadu (9.1%; Schensul et al., 2009). About half of the men in these areas moved with their natal family, while the other half arrived as young men and stayed with extended family or in rented rooms so that they could work in the city and later bring their wives to live with them. The ethno-religious breakdown in the study communities is 82% Muslim, 14% Hindu, and 6% Buddhist and Christian.

Over 90 percent of marriages are arranged, and many spouses are strangers to each other on their wedding night. This lack of emotional connectedness and intimacy is exacerbated in many situations where men often live apart from their wives while finding work and/or wives come to live with husbands in homes with little privacy. Most (81.3%) homes have one room with an average of over 6 people per household, with a designated area for cooking and bathing. Homes are either *pucca* (permanent concrete structures), *semi-pucca* (homes made of a mix of concrete and other supplementary materials such as metal sheets, wood, and a dirt floor), or *katcha* (homes constructed of “found materials” such as metal or cardboard), the latter belonging to the poorest families and often found near dumps or bogs. Homes are typically arranged in rows or plots as part of a larger subarea.

The socioeconomic status of most households in the study is low. Husbands work in a variety of occupations with an average salary of US\$72 per month. Husbands are daily wage workers (39.8%), petty traders and business owners (27.5%), salaried factory and private workers (13.2%), drivers (8.3%), government employees (5.3%), and construction workers (4.4%). Of the women in the survey sample, 28% work for cash income both in the house (embroidery, piece

goods), or out of the home in domestic work or selling produce. Twenty-two percent of homes also have another family member who works.

### The Women's Project

This project involved both qualitative and quantitative data analysis. The data for this thesis was drawn from the project, "The Prevention of HIV/STI among Married Women in Urban India" funded by NIMH/NIH from 2007-2013. This project generated: quantitative data collected from interviews with 1125 women who presented to an urban health center with gynecologic complaints, and qualitative data from 39 in-depth interviews with women regarding issues related to reproductive and sexual health. The qualitative interviews were conducted in 2-3 sessions lasting 1-1.5 hours each in private settings away from husbands and children. Interviews were conducted by female research investigators in Mumbai Hindi. Interviews covered family and home life, physical and sexual health, and other topics related to sexual health and STI risk, including domestic violence. The data used in this project was collected at baseline, before interventions were implemented.

### Qualitative data

Qualitative data analysis was collected to understand cultural and sub-cultural patterns and to guide the selection of variables tested in the quantitative analysis. First, an analysis of the interview data was also done using ATLAS.ti software. Previous investigators had labelled quotations in the interview manuscripts with key words. An initial search was done to find quotations coded as "violence." To look for associations, Atlas.ti allows Boolean searches with violence and other codes find text segments coded with both "violence" and additional codes including: "marital problems," "children," "marital sex," "evaluation of husband," "sex risk," "non-family social relationships," "extended family," "*safed pani*/white discharge," "physical health," "economic problems," "spousal communication," "reproductive health," "emotional health," "husband support," "alcohol/substance abuse," and "empowerment."

Transcripts of the 39 in-depth interviews were also reviewed by the investigator. Quotations about domestic violence were noted, including any mention of associated factors that exacerbated or ameliorated the violence described. While reading the transcripts, more quotations related to violence were noted and labeled with appropriate descriptors.

#### Dependent Variables

In this analysis, four types of violence are defined as separate dependent variables: physical violence, sexual violence, emotional violence and marital control. Analysis was done to identify risk factors associated with these four types of violence.

**Physical violence** was measured by asking women about their husbands doing any of the following actions:

- Slap you
- Twist your arm or pull your hair
- Push you, shake you or throw something at you
- Punch you with fist or something that could hurt you
- Kick you, drag you, or beat you up

The question set showed high internal consistency (Cronbach's  $\alpha = 0.96$ ). Results were skewed and untransformable, so results were recoded as a dichotomous variable. Women responding positively to one or more of the questions in this category were counted as positive for physical violence.

**Sexual violence** was reported by asking women about their husbands doing any of the following actions:

- Physically force you to have sexual intercourse with him even when you do not want to
- Force you to perform sexual acts you did not want to

The question set showed high internal consistency (Cronbach's alpha= 0.89). Results were skewed and untransformable, so results were recoded as a dichotomous variable. Women responding positively to either or both questions in this category were counted as positive for sexual violence.

**Emotional violence** included the following behaviors:

- Says or does something to humiliate you in front of others
- Threatens to hurt or harm you or someone close to you
- Insults you or makes you feel bad about yourself.

The question set showed reasonable internal consistency (Cronbach's alpha = 0.80). Results were skewed and untransformable, so results were recoded as a dichotomous variable. Women responding positively to one or more the questions in this category were counted as positive for emotional violence.

**Marital control** included the following behaviors by husbands:

- Is jealous or angry if you talk to other men
- Frequently accuses you of being unfaithful
- Does not permit you to meet your female friends
- Tries to limit your contact with your natal family
- Insists on knowing where you are at all times
- Does not trust you with any money.

The question set showed reasonable internal consistency (Cronbach's alpha = 0.82). Results were skewed and untransformable, so results were recoded as a dichotomous variable. Women responding positively to one or more the questions in this category were counted as positive for marital control.

A composite scale, **any violence**, was constructed with these subscales. This scale was also dichotomous; if a woman was counted positive for at least one subtype of violence, the

respondent was considered positive for “any violence.” In this community, more subtle forms of violence may be culturally acceptable, so creating dichotomous variables was appropriate for this study because it created a reasonable threshold for detecting violence.

#### Independent variables

For the quantitative data analysis, variables related to women, husbands, and couples were selected and tested for associations with the four types of violence and the omnibus violence variable. Variables were chosen based on causative associations reported in the literature and in the qualitative analysis. The interactions between the independent variables and domestic violence are depicted below in Figure 1.

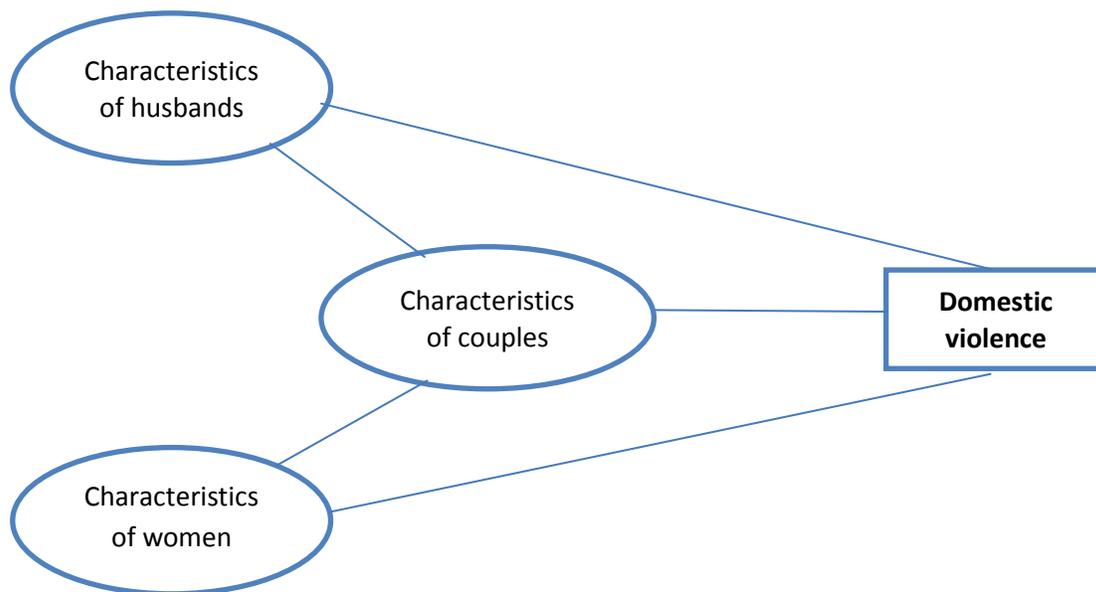


Figure 1: Independent Variables Affecting Domestic Violence.

Independent variables related to domestic violence in this study include characteristics of husbands, women, and couples. The variables were tested for associations with domestic violence. Characteristics of the women and husbands may also affect the nature of the couples’ relationships, so these variables may also be related.

Characteristics of the **women** that were tested for significant associations with violence are described in Table 1 and included: current age, education level, migration status, age at

marriage, employment, hunger, participation in organizations, empowerment status, response to marital conflicts, tensions, social support networks, reproductive health, contraceptive use, sexual practices, sexual health, general health, and interaction with NGOs.

