Correlates Of Gender-based Physical Violence In Peri-Urban Area Of Chandigarh. India

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Citation

N Agarwal, D Kumar, H Swami, R Kumari. *Correlates Of Gender-based Physical Violence In Peri-Urban Area Of Chandigarh. India*. The Internet Journal of Health. 2008 Volume 9 Number 1.

Abstract

Objectives: (1) to explore the prevalence and nature of gender based physical violence among women in slum population of UT Chandigarh (2) to understand factors contributing towards physical violence (3) to explore the perceived consequences of violence on women's health (4) to examine the coping mechanism adopted by women while facing the violence. Setting: Slum population of UT Chandigarh, India. Participants: Married women in reproductive age willing to participate in the survey. Sample size: 294 respondents by complete enumeration in the selected area. Study Variables: Age, educational status, religion, age at marriage, literacy, socio-economic status, and various aspects of violence like type of violence, perceptions regarding reasons of being victim of violence, coping mechanism, perceived consequences of physical violence etc. Statistical Analysis: Student's t-test, Chi square test, Odds ratios along with their confidence intervals, and logistic regression model for predicting risk factor of physical violence. Results: About 40% married women in the reproductive age suffered from violence mainly by their husbands. Physical violence varied from slapping (56.9%), physically hurt (33.6%), and kicking (9.5%). Most of the women (63.8%) were victim of violence more than once in a month. Elderly women faced violence more as compared to younger women. Husband's short temper (27.6%), alcohol addiction (21.5%) and disinterest of respondents in sexual activities (9.5%) were most frequently reported perceived reasons. Sex related consequences of violence were mainly in the form of forced sexual act experienced by 82.8% respondents. Elderly females irrespective of marital duration, SES, literacy status, and other factors were at higher risk of physical violence.Suggestions: Gender based violence should be dealt as a psychosocial problem apart from a medical problem. Risk of physical violence against women cannot be lowered merely by improving female literacy and SES. There is a need of some further community-based psychosocial interventions to cope with Indian situations to tackle the problem.

INTRODUCTION

Violence against women is a worldwide phenomenon, rooted deep in its tradition most pervasive and yet the least recognised human rights abuse in the world. The World Health Organization defines domestic violence as “the range of sexually, psychologically and physically coercive acts used against adult and adolescent women by current or former male intimate partners” [1]. Violence against women include: 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[2]. World-wide one of the most common form of violence against women is abuse by their male partners. Violence against women, by an intimate partner includes physical aggression, psychological abuse, forced intercourse and other forms of sexual coercion, and various controlling behaviors[3]. This study found that 10% to 69% of women reported that they had experienced physical violence from a male partner during their life time. Lifetime intimate partner violence is reported to be 43% in China[4]. Domestic violence occurs in all countries and transcends social, economic, religious and cultural groups. There are possible linkages between domestic violence and a range of adverse physical, mental, and reproductive health outcomes also[3567]. A recent community -based study[8] give an interesting detailed account of individual and community level influences on domestic violence in Uttar Pradesh, North India. In Indian context, some studies[910111213] conducted mostly in hospital set-up gave varied results in different populations on violence against women. Present community-based study was conducted in peri-urban area of UT, Chandigarh. India with the objectives: (1) to explore the prevalence and nature of domestic violence among women in slum population of UT Chandigarh (2) to understand factors contributing towards domestic violence (3) to explore the perceived consequences of violence on women's health (4) to examine the coping mechanism adopted by women

while facing the violence.

METHODS

This cross-sectional study was conducted in 2005-06 at Rural Health Training Centre (RHTC) attached with the Department of Community Medicine, Government Medical College, Chandigarh, India. A total population of about 3000 in peri-urban area attached with the RHTC and surrounding slum population was covered. All the households in the study area were enumerated and married women in reproductive age willing to participate in the survey were included as respondents. Information on background characteristics like age, age at marriage, literacy, socio-economic status etc, and various aspects of physical violence like type of violence experienced during last one year, perceptions regarding reasons of being victim of violence, coping mechanism, perceived consequences of physical violence etc was collected. Verbal consent from respondents was taken and confidentiality of individual responses was ensured following Ethical Guidelines of Helsinki [13]. Respondents were interviewed in privacy and they were free to withdraw at any stage of interview if they wish. A total of 296 respondents gave consent to participate in the survey and only a small proportion of non- respondents was observed. Non-response was mainly due to shyness and hesitation in sharing problems. Data were analysed using Student's t-test, Chi square test, and Odds ratios along with their confidence intervals. Logistic regression model was also used for predicting risk factor of physical violence. Data were analysed using SPSS -12 Software.

