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Original Research Article

Domestic violence in rural currently married women: effects on utilization of reproductive and maternal health services

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ABSTRACT

Background: Domestic violence remains a public health concern in India due to its high prevalence and adverse effects on pregnancy outcomes. Domestic violence in low and middle income countries has emerged as a priority among researchers and policy makers who are primarily concerned with women s health and empowerment. The study aimed to assess the relationship between domestic violence and women's use of reproductive and maternal health services.

Methods: The present study was conducted among currently married rural women in reproductive age group (15-49 Years). Four villages in Kot Balwal Block were selected randomly and all the currently married women who were willing to give informed verbal consent were administered the questionnaire. The questionnaire was pilot tested by the authors. Data was analysed using proportion sand chi square test was used as a test of significance.

Results: Prevalence of domestic violence was reported to be 49.12%. Regarding empowerment, the results revealed that while 65.3% of the respondents were able to decide on their health, only 20.7% had say in household purchases. Attitude towards wife beating was strongly negative as 95.7% rejected wife beating. Levels of education, exposure to media, intake of alcohol by partners and spousal age difference were statistically significant ($p<0.05$) in relation to use of reproductive and maternal health services.

Conclusions: The study has revealed that women's empowerment has a positive impact on use of reproductive and maternal health services. Multi-sector collaboration in initiating programs and interventions to improve women's empowerment, increase educational attainment and reduction of gender based violence should be a priority for the health planners.

Keywords: Domestic violence, Reproductive and maternal health services, Women empowerment

INTRODUCTION

The issue of domestic violence against women in resource poor countries has emerged as a growing concern among policy makers concerned with women's health and empowerment. World Health Organisation (WHO) has defined 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", illustrating that domestic violence includes more than physical violence.[1] Estimates

suggest that the life time prevalence of partner violence falling between 23% and 49%.[2]

Maternal, newborn and child mortality skill remain the major public health problems in India. Estimates show that 2, 87,000 women die worldwide from complications of pregnancy and childbirth with 87% of these deaths occurring in sub Saharan Africa and South Asia.[3]

Access to modern contraceptive methods can avert 22-30% of maternal deaths while presence of skilled birth attendant during childbirth and emergency obstetric care can prevent up to 60% of maternal deaths and 40% of intrapartum related neonatal deaths.[4,5] Besides, women's empowerment, autonomy and decision-making power in family affairs including spending money have shown to positively influence the use of contraception, antenatal care, skilled birth attendant and vaccination services.[6-8]

Previous studies on the association between domestic violence and use of reproductive and maternal services had varied results. Studies in India, Bangladesh and Nepal have shown that women who experienced either physical violence alone or both physical and sexual violence have lower odds of receiving antenatal care compared with other women.[6,7,9] Kishore et al found no association between use of antenatal care and domestic violence.[10]

There have been quite a few studies on prevalence of domestic violence and influence of socio demographic characteristics on domestic violence in India but there was paucity of research on the association between domestic violence, women's empowerment and use of reproductive and maternal health services.

The present study explores the association of spouse violence, women's empowerment and various socio demographic characteristics related to health care seeking for family planning, antenatal care and delivery service in rural currently married females in Northern India. Authors hope that evidence so generated would help policy makers and providers increase women's utilization of reproductive and maternal health services by facilitating development of strategies to address the issues of domestic violence and women s empowerment.

METHODS

The present cross sectional study was conducted among the currently married women in the age group of 15-49 years in a rural area of Jammu district. Before the start of the study, due permission was sought from Institutional Ethical Committee of GMC Jammu.

The study was conducted in Kot Balwal block of Jammu district. This health block was divided into four zones viz East, West, North and South. Using simple random technique, one village was selected from each of these zones. Thus, four villages were selected randomly for the purpose of the current study. The study sample was the currently married females (15-49 years) who were administered the questionnaire. The questionnaire was developed by the authors and was pilot tested on a group of 20 rural women attending the OPD of a tertiary care hospital. After pilot testing, some modifications were incorporated before putting it finally to the use.

All the eligible women in the selected villages were enquired about the domestic violence. The term domestic violence in the context of current study meant if the respondent had ever experienced physical violence or sexual violence or both. Only those females who gave a positive history of domestic violence were further interviewed. At the onset of the interview, respondents were enquired about socio demographic characteristics like fertility, literacy, employment status, age at marriage, partners alcohol intake and age difference between the spouses.