<b>Table 1: Independent Variables Related to Women's Characteristics</b>	
<b>Independent Variable</b>	<b>Description</b>
Current Age	Continuous variable reported in number of years
Education level	Continuous variable reported in number of years of education completed
Migration status	Dichotomous variable; reported as born in Mumbai or not
Age at marriage	Continuous variable reported in number of years
Employment	Dichotomous variable; reported as working or not
Hunger	Dichotomous variable coded from a set of questions regarding food insecurity; one positive answer considered positive for hunger
Participation in Organizations	Dichotomous variable coded from a set of questions regarding participation in organizations; one positive answer considered positive
Empowerment to make decisions	Continuous variable coded from a set of dichotomous questions regarding ability to make family size and purchasing decisions
Empowerment to act without permission	Continuous variable coded from a set of dichotomous questions regarding ability to go places without permission
Response to marital conflicts	Continuous variable coded from a set of dichotomous questions regarding responses to verbal arguments with husband
Tension concerns	Continuous variable coded from a set of dichotomous questions regarding presence of "tension" or stress in woman's life
Tensions consequences	Continuous variable coded from a set of dichotomous questions regarding consequences of "tension" or stress in a woman's life
Social Support Networks	Dichotomous variable coded from a set of questions regarding social support networks
Total number of pregnancies	Continuous variable reported as whole numbers
Number of live births	Continuous variable reported as whole numbers
Number of living children	Continuous variable reported as whole numbers
Elective abortions	Dichotomous variable- positive if at least one abortion reported
Spontaneous abortions	Dichotomous variable- positive if at least one abortion reported
Deceased children	Dichotomous variable- positive if at least one death reported
Age at first pregnancy	Continuous variable reported as whole numbers
Contraceptive Use	Dichotomous variable- positive if contraceptive use reported
Method of contraception	Categorical variable
Sterilization	Dichotomous variable- positive if sterilized
Initiates sex	Categorical: always, sometimes or never
Refuses sex	Dichotomous; can refuse or not
Sexual Health	Continuous variable coded from a set of dichotomous questions regarding sexual health symptoms
STD knowledge	Continuous variable coded from a set of dichotomous questions regarding STD knowledge
General health	Continuous variable coded from a set of dichotomous questions regarding health symptoms

Health treatment	Continuous variable coded from a set of dichotomous questions regarding health care utilization
Infertility	Dichotomous; positive if unable to conceive for past 6 months
Treatment for infertility	Dichotomous; positive if treated for infertility in past 6 months
Pain with intercourse	Dichotomous; positive if reported pain with intercourse
Perceived risk of STDs	Dichotomous; positive if had at least one risk factor for STDs
NGO exposure	Dichotomous variable coded from a set of questions regarding exposure to NGOs in the past 3 months; one positive answer considered positive
NGO meeting	Dichotomous variable coded from a set of questions regarding meeting people from NGOs in the past 3 months; one positive answer considered positive
NGO participation	Dichotomous variable coded from a set of questions regarding participation in NGO activities in the past 3 months; one positive answer considered positive
NGO help	Dichotomous variable coded from a set of questions regarding receiving help from NGOs in the past 3 months; one positive answer considered positive

Characteristics of **husbands** that were tested for significant associations with each type of violence are described in Table 2 and included: age, education level, age at marriage, income, time away from home or in leisure, participation in household chores, treatment of wife when angry, use of alcohol and tobacco, health problems, extramarital sexual activity, and participation in Masjid/Mandir/Church.

<b>Independent variable</b>	<b>Description</b>
Age	Continuous variable reported in number of years
Education level	Continuous variable reported in number of years
Age at marriage	Continuous variable reported in number of years
Income	Continuous variable
Stays away from home overnight for work	Dichotomous; yes or no
Time spend in leisure	Categorical based on frequency
Time spent with friends outside the home	Categorical based on frequency
Helps at home	Dichotomous; positive if helps wife with household chores
Behavior when angry	Continuous variable coded from a set of dichotomous questions regarding treatment of wife when angry
Use of tobacco	Dichotomous; yes or no
Use of alcohol	Dichotomous; yes or no
Number of days has come home drunk in the past 30 days	Continuous variable reported in number of days
If drinking left the family without	Dichotomous; yes or no

adequate funds	
General health	Dichotomous; positive if has at least one health problem known to wife
Discusses women's issues after attending Masjid/Mandir/Church	Continuous variable coded from a set of dichotomous questions regarding gender equity topics discussed when returning from religious services
Participation in religious services	Dichotomous; yes or no
Frequency of religious service attendance	Categorical (rarely, monthly, weekly, more than weekly, daily)
Extramarital sex	Dichotomous variable coded from a set of questions regarding sexual behaviors outside of marriage; positive if wife reports at least one behavior

Characteristics of **couples** that were tested for significant associations with each type of violence are described in Table 3 and included: age difference, income, nature of communication, strength of relationship, contraceptive use, and frequency of sexual intercourse.

<b>Independent Variables</b>	<b>Description</b>
Age difference	Continuous variable reported in number of years
Income of couple	Continuous variable
Husband/wife agreement	Continuous variable coded from a set of dichotomous questions regarding agreement on family matters
Marital relationship	Continuous variable coded from a set of dichotomous questions regarding parts of the marital relationship the wife would like to improve
Who decides method of contraception	Categorical; husband alone, husband and wife together, or wife alone
Frequency of sexual intercourse	Continuous variable reported in number of times in the past month

### Data Analysis

Variables were dichotomous, categorical or continuous. Continuous variables were considered normally distributed if skewedness fell between -1 and 1. Variables that were originally collected as continuous variables and were untransformable were recoded as dichotomous variables. Bivariate relationships were explored using chi-square, one-way ANOVA, and Pearson correlation coefficient,  $r$ . All significant variables ( $\alpha = 0.05$ ) were then analyzed together in a second step using a binary logistic regression model in order to control for all other variables. Quantitative data analysis was done using SPSS 22 software.



The qualitative data analysis synthesizes information from 39 in-depth interviews with women in the community. Women's discussion of their experiences with domestic violence and risk or protective factors were considered. Experiences with physical, sexual, and emotional violence and marital control were discussed in the interviews. Several common themes emerged, including the role of alcohol, financial concerns, women's employment, disagreements about family planning and fertility, presence of other family members, extramarital sex, and religious activity as consistently associated with higher levels of abuse. Poor health and good anger-management emerged as protective factors for abuse. Women's social networks were examined and found to play a role in triggering or protecting from abuse. Throughout most of the interviews, however, acceptance of abuse as a part of marriage was pervasive. Therefore, while certain factors may increase or decrease the amount of abuse a woman experiences, women that were interviewed live communities in which some degree of domestic violence is culturally normative.

### Describing Violence

Each of the four types of violence (physical, sexual, emotional and marital control) are described by the women. Routine violence is prevalent, culturally accepted and sometimes expected by women in the study population. Twenty six of the 39 interviews mentioned at least one experience of violence. Many also recognize the prevalence of violence in their communities. When asked about her own abuse, one 30-year-old woman remarks, "Who is there who does not beat his wife?" And after describing her experience with being forced to have sexual intercourse and being humiliated in public by her husband of 21 years, another 30-year-old woman said, "People live lives worse than this." Another woman described men in her lane that "beat their wives till they bleed." Abuse also seems to continue from one generation to the next. One 32-year-old woman, looking for support because her husband of 17 years hits and yells at her

said she could not go to her mother because she also experienced abuse, and she did not want to add to her mother's stress. Only one woman interviewed did not know anyone who was abused.

Low levels of physical violence were often accepted by the women, and some believe they deserve abuse for transgressions in household maintenance. One 33-year-old woman described her experience with physical abuse this way:

*“My husband hits me sometimes when it is my mistake. He also beats me when I back answer him when he is tired and has worked hard throughout the day....Naturally, a man will beat his wife when she is wrong.”*

A 29-year-old woman described violence caused by saying something bad about her husband's mother: “I expected him to beat me up after this and it followed. I was at fault, so I kept quiet.”

When another woman (32-years-old, married 13 years) discussed looking to her neighbor for support after abuse, her neighbor responded that women need a regular beating.

Women often saw daily activities as common reasons for abuse. A 26-year-old woman married 1.5 years said:

*“Sometimes he is angry when he comes home and he gets out the anger on me. The triggers are like less salt in the vegetable, no water kept for him while having food, ...”*

Other women cited abuse resulting from failure to have food ready at a certain time, not finishing the wash, and not keeping the children quiet. One respondent reported that if she did not keep busy with household work, “he will break my legs. He beats in such a way that body pains and I do not wish to get up in the morning.”

A common view seen in the interviews was that women must agree to sex and specific sexual behaviors whether she desired sex or not. Sexual violence in the form of coercive or forced sex occurred frequently, but was often seen by women as normal in marriage. When one 33-year-old respondent speaks of forced sexual activity by her husband of 18 years, she

remarked, “This is the life of women.” A 29-year-old woman, married 8 years, was noted by the interviewer to casually remark, “Sometimes when I say no, he argues, abuses and sometimes hits. So then after that I have to do it.” Two other women, 32 and 33-years-old respectively, stated, “He has to have sex,” and “He says once married it is the duty of the wife to satisfy the husband.” One 33-year-old woman described that allowing her husband to have sex with her improved other aspects of their relationship, so it was worth dealing with his forceful behavior. One 26-year-old woman who refused sex from her husband identified her refusal as the reason for his infidelity. Another form of sexual abuse identified was being forced to watch pornography. A 26-year-old woman described: “He watches blue films and after watching those films he tells [me] to perform those acts and [I don’t] like it.”