RESULTS

Overall mean age of 294 respondents interviewed was 28.66 years and more than half (53.4%) were between 26 and 35 years of age and majority of them (70.5%) had been married for more than 5 years. Means of age and marital durations of women who faced physical violence were significantly higher (P<0.001) than those of women who never faced physical violence in their married lives. Nearly 25% women were having children more than 3 (Table - 1).

Social characteristics of respondents are shown in Table-2. Large proportion of women was belonging to a nuclear family (86.7%), low socio-economic status (64.6%) and mostly they were housewives (96.9%). Literacy was significantly associated with facing of physical violence (χ_2 = 9.87, P = 0.04). Illiterate women faced physical violence more as compared to literate women. Number of children (χ^2 = 1.10, P = 0.29), work status (χ_2 = 1.01, P = 0.31), type of family (χ^2 = 0.02, P = 0.89), and SES (χ^2 = 0.98, P = 0.32) were not found to be significantly associated with experiencing physical violence.

Among all respondents, 116(39.4%) faced some form of physical violence sometimes during their married life Respondents who faced physical violence were asked about type of violence faced. Physical violence varied from slapping (56.9%), physically hurt (33.6%), and kicking (9.5%). Most of the women (63.8%) were victim of physical violence more than once in a month. Husbands were the most frequently reported perpetrators of violence reported by 98 (84.5%) respondents. Physical violence was faced even during pregnancy by 88 (75.9%). Neighbours were also reported to be aware of violence in 99 (85.3%) cases (Table-3).

Women, who reported facing of physical violence sometime in their married life were also asked what they perceived as the commonest reasons for violence in their household. Husband's short temper (27.6%), alcohol addiction (21.5%) and disinterest of respondents in sexual activities (9.5%) were most frequently reported perceived reasons. In spite of being victims of physical violence, only 42 (36.2%) women were the opinion that only husbands were fully responsible for it. Majority of them 72 (62.1%) blamed themselves also to some extent and only 2 (1.7%) respondents blamed other members. The sex related consequences of physical violence were reported in the form of forced sexual act by partner (82.8%), STD among respondents/spouses (17.2%), and extra marital affair of husbands (10.3%) and suspicion of extra marital affair of respondents by their husbands (18.7%). Other perceived consequences of physical violence were abortion (14.8%), sense of fear from partner (51.7%), and victimization of children (34.5%) (Table-4).

On being asked about coping mechanism against violence, most of the women reported remain to be passive by (60.3%) and quitting the house temporarily (20.7%). Few women had utilised some protection by interference of family members (9.5%) while some opted counter physical action (16.4%) as coping mechanism. In spite of physical violence respondents stayed with their husband mainly for the sake of future of the children (61.2%), sake of marital bond (35.3%) and social compulsion (15.6%) (Table-5).

On the basis of multiple logistic regression analysis, age above 25 years, a single factor came out to be a highly significant (P<0.001) risk factor for physical violence (Table-6).Literacy, which was significantly associated with

physical violence on the basis of bivariate analysis, lost its significance in multivariate logistic regression analysis. Other factors like working status, SES, and number of children in family were not found significant risk factors for physical violence.

Figure 1

Table 1: Reproductive Characteristics Of Respondents By Physical Violence

Characteristics	Physical Violence				Total (N=294)	
	Experienced (N=116)		Not experienced (N=178)			
	No	%	No	%	No	%
Age (years)						
18 – 25	15	(16.7)	75	(83.3)	90	(30.6)
26 – 35	70	(44.6)	87	(55.4)	157	(53.4)
36 – 45	31	(65.9)	16	(34.1)	47	(16.0)
Mean ± SD	**30.99 ± 5.97**		**27.15 ± 5.42**		**28.66 ± 5.94 (P<0.001)**	
Marital Duration						
Below one year	1	(6.7)	15	(93.3)	16	(5.4)
1 – 5	16	(22.5)	55	(77.5)	71	(24.1)
6 – 10	43	(39.4)	66	(60.6)	109	(37.1)
11 – 15	22	(50.0)	22	(50.0)	44	(15.0)
15+	34	(63.0)	20	(37.0)	54	(18.4)
Mean ± SD	**12.08 ± 6.52**		**8.26 ± 5.84**		**9.77 ± 6.39**	**(P<0.001)**
Number of Children						
0 - 3	91	(41.2)	7	(58.8)	221	(75.2)
4 – 5	25	(21.5)	48	(78.5)	73	(24.8)
						P = 0.29