Among the utilization of reproductive and maternal health services, the respondents were enquired about current use of modern contraceptive method, utilization of 4 or more antenatal care (ANC) visits and availability of skilled birth attend (SBA) during the most recent birth. The women who gave birth in the five years preceding the survey were enquired if they have received antenatal care for their most recent birth and the number of ANC visits. The respondents were further enquired about their participation in household decision making and attitude towards wife beating.

Statistical analysis

The data thus collected was tabulated and analysed. Frequency distribution and percentages of socio demographic and key outcome variables were examined. (Chi square test was used as test of significance and p value <0.05 were considered statistically significant.

RESULTS

During the course of the study, 570 rural currently married women were enquired about the history of domestic violence and of these, 280 women gave positive history of domestic violence. The prevalence of domestic violence was found to be 49.12% (280/570). So, these 280 currently married women with a positive history of domestic violence were administered the questionnaire.

Among the respondents, 43.57% were in 25-34 year age group while 35.35% were in 35-49 year age group. More than two-third were educated upto secondary or higher levels and only about one-third of them were employed. About 91% of the respondents had exposure to media and had married at age > 18 years. About half (49.2%) of the respondents had 1-2 living children and 31% had partners who consumed alcohol. Regarding spousal age difference, men were older in 90% cases and 60.4% respondents had a living son (Table 1).

Table 1: Distribution of currently married women interviewed for DV by selected socio-demographic characteristics (n=280).

Socio demographic variable		Number	Percentage
Age in completed years	18-24	59	21.07
	25-34	122	43.57
	34-49	99	35.35
Education level	Illiterate	27	9.64
	Primary	61	21.78
	Secondary or Higher	192	68.57
Employment status	Employed	92	32.85
	Not employed	188	67.14
Exposure to media	Yes	256	91.43
	No	24	8.57
Number of living children	0	12	4.28
	1-2	138	49.28
	>3	130	46.42
Age at marriage	<18 years	25	8.93
	≥18 years	255	91.07
Partners alcohol intake	Yes	87	31.07
	No	193	68.93
Spouse age difference	None	27	9.64
	Man older	252	90.00
	Women older	01	0.35
Has a living son	Yes	162	60.44
	No	106	39.56

Table 2: Distribution of CMW interviewed for DV by empowerment in family- decision making and usage of specific reproductive and maternal health services (n=280).

Question	Response	Number	%
Family Decision Making	Yes	183	65.36
	No	97	34.64
Decide on own health	Yes	58	20.71
	No	222	79.29
Decide on household purchases	Yes	129	46.07
	No	151	53.93
Decide on visiting relatives/friends			
Attitude towards wife beating	Yes	268	95.71
Rejects wife beating	No	12	4.29
Currently using a modern contraceptive method	Yes	176	62.86
	No	104	37.14
Has availed 4 or more antenatal visits during pregnancy	Yes	232	82.86
	No	48	17.14
Skilled birth attendant present during delivery	Yes	256	91.43
	No	24	8.57
Capable of taking a sick child to hospital	Yes	223	79.64
	No	57	20.36

The respondents were enquired about their empowerment in family as far as the decision making was concerned. 65.3% respondents were deciding on their own health, 79.2% had a say in household purchases while only 46.07% could decide on visiting a friend/relative.

An overwhelming 95.7% were rejecting wife beating. Among the utilization of reproductive and maternal health services, 62.8% respondents were using a modern contraceptive method while 82.8% had availed 4 or more antenatal visits during pregnancy.

Further 91.4% had skilled birth attendant (SBA) present during delivery and about 80% were capable of taking their sick child to the hospital (Table 2).

Table 3 shows that women's use of reproductive and maternal health services varies by socio-demographic characteristics.

The indicators like use of modern contraceptive methods, four or more antenatal care visits and delivery assisted by a skilled birth attendant varied in relation of socio demographic variables. For example, women in the age group of 18-24 years were using a modern contraceptive less than women in the age group 25-34 years.

Similarly, women in the age group of 25-34 years were having the maximum proportion (84.4%) of antenatal visits as well as presence of skilled birth attendant during child birth (96.7%) in comparison to other age groups.

Among other socio-demographic variables, levels of education, exposure to media, intake of alcohol by partner and spousal age difference were all significantly associated with use of reproductive and maternal health services by the respondents ($p<0.05$).