Emotional abuse was also described but not often recognized as violence. Many women spoke of “abusive language” or a “raised voice” used in their relationships with their husbands at home. A few women also described being treated poorly in front of others even if their husbands treat them well in private. One 30-year-old woman, married 21 years, described the distress this caused: “It hurts when he says things to me in front of people.” One 22-year-old woman, married 2 years, said her husband “does not express his love for me in front of others.” A 20-year-old, married 3 years, says,

*“One moment he showers all sorts of abusive words on me and my family and the next moment he takes me in his arms and makes love to me. He is a different person when he is lying on the bed next to me.”*

Therefore, women experienced emotional abuse both at home or in public.

The most common, yet also the most subtle form of domestic abuse described in the interviews was marital control. Lack of husbands’ trust and/or freedom to make daily decisions were common experiences for the women in these communities. Many men did not trust women with household management. As one 30-year-old woman, married 8 years, described,

*“I told him what was happening in the house. But he would not trust me. This happened for days together and finally we ended up fighting with each other.”*

Other women also mentioned husbands not giving them sufficient money for household purchases.

Men also limited their wives interactions with others. A 35-year-old woman said, “he does not like me going out and spending time with others.” Several women were restricted from talking to neighbors, and their husbands became angry or physically violent if they did. Men were reported to “doubt” their wives and have “suspicions” about them, which is the reason they give for prohibiting their interactions with neighbors and relatives, especially other men. One 32-year-old woman, married 16 years, said, “I think my husband is an ideal man, he gives me *izzat* (*honor*),” and then later she said, “My husband does not like or want me to talk to men.” This woman felt respected and treated well by her husband even though she experienced excessive marital control.

### Risk Factors

Women identified several risk factors that increased the amount of violence they experienced. Husband’s alcohol use increased the amount of all types of violence. A 38-year-old woman reported: “I went towards him [and] he tried to press my neck [and] I pushed him and he fell down. He had drunk country liquor (*daaru*) as well.” The same woman also described sexual abuse related to alcohol: “My husband drinks alcohol and he demands for sex [and] I refuse him ... but sometimes he forces [and] then I have to agree.” A 30-year-old woman described alcohol associated with emotional violence: “When my husband comes back after taking alcohol he calls me names.” Alcohol also triggered distrust and marital control, as one 30-year-old woman, married 3 years, described: “That night this [curse word] came back home drunk and he started abusing me saying I was spreading all wrong things about him.”

Depending on the frequency of their husbands' drinking, alcohol was an occasional or constant risk factor. "When he becomes normal, he apologizes to me," was the experience of a 30-year-old woman only abused by her husband when he was intoxicated. However, for a 28-year-old woman, for the past 5-6 years

*"he usually comes home drunk and is never in a state of talking to.*

*If ever I try to talk to him on any issue it turns into an argument and*

*finally he beating me."*

The association between alcohol and abuse seemed to be commonly known to many interviewees, exemplified in a 20-year-old woman's comment about other men: "some of them drink and come and beat their wives for no reason." Less frequently, but also seen, was tobacco use triggering arguments. A 36-year-old woman, married 17 years, said: "He smokes a lot of cigarettes and this is one of the most common reasons for me to get angry with him." In many interviews, women referred to drinking and other drug use as "bad habits."

Several women reported that their husbands spent money on tobacco or alcohol that could have been used for needed household expenses. A 30-year-old woman said,

*"he gets angry. He eats beetle nut, smokes bidi [home rolled small*

*cigar]and cigarette. Does not give any money for the household*

*expenses. We have not paid rent for the last 5 months."*

In several interviews, women mentioned marital conflict stemming from a husband's inability to provide sufficient finances for household maintenance either because of underemployment or lack of desire to work. A 35 year-old woman, married 15 years, said: "...he sits here and keeps watching the TV. We often have fights on this issue." A 24-year-old woman, married 9 years, said, "he was doing nothing and staying whole day at home, so he was total irresponsible and for this reason, we had fought a lot of time."

Financial problems were strongly connected with physical abuse. In several interviews, women described that men's unemployment or underemployment was often a reason for them to

argue with their husbands, which in turn then led to abuse. A 32-year-old woman, married 13 years, said:

*“Then also I told him to find some work and earn ... and he got angry. He beat me and told me to leave the home. He beats with hand or whatever is in his hand be it a wooden rod and call me names.”*

A 26-year-old woman said, “If I keep nagging him continuously to take up work, he beats me.”

A 35-year-old woman said, “If I say something about money problem or anything he hits me.”

Men’s unemployment was troubling to wives because they were concerned about not having funds for household expenses, which undermined her culturally prescribed role as the maintainer of the household . The 32-year-old woman, married 13 years, quoted above, said, “If he does not earn, who will take care of the children?” A 30-year-old woman, married 5 years, said “he had to take up a job as the expenses would be on a rise... after a number of arguments and disagreements [he] found a job that would suffice our needs.”

Underemployment was troubling to men because inability to provide was a source of shame as they failed to meet their culturally prescribed role as provider. A 27-year-old woman, married 8 years, described having guests and not enough food to provide for them:

*“When my husband came for dinner he got angry as there was no chapatti. When I told him that there was only little wheat flour ...and then my husband started beating me in front of everyone.”*

A 35-year-old woman, married 21 years, described being abused by a husband frustrated that he could not find work:

*“I told him to find work and get money. So he started shouting at me. He said nobody gives him work. He said he cannot work now. He was shouting at me and abusing me. Then he ran towards me to hit me.”*

Another woman shared that her relationship with her husband improved after he found a better job, and the domestic abuse stopped.

Women's financial dependence on husbands was a reason to stay in a marriage and allow physical abuse to continue. When describing that her first husband would abuse her after returning home from work, one 38-year-old woman said, "I wanted to leave him and go away ... I had no source of income to take care of my children's needs and their education." A 32 year-old woman said similarly,

*"When my husband beats me I just cry. I cannot do anything else. I think to myself of leaving him and going away. But then I think about my children... (in tears), I cannot stay with them on streets."*

Other physically abused women described having nowhere to go if they were to leave their husband. One 32-year-old woman only hoped to stop the cycle of abuse for the next generation,

*"My daughters should stand on their feet and not be dependent on their husband's like me. That's when husbands take advantage of their wives and wives have to suffer."*

However, trying to gain financial resources often made physical abuse worse or led to marital control. While two women interviewed were employed and did not experience abuse, other working women cited their jobs as a trigger for abuse. One 38-year-old woman describes starting an embroidery business, and while her husband had never abused her before, "my husband was very upset with me... from two months of me starting the business, he had started beating me too." Several interviewees mentioned husbands or in-laws that were against women working, and restricting a woman's activity in this way was a form of marital control. One 32-year-old woman said, "I asked if I could go out to earn money, but he said no to it."

In homes with joint families, other family members could be involved with physical and emotional abuse and marital control. For example, one 27-year-old woman, married for 8 years,

described her brother-in-law laughing as her husband beat her with a plank, and her co-sister (sister-in-law) did nothing to stop it. For some women, violence began only at the encouragement of other family members. One 28-year-old woman described a positive relationship with her husband that changed as her mother-in-law

*“...would tell him [her husband] that a wife is not supposed to be treated like this. According to her a wife should be beaten-up, treated as if she was got in the house only to do work, satisfy the man at night and bear children so that the family has an heir.”*

A 32-year-old woman said, “parents’-in-law returned home after 2 months. That’s when problems started between me and my husband.” One 26-year-old woman claimed the only time her husband beats her is when he listened to his mother. She described her experience this way:

*“My mother-in-law complained about this to my husband when he returned home in the evening. He beat me without even asking me what the reason was.”*

And a 20-year-old woman, married 3 years, said,

*“My mother-in-law does not feel at peace till she hears my husband scream at me. Sometimes when it gets too much and my husband starts abusing me verbally.”*

In-laws also made marital control worse. One 26-year-old woman felt lonely because she could not leave the house, and her mother-in-law prevented her from visiting her sisters. A 20-year old woman says she could not leave the house without her husband, and even that upset her mother-in-law. Only one woman, 26-years old, gave an example of her husband’s family protecting her from abuse; in this case a sister-in-law saved the woman from physical violence. More common, however, were homes where family members supported husbands’ abuse.

In other instances, neighbors and community also condoned or encouraged abuse. One 25-year-old woman described feeling shame from emotional violence; her husband had told the

neighbors that she urinated in bed and they laughed and did not defend her. The same woman described her experience with witnessed physical abuse: “One day he abused me in front of the staff of the NGO. But those people kept on listening and watching only.” Another 38-year-old woman’s religious community did not believe she was being physically abused by her first husband. She said,

*“This community or the religion did not come to help me when I was in crisis, and now they were threatening of throwing me out. I did not need a community or support from the religion that was so biased.”*

Another frequently cited cause of physical, sexual, and emotional abuse was disagreement over reproductive decisions and childbearing. For example, some violence was associated with a woman’s infertility. A 29-year-old woman, married 9 years, described physical and sexual violence when she could not get pregnant:

*“Now he argues because I am not able to conceive.... I told you it happens only on sleeping together. He insists on it and I do not like it much...he gets angry and hits. And few times he has complaints about my not getting pregnant.”*

A 26-year-old woman described trying to become pregnant for a year: “My husband would get angry with me. When I conceived my husband was the happiest person.” Inability to conceive male children also triggered abuse. A 28-year-old woman described abuse after her first child was female: “everyone in the family wanted a boy. My husband changed totally after that.”