Figure 2

Table 2: Social characteristics of respondents by physical violence

Characteristics	Physical Violence				Total (N=294)	
	Experienced (N=116)		Not experienced (N=178)			
	No	%	No	%	No	%
Literacy Status						
Illiterate/Just Literate	62	(43.7)	80	(56.3)	142	(48.3)
Below Class V	18	(34.0)	35	(66.0)	53	(18.1)
Class VI-VIII	16	(25.8)	46	(74.2)	62	(21.1)
Class IX-X	15	(53.6)	13	(46.4)	28	(9.5)
Class XII & Above	05	(55.5)	04	(44.5)	09	(3.1)
						P = 0.04
Work Status						
Housewife	111	(38.9)	174	(61.1)	285	(96.9)
Working	5	(55.5)	4	(44.5)	9	(3.1)
						P = 0.31
Type of Family						
Nuclear	101	(39.6)	154	(60.4)	255	(86.7)
Joint	15	(38.5)	24	(61.5)	39	(13.3)
						P = 0.89
Socio-economic Status						
Low	71	(37.4)	119	(62.6)	190	(64.6)
Middle/High	45	(43.3)	59	(56.7)	104	(35.4)
						P = 0.32

Figure 3

Table 3: Pattern Of Physical Violence Experienced By Women

Pattern	Frequencies (N=116)	
	No.	%
Type of Physical Violence		
Slapped	66	(56.9)
Kicked	11	(9.5)
Physically Hurt	39	(33.6)
Frequency		
Often	74	(63.8)
Once a month	20	(17.2)
Occasional	22	(18.9)
Involvement in Physical Violence		
Husband only	98	(84.5)
Other family members	11	(9.5)
Both	07	(6.0)
Physical Violence ever faced during pregnancy		
Yes	88	(75.9)
No	28	(24.1)
Neighbor's Knowledge		
Yes	99	(85.3)
No	17	(14.7)

Figure 4

Table 4: Reasons, Responsibility, And Consequencies Of Physical Violence, Perceived By Women

Reason	No. of Respondents (N=116)	
	No.	%
Husband's short tempered	32	(27.6)
Alchol intake of husband	25	(21.5)
Lack of respondent's interest in sex	11	(9.5)
Inlaws influence	09	(7.8)
Drug addiction of husband	08	(6.9)
Small family issues	07	(6.0)
No male child	07	(6.0)
Inefficiency in domestic work	05	(4.3)
Extra marital relation of husband	03	(2.6)
Unemployment	03	(2.6)
Dowery demand	02	(1.7)
Lack of understanding	02	(1.7)
Responsibility		
Husband is fully responsible	42	(36.2)
Husband is more responsible	56	(48.3)
Equally responsible	09	(7.8)
Only familymembers are responsible	02	(1.7)
Self blaming	07	(6.0)
Sexual Consequences		
Forced sex	96	(82.8)
Suffering from STD/RTI	20	(12.7)
Extra marital affair of husband	12	(10.3)
Extra marital affair of suspicion respondents	22	(18.7)
Other Consequences		
Abortion (N=88)	13	(14.8)
Children became Victims (N=116)	40	(34.5)
Afraid of Partner	60	(51.7)

* **Multiple Response**

Figure 5

Table 5: Coping Mechanisims And Reasons Of Staying With Husband Against Violence Adopted By Women Experiencing Physical Violence

Coping Mechanism/ Reason of staying	Frequency (N=116)	
	No.	%
Coping Mechanism*		
Passive mechanism / no reaction	70	(60.3)
Quit the place temporarily	24	(20.7)
Seek Inlaw's interventions	11	(9.5)
Seek neighbours / others interventions	07	(6.0)
Counter physical action	19	(16.4)
Counter arguments	11	(9.5)
Reasons of staying with husbands*		
For future of children	71	(61.2)
For the sake of marital bonds	41	(35.3)
Social compulsions	18	(15.6)
No other shelter	07	(6.0)
Destiny	08	(6.9)
Others	03	(2.6)

* **Multiple Responses**

Figure 6

Table 6: Logistic Regression Analysis Of Risk Factors Of Physical Violence

Risk Factor	Value of β	SE	Odds Ratio estimate exp (β)	P-Value
Dummy Variable	0.7446	0.2138	-	-
Age above 25	0.5968	0.2058	1.8163	P<0.002
Marital Duration Above 5 years	0.2675	0.2070	1.3067	P>0.10
Middle / High SES	0.0694	0.1322	1.0718	P>0.10
Nuclear family	-0.1209	0.1920	0.8862	P>0.10
Illiteracy	-0.441	0.1299	0.9568	P>0.10

DISCUSSION

This study explores the extent of physical violence against married women and its associated factors. About 40% married women in the reproductive age suffered from physical violence mainly by husbands. Women in the higher age groups faced physical violence more as compared to younger women. The study also explores the reasons, types of violence, its perceived consequences on reproductive health and coping mechanisms adopted by women. Physical violence resulted mostly in terms of forced sex which is itself a form of sexual abuse.