Empowered women who had a say on their own health care or visiting family/relatives were having significantly higher usage of modern contraceptive methods ($p<0.05$).

There was no association between women facing domestic violence and usage of reproductive and maternal health services (although the respondents who were rejecting wife beating were using all three of these services in higher proportion).

Also, those respondents who were capable of taking their sick child to a hospital were also using reproductive and maternal health services in higher proportion compared to the females who were unable to take their sick child to a hospital (Table 4).

DISCUSSION

The prevalence of domestic violence was found to be 49.12%, which was consistent with the results of Hindin et al and Rahman et al in Kenya and Bangladesh respectively.[6,11] A lower rate to the tune of 39% was reported by Msuya SE et al in Tanzania.[12]

Table 3: Relationship of women's use of reproductive and maternal health services by selected socio-demographic characteristics.

Variable	Total	Current use of modern contraceptive method (n=176)		P value	4 or >ANC visits (n=232)		P value	Skilled birth attends during delivery (n=256)		P value
		Yes (%)	No (%)		Yes (%)	No (%)		Yes (%)	No (%)	
Age (years)										
18-24	59	38(64.41)	21(35.59)	0.00	52(88.13)	07(11.87)	0.00	55(93.22)	04(6.78)	0.00
25-34	122	92(75.40)	30(24.59)		103(84.42)	19(15.57)		118(96.72)	04(3.28)	
34-49	99	46(46.46)	53(53.54)		21(21.21)	78(78.79)		83(83.83)	16(16.16)	
Education level										
Illiterate	27	9(33.33)	18(66.67)	0.00	20(74.07)	07(25.93)	0.00	21(77.78)	06(22.22)	0.01
Primary	61	31(50.81)	30(49.18)		42(68.85)	19(31.15)		54(88.52)	07(11.48)	
Secondary or Higher	192	136(70.83)	56(29.17)		170(88.54)	22(11.46)		181(94.27)	11(5.73)	
Employment status										
Employed	92	86(93.47)	6(6.52)	0.00	80(86.96)	12(13.04)	0.20	88(95.65)	04(4.35)	0.07
Not employed	188	90(47.87)	98(52.13)		152(80.85)	36(19.15)		168(89.36)	20(10.64)	
Exposure to media										
Yes	256	166(64.84)	90(35.16)	0.02	220(85.93)	36(14.06)	0.00	242(94.53)	14(5.47)	0.00
No	24	10(41.67)	14(58.33)		12(50.00)	12(50.00)		14(58.33)	10(41.67)	
Number of living children										
0	12	04(33.33)	8(66.67)	0.06	08(66.66)	04(33.33)	0.10	06(50.00)	06(50.00)	0.00
1-2	138	92(66.67)	46(33.33)		120(86.95)	18(13.04)		128(92.75)	10(7.25)	
>3	130	80(61.53)	50(38.46)		104(80.00)	26(20.00)		122(93.84)	08(6.15)	
Age at marriage										
<18 years	25	16(64.00)	9(36.00)	0.90	15(60.00)	10(40.00)	0.00	16(64.00)	09(36.00)	0.00
>18 years	255	160(62.74)	95(37.25)		217(85.09)	38(14.90)		240(94.11)	15(5.88)	
Partners alcohol intake										
Yes	87	20(22.98)	67(77.01)	0.00	52(59.77)	35(40.23)	0.00	70(80.45)	17(19.54)	0.00
No	193	156(80.83)	37(19.17)		180(93.26)	13(6.74)		186(96.37)	07(3.63)	
Spouse age difference										
None	27	26(96.29)	01(3.70)	0.00	18(66.67)	09(3.33)	0.00	20(74.07)	07(25.93)	0.00
Man older	252	150(59.52)	102(40.48)		214(84.92)	38(15.08)		235(93.25)	17(6.75)	
Women older	01	00(0.00)	01(100.00)		00(0.00)	01(100.00)		01(100.00)	00(0.00)	
Has a living son										
Yes	162	85(52.46)	77(47.53)	0.00	142(87.65)	20(12.35)	0.51	157(96.91)	05(3.09)	0.29
No	106	91(85.84)	15(14.15)		90(84.90)	16(15.09)		99(93.39)	07(6.60)	

Table 4: Women's utilization of reproductive and maternal health services by their empowerment variables (n=280).