For other women, physical or emotional violence came with bearing too many children. Men physically beat or emotionally harmed their wives due to unwanted pregnancies. A 29-year-old woman said, “he said it was my problem if I was pregnant and that he did not want the child...I expected him to beat me up after this and it followed.” A 37-year-old woman described a miscarriage at six months after being hit by her husband. Another husband and mother-in-law

were arrested after they caused a 5-month pregnant woman to slip down a ladder and lose the baby.

Some women who experienced violence also described efforts to limit family size with or without their husband's knowledge. When a 26-year-old woman discussed personally desiring intrauterine birth control, she said, "I am sure he will beat me." A 38-year-old woman who experienced violence had six abortions after bearing five children. Another 38-year-old woman had a sterilization procedure against the wishes of her husband and mother-in-law. Conversely, two women who described positive relationships with their husbands also reported that their husbands used condoms at their request.

Another factor discussed by some women related to violence was husbands' extramarital sex. A 32-year-old woman said: "My parents are also aware of my husband's affair but they say you adjust yourself. Don't argue." A 38-year-old described her first husband having "an illicit relationship with another young woman." Another 25-year-old woman said, "his habit was not good. In Assam females were available without paying money. He had relations with 4 to 5 females." A 32-year-old woman described the stress on the marriage that her husband's affair had. She reported that when confronted about it, "he started using bad words to my sister. He was beating me like anything else."

Fear of extramarital sex was associated with sexual violence. A prevalent belief among women interviewed was that they had to allow unwanted sex in order to prevent their husbands from going to other women. A 29-year-old woman, married 10 years, said,

*"If the woman in the house does not give it to them, they can always find it somewhere out. It's like food. If food is not made at home it is always available in the hotels or the dhabas [places to get food associated with long distance drivers]."*

When asked if she could say no to sex, a 20-year old woman responded, "I don't refuse most of the time as I am scared my husband may go out to some other lady if I don't satisfy him." A 28-

year-old woman was warned by her mother-in-law that “I should listen to my husband and allow him to do all that he wants to do. Otherwise such shows will continue and my husband will go to some other lady.”

Specifically, Muslim women were at increased risk of sexual abuse. Some feared that their husbands would find a second wife, which was permitted by their religion, and, according to a 30-year-old woman, “[the Quran] says a woman should allow her husband to have sex whenever he feels like.” A 32-year-old woman articulated the common desire that “Even though our religion allows a man to have more than one wife I don’t want my husband to do it.” Therefore, to prevent extramarital sex, Muslim women often performed unwanted sexual acts. One 20-year-old Muslim woman expressed her concerns this way:

*“If don’t give him all that he wants, he can always go out to other women. ... Our religion allows him to get another wife so who can stop him?”*

Another 27-year-old woman worried, “He will get new body (breasts and vagina), then I will lose importance. This is the only reason men get married.” Women feared they will be treated more abusively if their husband were to take a second wife or go to another woman, so they permitted sexual violence.

Religious beliefs or activity were also associated with other types of violence in addition to sexual violence. For example, physical abuse happened after breaking religious norms. After being seen talking to another man without a *dupatta* [head scarf], a 25-year-old woman said her husband yelled at her and “hit me and put the dupatta on the kerosene stove.” Another 27-year-old remembered an incident when once her “dupatta slipped from my head. My husband saw this. That evening only he beat a lot.” A 38-year-old woman, experiencing violence from her husband remarked that

*“The Maulana (Imam) also told me that he being my husband I could not remove him out of the house. Our religion is sick. It only sides with the men. It is hell for women to be born a Muslim.”*

In this case, this woman felt she had no choice but to allow her husband’s behavior to continue.

### Protective Factors

Three factors in the interviews emerged as protective factors for domestic violence. First, a woman’s poor health was often associated with decreased levels of violence. For many women, health problems they have experienced provided opportunities for their husbands to show them affection and care instead of abuse. A 32-year-old woman said, “My health problems have had all positive effects on my relationship with my husband.” One 27-year-old respondent said her husband did not fight with her because of her blood pressure problem. Regarding sexual abuse, another 35-year-old woman said,

*“Because I start having backache after that I tell him to finish it off early. He also does not insist on it now. ...He then does not bother me with it as he knows that my health is not good.”*

In only one interview did a 28-year-old woman describe physical abuse when she refused to have sex because of health problems, and another 26-year-old woman said her husband “scolds” when she refused to have sex because of pain. Overall, however, poor health seemed to protect women from abuse.

Second, couples with positive anger-management strategies seemed to have decreased levels of physical violence and domestic conflict overall. If at least one person in the couple could control his or her temper, this seems to diffuse situations that lead to violence. One 25-year-old woman says, “When he is angry I keep quiet and when I am angry he keeps quiet.” She only reported one isolated incident of physical abuse. Two other women who reported never

experiencing violence had similar patterns of behavior. A 28-year-old woman said, “when we get angry, we just shut our mouth. When I get angry, I start murmuring to myself as I don’t shout.” A 35-year-old woman said, “after sometime if I am angry he stops talking or if he is angry I do not react. So we do not have a heated argument.” The women and couples that could control their anger reported minimal or no violence.

Having a supportive social network could decrease risk of abuse. For some women, their community, neighbors, and social networks provided a means of protection. One 32-year-old woman remembered that, “my husband beat me till I was bleeding. Sometimes the neighbors would come to my rescue.” Another 25-year-old woman’s office where she worked was a place of refuge from physical abuse.

Not all women experienced violence; in fact, several women described loving relationships with their husbands. A 20-year old, married 3 years, said that her husband liked to spend time with her at home. A 38-year old woman described her second husband this way: “We discuss problems to come to a solution. ... We talk about everything to each other. We talk about my tensions.” Even when risk factors were present, some women were able to avoid violence. For example, a 28 year old woman works and has family financial problems but said, “We never quarrel over money as I know he tries his best to earn more, so why fight and create tense situation at home?”

In summary, all types of domestic violence were experienced by women in the interviews. Violence was culturally common and often unrecognized. Several risk factors, such as alcohol, financial concerns, women’s employment, disagreements about family planning and fertility, presence of other family members, extramarital sex, religious activity, and poor social support, were identified as increasing one’s risk of abuse. Protective factors, such as poor health, anger-management strategies, and supportive social networks, were identified as factors that decrease one’s risk of abuse. These results provide a better understanding of women’s experiences of abuse in low socioeconomic, urban communities in India.

## Chapter 4: Quantitative Results

Quantitative data from a survey of 1125 women coming to the municipal urban health center in the study community were analyzed for associations between domestic violence and characteristics of the women interviewed, their husbands, and as couples. It was found that 45.8% of women interviewed experienced at least one type of domestic violence. The most common type of violence was marital control; 42.1% of women responded affirmatively to at least one question related to control. Physical violence was experienced by 35.5% of the sample, sexual violence by 24.7% of the sample, and emotional violence by 18.4% of the sample. Based on data from the qualitative analysis and literature review, characteristics of the women, husbands, and couples were chosen as variables that were analyzed for associations with domestic violence using logistic regression. Each type of violence was considered separately, and a conglomerate variable, “any violence,” was also used.

### Variables that describe women

#### Characteristics of women and any violence

Independent variables related to women’s characteristics were evaluated for associations with any violence. In the logistic regression analysis, two variables related to women were statistically associated with experiencing any violence, and the beta, significance (p-value) and odds ratio for these variables are shown in Table 4. First, empowerment to make purchasing and family size decisions was found to be significant. The scale for this variable was created by calculating the mean of a woman’s responses to a series of dichotomous questions relating to a woman’s ability to make decisions regarding purchasing major household goods, working outside the home, having children, buying items for herself, and saving money. Responses were coded as either one or three, so this was a continuous variable with a range of two. Women were considered to have more empowerment if they were able to make more of these decisions on their own. Second, a woman’s ability to respond to conflict was also found to be significantly related

to experiencing any violence. The scale for this variable was also created by calculating the mean of a woman's responses to a series of dichotomous questions regarding behaviors practiced during verbal arguments with husbands. Responses were coded as either one (representing ineffective behaviors in response to conflict) or two (effective behaviors), so this was a continuous variable with a range of one. Women were asked about the following behaviors in response to verbal arguments: talking to others in the house or community, discussing problems calmly with husband, seeking help from an NGO or religious community, leaving the house, yelling at husband, throwing things, hitting children, isolating herself, crying, going to her natal family, or not eating food.