The study included respondents representing all age groups within reproductive age mostly housewives of low SES from nuclear families and. Husband came out to be the principal perpetrator in our study. Frequent slapping by husband was the most common form of physical violence. Short temperament and alcohol addiction of husbands were the most common perceived reasons. Sex related issues and socio-economic reasons were not so common reasons responsible for physical violence according to respondents.

Respondents also blamed themselves to some extent but husbands were blamed more responsible for physical violence. Blaming themselves for physical violence by respondents reflects the traditional image of Indian housewives. Respondents reported several adverse reproductive health related outcomes, as consequences of physical violence like forced sex, abortion, fear from partners etc. No counter action to violence was adopted by most of respondents to cope with the physical violence situations. Respondents opted to quit the place temporarily at the time of violence in most of cases or interventions of family members and neighbours resolved matters in some cases. For the sake of future of children and maintaining marital bonds respondents stayed with their husbands in spite of physical violence.

Females in the higher age groups, irrespective of marital duration, SES, literacy status, and other factors were at higher risk of physical violence against the usual hypothesis that younger and uneducated women are more prone to physical violence due to some added risk factors like dowry demands etc in Indian community. Physical and sexual violence was found associated with the individual-level variables of childlessness, economic pressure and intergenerational transmission of violence[8]. Higher SES was found to be protective against physical violence in this study. Risk factors of intimate partner violence in the present study also do not agree with those among women in China[4]. Younger age, low literacy and low SES were among multiple risk factors among Chinese women unlike among Indian women. Probable reason of SES not found a significant correlate of violence in the present study may be that although the root causes of domestic violence are same but its expression varies significant according to SES. It may be more hidden in higher SES. Sexual violence and psychological violence may be more common than physical violence among women in high SES category as compared to their counterparts.

The prevalence rate of physical violence (39.6%) found in the present study is higher as compared to only 28.4% among pregnant women admitted in the antenatal ward of the hospital in the same city[9]. In a northern Indian district, 42-48% prevalence rate of domestic violence has been reported[15]. In Karachi, Pakistan this rate has been reported 34% among patients attending out patient clinics[16]. In a hospital-based study about 40% prevalence of history of abuse is reported[17]. Physical violence in intimate relationships is accompanied with abortion (53%), anxiety /

depression (42%)[16]. Nature of violence is also likely to be influenced by socio-economic conditions of women whereas, in the present study SES does not come out to be a significant factor influencing physical violence. Higher SES was found to be protective against physical violence but not sexual violence in a recent study[8].

In our study husbands came out to be the main perpetrators and their addictions came out to be one of common reasons of violence in agreement with several other studies[9,19]. Addiction to alcohol consumption came out to be the second most reason after short-temperament of husbands in the present study. However, dowry demand does not come out to be a reason responsible for physical violence in our study unlike other studies in Indian context [12,19].

This study conducted in an Indian community rules out some chances of selection bias present in hospital-based studies. This study also explores prevalence and different nature of physical violence existing in specific community of peri-urban and slums mainly consisting migratory population. Different types of perceived reasons and consequences of physical violence, and coping mechanisms adopted by victims in Indian situations unlike in some developed countries are also suggestive of developing some specific strategies to tackle this important public health problem having important reproductive health concerns. Higher prevalence rate of physical violence found in the present study is consistent with the finding of other studies. This study supports the need of developing community-based strategies including psychosocial interventions to tackle the problem of physical violence.

There are a number of limitations to the present study. Violence against women includes physical, sexual, psychological and economic abuse. This study was confined only to physical violence and several other aspects of gender-based violence other than physical could not be assessed due to some difficulties faced in conducting interviews on such issues. Majority of women who suffer any physical aggression generally experience multiple acts over time. Prevalence of physical violence reported in the present community-based study may also suffer under-estimation due to hesitation, shyness, reluctance and embarrassment in reporting such issues by respondents in spite of taking all possible measures to deal such issues. The study has also limitations in terms of not studying partner related characteristics as potential correlates of domestic violence. Reasons of violence may also vary with episodes of violence whereas this study reports only the most common reasons. Timing of first episode of violence and its frequency also could not be asked. The study also lacks in establishing temporal ordering between violence and related factors considered.