Variable		Current use of modern contraceptive method (n=176)			4 or >ANC visits (n=232)		Skilled birth attends during delivery (n=256)	
		Total	N	P value	N	P value	N	P value
Decision on own health	Yes	183	143(78.14)	0.00	151(82.51)	0.94	163(89.07)	0.68
	No	97	33(34.02)		81(83.50)		93(95.87)	
Decision on household purchases	Yes	58	46(79.31)	0.09	51(87.93)	0.72	52(89.65)	0.90
	No	222	130(58.55)		181(81.53)		204(91.89)	
Decision on visiting relatives/ friends	Yes	129	111(86.04)	0.00	112(86.82)	0.62	116(89.92)	0.86
	No	151	65(43.04)		120(79.47)		140(92.71)	
Rejects wife beating	Yes	268	168(62.68)	0.88	222(82.83)	0.98	244(91.04)	0.82
	No	12	08(66.66)		10(83.33)		12(100.00)	
Capable of taking a sick child to hospital	Yes	223	150(67.26)	0.13	202(90.58)	0.02	216(96.86)	0.15
	No	57	26(45.61)		30(52.6)		40(70.17)	

Despite a constant feature in the society, domestic violence was found not to be associated with any of the reproductive and maternal health service utilization indicators, current use of modern contraceptive methods, having four or more antenatal care visits during the most recent pregnancy and delivery assisted by a skilled birth attendant. These findings are in agreement with those reported by Msuya SE et al in Tanzania and Tuladhar et al from Nepal.[7,12] Kishor and Johnson didn't find an association between domestic violence and antenatal care use in seven of the nine countries reviewed in their study, but they did observe that domestic violence influenced the use of antenatal care during the first trimester.[10]

Lack of consistent associations between domestic violence and use of antenatal care or institutional delivery has been reported by Hindin et al.[11] In contrast Rahman et al reported from Bangladesh that women's experience of domestic violence was associated with 31% and 52% lower odds of utilising antenatal care during pregnancy and skilled birth attendant services during child birth respectively.[6] Hindin et al found that Rwandan women who had experienced domestic violence had 29% lower odds of delivering in the health facilities.[11] Meiksin R et al reported that overall women who experienced domestic violence were more likely than other rural women to have an unplanned pregnancy, fewer than four antenatal visits or a baby born smaller than average.[13] On the other hand Alio AP et al reported that women who had experienced domestic violence were significantly more likely to report that they had used contraception compared to women who hadn't experienced domestic violence.[14]

Among the women's empowerment indicators decision on her own health and decision to visit friends/relatives was associated with current usage of modern contraceptive methods. These results are congruence with Wado et al who also reported that decision making autonomy was positively associated with ever use of contraceptives among married women in Ethiopia.[8] Tuladhar et al from Nepal reported that highly empowered women were significantly more likely to have four or more antenatal visits during pregnancy compared to women with low/moderate empowerment.[7] However Msuya SE et al Tanzania found that women's empowerment was associated with usage of modern contraceptive, having four or more antenatal visits as well as use of skilled birth attendant during child birth.[12]

Use of contraception is a sensitive matter in most of the rural patriarchal societies and women most of the time needs consent from spouse before adopting a contraceptive method. To use health facilities during delivery, women need cooperation from their husbands in matters pertaining to travel and financial help in case of emergencies and health facility costs. So, strengthening women's empowerment should be a priority using mechanisms both inside and outside the health sector.

The socio-demographic variables that influenced women's utilisation of reproductive and maternal health services in the current study were age in years, education levels, exposure to media, partner's alcohol intake and spousal age difference. Consistent with the findings of the present study, results from the other developing countries have shown that educated women living in wealthier households and who live in urban areas have better utilisation of reproductive and maternal health services compared to rural and less educated women.[5,15,16] Need of the hour is for a multi-sectoral approach in addressing these factors to improve overall health and outcomes for women and their children.

The cross-sectional nature of the study doesn't allow the inference of causal relationships. A small sample size limited to a certain geographical area is another limitation. Domestic violence and utilization of reproductive and maternal health services rely on the respondents self-reporting and under reporting can occur.

CONCLUSION

The study has revealed that instead of domestic violence, it is women's empowerment which is related to the utilization of reproductive and maternal health services with empowered women having higher levels of service utilization. Utilization of services was affected by women's literacy, exposure to media, partners alcohol intake and spouse age difference. National Health Programs particularly related to mother and child welfare have contributed to better utilization of the services by the stake holders, even in rural areas, as the results of the current study have depicted.

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