Significant Variables	B	Sig. (p-value)	Exponent
Low empowerment to make purchasing and family size decisions	1.35	<0.001	3.8
Responds poorly to conflicts with husband	3.85	<0.001	4.8
Variables controlled for in the logistic regression analysis include: employment status, nutrition status, husband's leisure time, husband's alcohol use, husband's tobacco use, frequency of sexual intercourse, who decides method of contraceptive use, ability to initiate sex, ability to refuse sex, husband's health status, husband's extramarital sex, health status, treatment of health problems, sexually transmitted disease risk, pain with intercourse, exposure to NGOs, discussing women's issues with husband after attending religious services			

These results show that women with lesser empowerment in terms of ability to make purchasing and family size decisions are more likely to experience at least one form of violence. Women who have no empowerment to make any purchasing or family size decisions are 3.8 times as likely to experience any form of violence compared to women who have the ability to make decisions in one half of the situations asked. Women who practice all ineffective behaviors in response to conflicts with husbands were 4.8 times more likely to experience at least one form of violence than women who practice all effective behaviors in response to arguments.

Empowerment and responding well to conflicts are protective for experiencing at least one form of violence.

#### Characteristics of women and physical violence

Variables related to women were examined for statistical associations with physical violence. The variable “not receiving help from an NGO” was found to be significantly associated with experiencing physical violence, and the beta, significance (p-value), and odds ratio for this association are shown in Table 5. This scale for this variable was skewed, so it was transformed into a dichotomous variable. Women who received no help were compared with women who received help from one or more of the following organizations in the past 3 months: Apnalaya, Niramaya, Stree Mukti Sangathan, CORO, Lok Seva Sangam, Hindustan Covenant Church, and RISHTA. In the sample, 9.6% of women had received help.

Table 5: Receiving help from an NGO and its association with physical violence			
Significant Variables	B	Sig. (p-value)	Exponent
Not receiving help from an NGO	1.95	0.006	7.0
Variables controlled for in the logistic regression analysis include: age at marriage, nutrition status, whether husband stays away from home for work purposes, husband’s leisure time, husband’s alcohol use, husband’s tobacco use, history of spontaneous abortion, history of elective abortion, age at first pregnancy, who decides method of contraceptive use, ability to initiate sex, ability to refuse sex, husband’s health status, health status, treatment of health problems, sexually transmitted disease risk, attitudes regarding community norms, pain with intercourse, exposure to NGOs, discussing women’s issues with husband after attending religious services			

This analysis shows that women who have not received help from an NGO in the past 3 months are seven times more likely to experience physical violence. Receiving NGO help is a protective factor for physical violence.

#### Characteristics of women and sexual violence

Variables describing women’s characteristics were analyzed for associations with sexual violence. Statistically significant associations were found between sexual violence and two

variables, and the beta, significance (p-values) and odds ratios for these variables are in Table 6. The first significant variable, empowerment to make purchasing and family size decisions, is described above. The second variable, experiencing pain with intercourse, is dichotomous. Women who had pain with intercourse in the past three months were compared to women who did not experience pain with intercourse in the past three months. In the sample, 42.4% of women have experienced pain with intercourse in the past three months.

Table 6: Empowerment and pain with intercourse and their association with sexual violence			
Significant Variables	B	Sig. (p-value)	Exponent
Low empowerment to make purchasing and family size decisions	2.01	0.003	7.7
Experiencing pain with intercourse	1.18	0.035	3.2
Variables controlled for in the logistic regression analysis include: age difference between husband and wife, nutrition status, husband's leisure time, husband's alcohol use, husband's tobacco use, age at first pregnancy, who decides method of contraceptive use, ability to initiate sex, ability to refuse sex, husband's extramarital sex, frequency of sexual intercourse, husband's health status, health status, treatment of health problems, sexually transmitted disease risk, discussing women's issues with husband after attending religious services, attitudes regarding community norms, if husband helps with household chores			

Women who had less empowerment to make purchasing and family size decisions were more likely to experience sexual violence. Since the scale has a range of two, women with no ability to make purchasing and family size decisions are 7.7 times as likely to experience sexual violence as women who are able to make decisions in one half of the situations asked. Empowerment is a protective factor for sexual violence. Women who experience pain during intercourse were 3.2 times more likely to experience sexual violence; dyspareunia is a risk factor for sexual violence.

#### Characteristics of women and emotional violence

Variables describing women's characteristics were analyzed for associations with emotional violence. Table 7 shows the beta, significance (p-value) and odds ratio for the three significant variables below. Women were asked at what age they were married- a continuous

variable normally distributed frequencies. The mean age at marriage was 17.6, with a range from three years of age to 34 years of age. Again, empowerment to make purchasing and family size decisions and a woman's ability to respond to conflict were also associated with emotional violence. These variables are described above.

Table 7: Age at marriage, empowerment, and response to conflict and their association with emotional violence			
Significant Variables	B	Sig. (p-value)	Exponent
Older age at marriage	0.21	0.047	1.23
Low empowerment to make purchasing and family size decisions	1.07	0.007	2.94
Responds poorly to conflicts with husband	4.44	<0.001	100
Variables controlled for in the logistic regression analysis include: level of education, employment status, age difference between husband and wife, age at first pregnancy, nutrition status, husband's income, husband's leisure time, husband's alcohol use, husband's tobacco use, who decides method of contraceptive use, ability to initiate sex, ability to refuse sex, husband's extramarital sex, frequency of sexual intercourse, husband's health status, health status, treatment of health problems, sexually transmitted disease risk, pain with intercourse, discussing women's issues with husband after attending religious services, attitudes regarding community norms, if husband helps with household chores, if husband stays away from home for work			

A woman's older age at marriage was found to be a risk factor for emotional violence, such that each year a woman waits to marry, her odds of experiencing emotional violence are 1.2 times greater. Women with less empowerment to make purchasing and family size decisions are more likely to experience emotional violence. Women who are unable to make any purchasing or family size decisions are 2.9 times more likely to experience emotional violence as women who can make half of the decisions asked. Responding poorly to conflicts with husbands was associated with emotional violence such that women who practice all ineffective behaviors in response to conflicts with husbands were 100 times more likely to experience emotional violence

than women who practiced all effective behaviors. Empowerment to make decisions and responding well to conflict are protective factors for emotional violence.

#### Characteristics of women and marital control

Variables relating to women were analyzed for associations with marital control. Table 8 shows the beta, significance (p-value) and odds ratio for significant variables. Empowerment to make purchasing and family size decisions as well as response to conflicts with husband were both found to be significantly associated with marital control. These variables are described above.

Table 8: Empowerment and response to conflict and their association with marital control			
Significant Variables	B	Sig. (p-value)	Exponent
Low empowerment to make purchasing and family size decisions	1.19	0.003	3.23
Responds poorly to conflicts with husband	3.64	0.002	33.0
Variables controlled for in the logistic regression analysis include: age at first pregnancy, nutrition status, husband's leisure time, husband's alcohol use, who decides method of contraceptive use, frequency of sexual intercourse, ability to initiate sex, ability to refuse sex, husband's extramarital sex, husband's health status, health status, treatment of health problems, sexually transmitted disease risk, pain with intercourse, discussing women's issues with husband after attending religious services, if husband stays away from home for work			

A woman with low empowerment in regards to purchasing and family size decisions is more likely to experience marital control. A woman who has no ability to make purchasing or family size decisions is 3.2 times as likely to experience marital control as a woman who has ability to make half of the decisions asked. Responding poorly to conflicts with husbands was also related to marital control, such that women who practice all ineffective behaviors in response to conflicts with husbands were 33 times more likely to experience marital control than women who practiced all effective behaviors.

### Variables that describe husbands

#### Characteristics of husbands and any violence

In the survey, women were asked to report several variables that describe their husbands. For any violence, only extramarital sex was shown to be significantly related. This was a dichotomous variable, and men were considered to have practiced extramarital sex if their wives said they had done at least one of the following: had pre-marital sex, had extra-marital sex, had sex with sex workers, or was currently involved in sex with other women. Women whose husbands have had extramarital sex were compared to those whose husbands did not. The beta, significance (p-value) and odds ratio for extramarital sex and its association with any violence is in Table 9.

Table 9: Extramarital sex and its association with any violence			
Significant Variables	B	Sig. (p-value)	Exponent
Extramarital sex	1.24	<0.001	3.45

Variables controlled for in the logistic regression analysis include: employment status, nutrition status, husband's leisure time, husband's alcohol use, husband's tobacco use, frequency of sexual intercourse, who decides method of contraceptive use, ability to initiate sex, ability to refuse sex, husband's health status, husband's empowerment to make decisions, response to conflict, health status, treatment of health problems, sexually transmitted disease risk, pain with intercourse, exposure to NGOs, discussing women's issues with husband after attending religious services

A woman who perceives that her husband has had extramarital sex currently or in the past was 3.45 times as likely to experience any form of violence.