This study has several potentially important implications related with public health policy and practices and aims at reducing physical violence against women. These findings will not only be helpful in developing strategies to reduce violence against women but will also address several issues related with their reproductive health. Women irrespective of their socio-demographic, economic and other conditions suffer from physical violence due to some avoidable reasons in Indian communities. Physical violence against women may have some serious consequences in terms of reproductive health problems. Health of children of women victim of domestic violence may also be affected adversely and may have even intergenerational repercussions. Risks of physical violence cannot be lowered merely by improvements in educational levels of respondents and their SES. Health policies should incorporate some psycho-social interventions to prevent violence in order to improve reproductive and child health. Problem of gender-based violence must be understood in its socio-cultural context to determine its root causes.. Clinicians should develop some tools to identify the root causes of this complex phenomenon. Women may have health problems as consequences of domestic violence, which remain, to a large extent unattended. Opportunity of imparting these interventions while providing health care delivery for various health problems should also be availed.

Further community based in -depth studies addressing all aspects of gender based violence with more sophisticated interviewed techniques are desirable in order to have actual estimates of the problem and its adverse reproductive health outcomes. Effects of psychosocial interventions in reducing reproductive health problems should also be studied. Future research is also needed to establish the other health related impacts of violence.

CONCLUSIONS AND SUGGESTIONS

High prevalence rate of physical violence indicates that the problem should be dealt as a public health problem. Risk of physical violence against women cannot be lowered merely by improving female literacy and SES. There is a need of some further community-based psychosocial interventions to cope with Indian situations to tackle the problem.

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References

1. Violence Against Women Geneva, Switzerland: World Health Organization: 1996. WHO document FRH/WHD/96, 27.
2. Heise, L. (1998). Violence Against Women, An integrated Ecological Framework, U.S.A.: Sage Publications.
3. Krug EG, Dalhberg LI, Mercy JA, Zwi AB, Lozano R : In World Report on Violence and Health. Genewa, Switzerland, World Health Organization, 2002:149-181.
4. Xiao Xu, RN Fengchuan Zhu, Partricia O' Campo et al. Prevalence of and Risk Factors for Intimate Partner Violence in China, American Journal of Public Health , 2005, 5,
5. Heise L, Ellsberg M, Gottemoeller M. Ending violence against women. Baltimore, Md: Johns Hopkins University School of Public Health, Population Information Program; 1999. Population Reports Series 1, No. 11.
6. Moore M. Reproductive health and intimate partner violence. International Family Planning Perspectives. 1999; 31:302-306,312.
7. Campbell JC. Health consequences of intimate partner violence. Lancet, 2002; 359:1331-1336.
8. Michael A, Koenig et al. Individual and Contextual Determinants of Domestic Violence in North India. American Journal of Public Health, Jan 2006; 96(1):132-138.
9. Khosla AH, Dua D, Devi L, Sud SS. Domestic violence in pregnancy in north Indian women. Indian Journal of Medical Sciences, May 2005; 59(5): 195-199.
10. Peedicayil A, Sadowshi LS, Jeyaseelan L, Shanker V, Jain D, Suresh S et al. Spousal physical violence against women during pregnancy. BJOG 2004; 3:682-7.
11. Martin SL, Tsui AO, Maitra K, Marinshaw R. Domestic violence in Northern India. American Journal of Epidemiology, 2000;150:417-26.
12. Rao, Vijayendra. Wife-beating in Rural South India: A Qualitative and Econometric Analysis, Social Science and Medicine, 1997; 44 (8):1169-1180.
13. Rathore AM, Tripathi R, Arora A. Domestic violence against pregnant women interviewed at a hospital in New Delhi: International Journal of Gynaecology and Obstetrics 2002;(76):83-85.
14. World Medical Association Declaration of Helsinki, 1996 version.
15. Jeejebhoy JS. Wife-beating in rural India: a husband's right evidence from survey data. Economic and political weekly 1988; April 11:855-62.
16. Fikree FF, Bhatti LI. Domestic violence and Health of Pakistani women. International Journal of Obstetrics and Gynaecology, 1999 (65):195-201.
17. Frankly H Geary, Jr. Cheryl B. Wingate. Domestic violence and Physical abuse of women: The grady memorial hospital experience: American Journal of Obstetrics and Gynaecology,1999;(81): S17-S21.
18. Camp bilk J, & Soeken K. Forced sex & intimate partner violence: effect on women's risk and women's health, violence against women 1999; 5(9):1017-1035.
19. Jejeebhoy SJ, Cook RJ. State accountability for wife-beating: the Indian challenge. Lancet 1997; 349:S110-S112.

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