#### Characteristics of husbands and physical and sexual violence

Variables that describe the husband were analyzed for associations with physical violence. No significant associations were seen. Variables that describe the husband were analyzed for associations with sexual violence. Associations with sexual violence were found with the following variables: if husband stays away from home overnight for work, time husband spends with friends outside the home, and husband's alcohol use. Table 10 shows the beta, significance (p-value) and odds ratio for these associations. Staying away from home overnight

for work purposes was a categorical variable with the following responses: never, rarely, monthly, weekly, and more than weekly. In the sample, 82.4% of husbands never spend time away from home for work. The time husbands spend with friends outside the home was reported by women as number of hours; this was a continuous variable with a mean of 2.5 hours. Alcohol use was a dichotomous variable, so women whose husbands drank alcohol were compared to those whose husbands did not. In the sample, 9.9% of husbands were reported to drink alcohol.

Table 10: Staying away from home, time with friends, and alcohol use and their association with sexual violence			
Significant Variables	B	Sig. (p-value)	Exponent
Stays away from home overnight for work purposes	0.72	0.005	2.1
Amount of time spent with friends outside the home each week	0.04	0.04	1.04
Alcohol use	1.43	0.02	4.2
Variables controlled for in the logistic regression analysis include: age difference between husband and wife, nutrition status, husband's leisure time, husband's tobacco use, age at first pregnancy, who decides method of contraceptive use, ability to initiate sex, ability to refuse sex, husband's extramarital sex, frequency of sexual intercourse, husband's health status, health status, treatment of health problems, sexually transmitted disease risk, discussing women's issues with husband after attending religious services, attitudes regarding community norms, if husband helps with household chores, pain with sexual intercourse, empowerment to make purchasing and family size decisions			

If husbands stay away from home overnight for work purposes, women show more than twofold increase in their odds of experiencing sexual violence. Women whose husbands consume alcohol are 4.2 times more likely to experience sexual violence. Both of these variables are risk factors. The greater amount of time husbands spend outside the home each week was also found to be significantly associated with sexual violence.

#### Characteristics of husbands and emotional violence

Variables related to the husband were analyzed for associations with emotional violence. Alcohol use, extramarital sex, and discussing women's issues after returning from Masjid/Mandir/Church were found to be statistically significant, as described in Table 11.

Alcohol use and extramarital sex are dichotomous variables described above. The scale for the variable “discussing women’s issues after returning from Masjid/Mandir/Church” was created by calculating the mean of several dichotomous variables. Women were asked if husbands come home from Masjid/Mandir/Church and talked about any of these issues: gender equality, good marital communication, marital roles and responsibilities, women’s health, reducing violence against women, elimination of extramarital sex, HIV/STI prevention, or other messages. The mean values of responses to these questions had a range of 0-1. Forty one percent of men discussed at least one of these issues.

Table 11: Alcohol use, extramarital sex, and discussion of issues and their associations with emotional violence			
Significant Variables	B	Sig. (p-value)	Exponent
Alcohol use	1.03	0.027	2.8
Extramarital Sex	1.16	<0.001	3.2
Never discussing women’s issues after returning from Masjid/Mandir/Church	1.14	0.013	3.1
Variables controlled for in the logistic regression analysis include: level of education, employment status, age difference between husband and wife, age at marriage, age at first pregnancy, nutrition status, husband’s income, husband’s leisure time, husband’s alcohol use, husband’s tobacco use, empowerment to make purchasing and family size decisions, response to conflict with husband, who decides method of contraceptive use, ability to initiate sex, ability to refuse sex, husband’s extramarital sex, frequency of sexual intercourse, husband’s health status, health status, treatment of health problems, sexually transmitted disease risk, pain with intercourse, discussing women’s issues with husband after attending religious services, attitudes regarding community norms, if husband helps with household chores, if husband stays away from home for work			

A woman whose husband drinks alcohol is 2.8 times as likely to experience emotional violence.

A woman whose husband has had extramarital sex is 3.2 times as likely to experience emotional violence. A woman whose husband never talks on any of the issues mentioned has 3.1 times the odds of experiencing emotional violence as a woman whose husband has discussed all the issues mentioned after attending Masjid/Mandir/Church. Alcohol use and extramarital sex are risk

factors for emotional violence, while a husband discussing women’s issues after attending religious services is protective for emotional violence.

Characteristics of husbands and marital control

Variables related to the husband were analyzed for associations with marital control, and extramarital sex was found to be significant. This dichotomous variable is described above and its association with marital control is shown in Table 12.

Table 12: Extramarital sex and its association with marital control			
Significant Variables	B	Sig. (p-value)	Exponent
Extramarital sex	1.15	<0.001	3.1
Variables controlled for in the logistic regression analysis include: age at first pregnancy, nutrition status, husband’s leisure time, husband’s alcohol use, who decides method of contraceptive use, frequency of sexual intercourse, ability to initiate sex, ability to refuse sex, husband’s extramarital sex, husband’s health status, health status, treatment of health problems, sexually transmitted disease risk, pain with intercourse, empowerment to make purchasing and family size decisions, responds well to conflicts with husband, discussing women’s issues with husband after attending religious services, if husband stays away from home for work			

A woman with a husband who has had extramarital sex has more than 3 times the likelihood of experiencing marital control compared to women whose husbands have never had extramarital sex.

Variables that describe couples’ relationships

In the survey, women were asked to respond to several questions that describe their marriage relationship. No characteristics of couples were associated with neither physical nor sexual violence. Who decides the method of contraception was found to have statistically significant relationships with women experiencing any violence, emotional violence, and marital control. This independent variable was categorical, with the husband alone, the couple together, and the wife alone as possibilities for who decides the contraceptive method. The husband alone decided the method of birth control for 15.2% of couples; the couple together for 64.8% of couples, and the wife alone for 17.8% of couples. Table 13 describes the association between who decides contraceptive decisions and any violence.

Table 13: Who decides contraception method and its association with any violence			
Significant Variables	B	Sig. (p-value)	Exponent
Who decides contraceptive method (husband alone, couple together, wife alone)	0.62	0.014	1.85
Variables controlled for in the logistic regression analysis include: employment status, nutrition status, husband's leisure time, husband's alcohol use, husband's tobacco use, frequency of sexual intercourse, empowerment to make purchasing and family size decisions, response to conflict with husband, ability to initiate sex, ability to refuse sex, husband's health status, husband's extramarital sex, health status, treatment of health problems, sexually transmitted disease risk, pain with intercourse, exposure to NGOs, discussing women's issues with husband after attending religious services			

Who decides the method of birth control is associated with experiencing any type of violence, with the wife alone associated with increased odds of violence. A woman who decides on the contraceptive method alone has 1.85 times the odds of experiencing violence as opposed to a woman who decides on contraception with her husband. A woman who decides on contraception with her husband has 1.85 times the odds of experiencing violence as a woman whose husband alone decides the method of contraception. The more control a woman has over contraception, the greater her odds of experiencing violence.

Table 14 shows the beta, significance (p-value) and odds ratio for the association between who decides the method of contraception and emotional violence. The variable “who decides contraception method” is described above.

Table 14: Who decides contraception method and its association with emotional violence			
Significant Variables	B	Sig. (p-value)	Exponent
Who decides contraceptive method (husband alone, couple together, wife alone)	0.72	0.005	2.0
Variables controlled for in the logistic regression analysis include: level of education, employment status, age difference between husband and wife, age at marriage, age at first pregnancy, nutrition status, husband's income, husband's leisure time, husband's alcohol use, husband's tobacco use, empowerment to make purchasing and family size decisions, response to conflict with husband, empowerment to make purchasing and family size decisions, response to conflict with husband, ability to initiate sex, ability to refuse sex, husband's extramarital sex, frequency of sexual intercourse, husband's health status, health status, treatment of health problems, sexually transmitted disease risk, pain with intercourse, discussing women's issues with husband after attending religious services, attitudes regarding community norms, if husband helps with household chores, if husband stays away from home for work			

A woman who decides on the contraceptive method alone has double the odds of experiencing emotional violence as a woman who decides on contraception with her husband. A woman who decides on contraception with her husband has double the odds of experiencing emotional violence as a woman whose husband alone decides the method of contraception. The more control a woman has over contraception, the greater her odds of experiencing emotional violence.

Table 15 shows the beta, significance (p-value) and odds ratio for the association between who decides the method of contraception and marital control. The variable “who decides contraception method” is described above.

Table 15: Who decides contraception method and its association with marital control			
Significant Variables	B	Sig. (p-value)	Exponent
Who decides contraceptive method (husband alone, couple together, wife alone)	0.55	0.024	1.74
Variables controlled for in the logistic regression analysis include: age at first pregnancy, nutrition status, husband's leisure time, husband's alcohol use, who decides method of contraceptive use, frequency of sexual intercourse, ability to initiate sex, ability to refuse sex, husband's extramarital sex, husband's health status, health status, treatment of health problems, sexually transmitted disease risk, pain with intercourse, empowerment to make purchasing and family size decisions, responds well to conflicts with husband, discussing women's issues with husband after attending religious services, if husband stays away from home for work			

A woman who decides on the contraceptive method alone has 1.7 times the odds of experiencing marital control as a woman who decides on contraception with her husband. A woman who decides on contraception with her husband has 1.7 times the odds of experiencing marital control as a woman whose husband alone decides the method of contraception. The more control a woman has over contraception, the greater her odds of her husband exerting marital control.

In summary, several independent variables emerged as significantly associated with any violence or subtypes of violence in this economically marginalized community in the outskirts of Mumbai. Women are more likely to experience at least one form of violence if she has: less empowerment to make decisions, poor responses to conflicts with her husband, not received help from an NGO in the past 3 months, pain with intercourse, a husband who has had extramarital sex, a husband who drinks alcohol, a husband who spends time away overnight for work, a husband who spend more time outside the home with friends, a husband who never talks on women's issues after attending Masjid/Mandir/Church, or more control over contraceptive decisions.

## Chapter 5: Discussion and Conclusions

The objective of this thesis was to identify risk and protective factors for domestic violence that could be used in interventions in low-income communities in Mumbai. A segment of the families in the study community manifested characteristics that have been identified globally as associated with increased violence, such as low socioeconomic status (Kimuna et al., 2013, Babu and Kar 2010), low education levels (International, 2007), and a patriarchal culture (Jejeebhoy, 1998). Respondents in the in-depth interviews reported a high frequency of violence in these communities. The quantitative data shows that 45.8% of women report experiencing at least one type of violence; this rate is well above the global and national prevalence of 35% and 39.7% respectively (International, 2007).

Women describe being victims of husbands' yelling, hitting, and forced sexual activity as common for themselves and those in their community. Domestic violence is experienced in each generation and often encouraged by mother-in-laws and other family. The women describe marital duties tied to traditional gender roles, such as making food, caring for children, bearing children, and satisfying their husbands sexually and that violence often results from failure to fulfill one of these expected tasks.

In a cultural context of male domination, women may have a definition of violence that is more narrow and severe than that defined by the WHO and in the variables measured in this study. In these circumstances, women may define a slap on the face from their husbands as not reaching the level of violence or may find such behavior an appropriate response to not meeting their responsibilities. Emotional violence and marital control were also described as normal manifestations of expected gender roles.

Traditionally, Indian women find their status in their title as wife and mother. Men are decision makers and heads of households, less constrained in terms of movement and behavior. Women are expected to comply; their value is in their ability to contribute to the household and

please their husbands. Therefore, some women fault themselves for abuse if they do not fulfill their domestic duties. Violence can be a means to reinforce traditional patriarchal family structure.

The most distressing type of violence for women was physical, as it resulted in physical health problems. Emotional violence also caused women to feel embarrassed or emotionally hurt, particularly in front of others. While many women may define their physical or emotional abuse as wrong, they have little recourse for situational change. Physical and emotional violence is frequently seen as an unfortunate but expected part of marriage for many, and since women have no financial means or family support to leave the marriage, they see no option but to accept their husbands' behaviors.

Sexual violence is also often described in interviews but not recognized as abuse. Women describe forced sexual intercourse not as a problem but rather as part of normal married life. Similarly, marital control as seen in many marriages is considered normative. Several factors, including a patriarchal culture, arranged marriages, dowries, and low socioeconomic status, make marriage more contractual than romantic. Therefore, sexual intimacy is something a wife is expected to provide for her husband, and a husband will decide when sex will occur, whether there is mutual interest or not. Women in these communities enter marriage with expectations shaped by a culture with inequitable gender roles and responsibilities. Therefore, while accepted forms of violence may affect women's quality of life, for many women they are less psychologically distressing than they would be in cultures in which there is greater gender equity.

The qualitative results of this study were helpful to consider if the definitions of violence used in this study are appropriate for the study population. Recent discussions in the literature suggest that culturally specific classifications of violence may be more useful than globally standardized definitions. In this sample, the violence described in interviews was not always recognized as an issue by the women. However, unrecognized violence may still cause health consequences for victims and their children. Therefore, in interventions targeting domestic

violence and its sequelae, it will be a challenge to address behaviors that are not perceived by women as problematic.

This study had several limitations. First, since the survey is cross-sectional, causal relationships between quantitative variables cannot be determined unless there is a chronological order to the variables. However, qualitative results and previous findings in the literature help to interpret the direction of the associations seen. Furthermore, some selection bias may be present in the qualitative review, as women who experience more violence or marital control may be less able to agree to long interview sessions.

### Risk Factors

Several risk factors were identified that increase a woman's risk of domestic violence. Many of the risk factors are tied to traditional gender roles in Indian culture. First, both qualitative and quantitative analyses show an increased risk of violence for women whose husbands drink alcohol. In interviews, women report physical, sexual, and emotional abuse precipitated by their husbands drinking, and men's alcohol use was also statistically associated with physical and sexual violence. These results are consistent with studies that show that men's alcohol use was associated with increased violence in India and worldwide (Kimuna et al., 2013). Targeting men's alcohol use may be a helpful approach for domestic violence interventions.

Unemployment and financial concerns were also associated with domestic violence in the qualitative analysis. This result was consistent with the literature suggesting globally, low socioeconomic status is associated with violence (Ismayilova and El-Bassel, 2013), and studies in India show that unemployment is associated with violence (Patel and Khan, 2014). Financial inadequacy may cause violence in patriarchal societies because it undermines gender norms. First, it may threaten a man's role as provider, in which women must push their husbands to find jobs or better jobs that will increase their allotment for household maintenance. Limited financial

allotments prevents woman from successfully meeting thier cultural responsibilities for managing the household.

However, no statistical associations were seen between economic factors (income, if alcohol use leaves family without adequate funds) and any type of violence in the quantitative analysis. This unexpected result may be because the sample population has a narrow range of incomes. It is also possible that a couple's management of household resources is a more important factor in violence than total income. As explained below, a woman's low empowerment to make purchasing decisions was a risk factor for violence. This fact suggests that a couple's discordant opinions about spending, even if funds are adequate, may be a risk factor.

Women's employment was associated with violence in the qualitative analysis but was not significantly associated with any type of violence in the quantitative analysis. In the interviews, women discussed both previous and current work and exposure to violence. Some quit their jobs or were prevented from working, but these incidents not captured by the survey data that only asked about current working status. Future quantitative studies could clarify this association by including questions about previous employment and violence. The literature suggests that women's employment in India is associated with increased violence (Patel and Khan, 2014), so it is reasonable to hypothesize that the same is true in this population. In earning money, a woman deviates from her expected gender role. She is less dependent on her husband as provider, has less time to manage the household and raise children, is more mobile, and interacts with male and female co-workers. The need for a second income to address rising prices is becoming more apparent in India; however in patriarchal communities this need is still perceived as a blow to male adequacy.

Women's older age at marriage was associated with increased emotional violence. Since a traditional role for women is to marry and bear children, waiting to marry is a deviation from traditional gender norms. Later marriage may be another example of deviation from gender norms that are associated with violence.

The influence of other family and community members was discussed as risk factors in the qualitative analysis. It was seen that mother-in-laws may complain about the women to their sons until they beat and/or yell at them. This pattern further reflects the cultural expectation, or at least the attitudes of women in the previous generation, that physical and emotional violence is normative in marriage. Perhaps the mother-in-law had similar experiences with her spouse and now feels she deserves to perpetuate the culture of spousal violence in the next generation. Community members, as well, were implicated in encouraging violence, such as the woman who describes shame from neighbors laughing at her husband's degrading comments. These results are consistent with the NHFS-3, which identifies domestic violence as accepted by both men and women in Indian communities (Kimuna et al., 2013). Therefore, interventions targeting domestic violence could benefit from involving the family and communities.

Disagreements over reproductive decisions and childbearing are associated with violence. Qualitative data indicates that reproductive disagreements can trigger physical, sexual, and emotional violence. Women report abuse both when they are unable to conceive or have unwanted pregnancies. A wife may feel pressure to bear children, especially a son, as this is her role as a woman. Again, the husband has the role of provider, and especially in low socioeconomic settings, expenses related to childbirth and child rearing may challenge his ability to provide sufficient resources. If either partner struggles to fulfill his or her expected role, this failure to meet expectations can be a cause of stress and increase the risk of violence. This association is consistent with studies that show that women in India are more at risk for abuse if they are childless or have a large number of children (Dala, 2012, Kimuna et al., 2013, Sabri et al., 2014, Babu and Kar, 2010, Patel and Khan, 2014). Analysis of NFHS-3 data in the literature found that the least abused women had 1-2 children (International, 2007); with this family size the couple has produced offspring but is less stressed economically than larger families.

Who decides the method of contraception for the couple is also statistically associated with emotional violence, marital control, and violence in general. More violence is seen in women

who make decisions alone about birth control; their risk is increased over those who make decisions as a couple, with the least violence seen if the men make contraceptive decisions alone. These findings may seem contradictory to the finding that women's empowerment to make purchasing and family size decisions is protective for violence. However, a woman deciding on contraception alone is less likely a measure of empowerment and more likely an effect of abuse. This pattern is seen in the qualitative data analysis, as well as previous studies from India, the U.S. and South Africa that show that abused women are more likely to use contraception secretly (Patel and Khan, 2014). There are several possible reasons; first, bearing more children may increase the couple's financial stress, which can increase abuse. Also, women dealing with the emotional distress of abuse may feel less equipped to raise children. In addition, if men see their role as the family decision-maker, they may not consider the wife's wishes regarding family size. This pattern is seen in the qualitative data; for example, with the woman who worries her husband will beat her if he found out about her contraceptive use. Also, the only mention of condom use in the qualitative data was by husbands who were not abusive. Since a woman making contraceptive decisions alone is more likely to experience violence, asking who in the couple makes contraceptive decisions could be used in screening for violence in health care or other settings where contraception is discussed.

Dyspareunia was also statistically associated with increased sexual violence, which is consistent with Campbell's meta-analysis that reports pain with intercourse as one health effect of violence (2002). Pain with sexual intercourse could be either a cause or an effect of sexual violence: women who experience sex as painful may consent to sex less often; therefore, husbands may turn to force in order to have sex. In addition, sexual abuse may cause pain, either from trauma, psychosomatic pain, or genital tract infections. Pain with sex was discussed in the qualitative interviews, but women did not connect it with sexual violence. This pattern may be because forced sexual activity is seen by many women as normative and expected.

Extramarital sex was also identified as a risk factor by both qualitative and quantitative data analysis. Men's extramarital sex was significantly associated with increased marital control and any violence. In the interviews, women talked of stress caused by extramarital sex that led to violence. Previous studies had also shown that men with multiple sexual partners were more likely to perpetrate abuse (Kimuna et al., 2013). This trend may be due to lack of emotional connectedness to a wife if she is not one's primary sexual partner. Husbands may have less respect for wives that do not satisfy them sexually, since women are expected to please their husbands. Women also described that they allowed sexual abuse because they wanted to prevent their husbands from going to other women. This attitude is consistent with the cultural gender norms that say a woman must please her husband and bear children. Therefore, forced sex is frequently viewed as a wife's conjugal duty, available whenever the husband demands it.

In addition, men spending time away from home for work reasons was also found to be significantly associated with sexual violence. In marriages characterized by physical separation, a husband may have less emotional connectedness to or concern for his spouse, which could lead to abuse. It also provides opportunities for men to have extramarital sex. Furthermore, a man who is absent may also feel insecure about his role as head of the household, and violence can allow a man to demonstrate dominance and re-establish his culturally-expected gender role.

Religious activity is identified as a risk factor in the qualitative analysis. In the interviews, women report religious leaders and communities endorsing traditional gender roles, which include male dominance. The majority (82%) of the study population is Muslim, and in the NFHS-3, Muslim religion was associated with increased violence (Kimuna et al., 2013). In this study, religious service attendance itself was not significantly associated with violence. However, men carrying home messages from Imams relating to gender equity after attending religious services was found as a protective factor resulting in decreased emotional violence. An initiative in these communities taken on by the RISHTA project (Schensul et al., 2009) involved encouraging gender equity messages from religious leaders. Since this thesis used baseline data,

these results reflect that the presence of religious institutions spreading gender equity messages was already effective means to decrease violence, even before this intervention. Men's religious activity could therefore either be either a risk factor if traditional gender roles are encouraged, or it could decrease abuse if religious leaders or institutions address women's issues. Religious leaders or religious groups may be an effective resource to address abuse because they help shape community values.

### Protective Factors

Responding well to conflict was strongly associated with decreased violence. Women who practiced all effective behaviors in response to conflict with husbands had a 5-fold decreased odds of any violence, 100-fold decreased odds of emotional violence, and 33-fold decreased odds of marital control compared to women who practiced all ineffective behaviors in response to verbal arguments with husbands. Similarly, the qualitative data shows examples of women who calmly respond to conflict and diffuse situations that could lead to violence. While women's response to violence may be related to natural temperament, conflict management strategies can also be learned. Conflict resolution education for women or couples could be an effective intervention to decrease one's risk of violence. Group couples' intervention was a strategy used later by the RISHTA program (Schensul et al., 2009). Also, identifying or creating systems of support in the community where a woman can seek help may allow a woman to better manage marital conflict, since seeking help from the community was one of the effective behaviors used in the scale. Overall, increasing a woman's conflict management skills could be a powerful tool for decreasing domestic violence.

Having a positive support network also independently decreases a woman's risk of violence. Neighbors and an NGO were mentioned in the interviews as places women went for support from abuse. Having received help from a local NGO was also statistically associated with decreased physical violence. This decreased risk could be because the NGO provided

assistance directly regarding abuse; however, the nature of the assistance received was not specified in the survey question. NGO interventions in the community may be an effective means to increase a woman's support in the community and directly address domestic violence.

Women's poor health was also associated with decreased domestic violence in the qualitative data. The literature describes many health problems that result from violence (Subaşı, 2001, McCaw et al., 2007, Campbell, 2002, Riecher-Rössler and Garcia-Moreno, 2013); at the same time, if a woman has a health condition unrelated to violence, this may protect her from abuse. The temporal nature of the relationship between poor health and abuse may explain why no significant association was seen between women's health and violence in the quantitative data; women experiencing poor health at baseline may be protected from violence, while poor health is also be a result of abuse. Another significant finding related to women's health was that pain with intercourse is associated with increased sexual abuse, but as discussed above, this symptom can be both a cause and effect of abuse. More specific questions about the time of illness and symptoms in relationship to abuse may further clarify the association between poor health and violence in future quantitative studies.

Women's empowerment to make purchasing and family size decisions was also associated with decreased violence. This finding may seem contradictory to earlier studies, in which measures of women's empowerment in patriarchal societies were associated with more violence. For example, women in India participating in education and training programs (Rocca et al., 2009) and employed women (International, 2007) experienced more violence. However, an earlier study also demonstrated that stronger patriarchal attitudes in the community were associated with increased domestic violence (Jejeebhoy, 1998). A common explanation for the results found in this study is that violence often results from perceived deviations from expected gender norms. Decreased violence with increased empowerment fits into this paradigm if empowerment to make decisions is also associated with less rigid expectations regarding gender roles. Instead of a cause and effect relationship explaining the association between greater

empowerment and less violence, perhaps both variables result from less patriarchal attitudes in these households. Examining the relationship between attitudes toward gender roles, empowerment, and violence in future studies would be helpful for clarifying this relationship.

### Conclusions

Domestic violence is a public health concern in India, and abuse is very prevalent in the study population. Several risk and protective factors that could inform targeted interventions aimed at decreasing domestic violence were identified, and most are related to cultural attitudes about male and female roles in the household. In this patriarchal culture, addressing domestic violence is challenging because it is often accepted or unrecognized. In a setting of firm and patriarchally-defined gender roles, violence is used to re-establish household dynamics when one party deviates from expected behaviors in a marriage. When a husband fails as provider, violence is a demonstration of male authority. When a wife does not adequately manage matters in the home, including pleasing her husband and bearing children, violence is a mode of readjustment. Family characteristics that hinder a man or woman's ability to fulfill cultural expectations were identified as risk factors for violence, such as financial struggles, alcohol use, men's unemployment, women's employment, and extramarital sex. Factors external to the couple themselves that increase the risk of violence were entities that strengthened traditional views of gender roles, including extended family members, religious institutions, and neighbors.

On the other hand, protective factors, such as interactions with NGOs or religious groups discussing women's issues, may foster less rigid family structuring. Similarly, characteristics of couples that were associated with decreased violence, such as responding calmly to arguments and allowing women to make more decisions, were also consistent with less rigid gender norms.

Therefore, one approach to targeting domestic violence could be to address the factors that are intrinsic to the couples themselves, such as socioeconomic factors, substance use, conflict management, and sexual health. Having strategies for responding to verbal disagreements stands

out as a powerful means to decrease one's risk of violence. Education regarding conflict management could be one effective intervention for protecting women from violence.

Another approach could be to address external factors that influence cultural gender norms, such as community groups, religious groups, or extended families. Addressing outside factors may be a more lasting and effective means to address violence, as they create an environment that can be either supportive for violence or against violence for many in a community. For example, religious communities siding with violent husbands were identified, and these were associated with increased abuse. However, when men heard more gender equitable messages from religious leaders and conveyed these messages to their wives after attending religious services, this communication was associated with decreased abuse. Religious institutions are an example of forces in the community that shape cultural norms. Community authorities and leaders are important resources to involve in interventions because they have the authority to redefine culturally acceptable family roles.

A woman's social network is also an external factor that can put her at risk or protect her from violence, depending on the nature of a woman's community interactions. This study shows that neighbors or extended family can encourage violence, but women's involvement with local NGO's or seeking help from neighbors or community groups are also protective factors. Perhaps possible interventions could focus on increasing social support for women in the community, either in the form of organizing structured community groups or engaging neighbors and family in domestic violence education. Overall, working with the forces in the community that shape cultural values may be the most effective means to address domestic violence because patriarchal gender norms provide a foundation upon which domestic violence is expected and justified.

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