

**School of Nursing and Midwifery
Centre for International Health**

**Intimate partner violence and common mental disorders in Indian
women – effects of autonomy, social support and spirituality**

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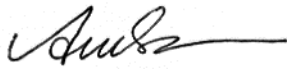
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Doctor of Philosophy
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Declaration

"To the best of my knowledge and belief this thesis contains no material previously published by any other person except where due acknowledgment has been made. This thesis contains no material which has been accepted for the award of any other degree or diploma in any university."

Signature:

A handwritten signature in black ink, appearing to be 'A. S. S.', written in a cursive style.

Date: 19th April 2013

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This thesis would not have been possible without the women that so generously and bravely answered my survey and allowed me a glimpse into their private world. I would hope that ultimately the results of this thesis will in some way benefit the women in my study as well as other women in similar situations.

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Abstract

Intimate partner violence (IPV) is a major public health issue in India, with prevalence rates ranging from 18-76%. The negative health effects of IPV are well established and include physical and mental issues such as broken bones, psychosomatic symptoms, and increased rates of sexually transmitted diseases, depression and post-traumatic stress disorder.

This study investigated the relationship between the different types of IPV (psychological, physical and sexual) and common mental disorders (CMD) in a group of Indian women from a low socio-economic area of Mumbai, India. Furthermore, the study investigated the effects of autonomy, experience of social support and spirituality on CMD outcomes in these women.

A cross sectional study design was followed using a modified version of the Demographic and Health Survey instrument and the short version of the General Health Questionnaire translated for use into Hindi and Marathi. Local Community Health Workers were employed and trained to carry out the data collection. Survey data were analysed using both descriptive and inferential analysis methods. In particular the variables of interest (IPV, CMD, autonomy, spirituality and social support) as well as predictor variables (age, income, religion etc) were fitted into a multinomial logistic regression model and the log-likelihood ratio test was used to assess goodness of fit.

A total of 907 women were surveyed, and the majority of respondents were Hindu or Buddhist and belonged to the Backward Castes and Scheduled Tribes but had a high rate of literacy with half the sample having completed high school. Over a quarter of the women in this sample (28.7%) reported experiencing IPV and a similar proportion of women (28.2%) had a Common Mental Disorder (CMD). As expected there was a large degree of overlap between all three forms of IPV

(emotional, physical and sexual) with 1 in 10 women experiencing all three. Rates of CMD increased with co-prevalence of emotional IPV, physical IPV and sexual IPV in that particular order. The results suggest that CMD and physical health may be mediated by experiences of IPV.

Statistical modeling explained the odds of women in this sample experiencing various forms of IPV and CMD but surprisingly there were no common determinants for all three types of IPV. Husband's controlling behaviour, his frequency of drunkenness and a woman's level of autonomy were significant risk factors for two types of IPV and CMD. Social support and the use of spirituality as a coping mechanism were not significantly associated with any of the variables of interest.

A framework for addressing IPV and IPV related CMD was developed for use by KJ Somaiya Hospital and proposes evidence based clinical and community models. A woman's journey through the system was also developed and the rationale for the various pathways is provided.

Several recommendations are suggested based on the results of this study including the development of a community mental health outreach program that targets all women, the development of policies and protocols to facilitate appropriate responses to IPV by medical staff at KJ Somaiya, screening women that attend the outpatient clinic for IPV and implementation of referral procedures, establishment of a program to address alcohol misuse by males in the community and initiation of a coordinated community response to IPV to change attitudes.

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Abbreviations and Acronyms

CEDAW	Convention On The Elimination Of All Forms Of Discrimination Against Women
CHW	Community Health Worker
CMD	Common Mental Disorders
CSW	Commission Of The Status Of Women
FGD	Focus Group Discussion
GDP	Gross Domestic Product
GHQ	General Health Questionnaire
INR	Indian Rupee
IPV	Intimate Partner Violence
IUD	Intrauterine Device
MCH	Maternal And Child Health
MDGs	Millennium Development Goals
NFHS	National Family Health Survey
NGO	Non-Government Organisation
OR	Odds Ratio
PHC	Primary Health Care
PTSD	Post-Traumatic Stress Disorder
STI(s)	Sexually Transmitted Infection(S)
UNAIDS	Joint United Nations Programme On HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization
WHOSEA	World Health Organization South East Asia

List of local terms

Dharma	Correct conduct
Dukha	Sadness
Jāti	Caste
Karma	Destiny
Klesha	Stress
Mahila mandal	Women's group
Moksha	Spiritual liberation

CHAPTER 1

INTRODUCTION TO THE STUDY

"Far away there in the sunshine are my highest aspirations. I may not reach them, but I can look up and see their beauty, believe in them, and try to follow where they lead." —Louisa May Alcott quoted in Elbert Hubbard's Scrap Book (1923) by Elbert Hubbard, p. 62

1.1 Introduction

This thesis investigates Intimate Partner Violence (IPV) and Common Mental Disorders (CMD) in a cohort of Indian women living in a lower socio-economic area of Mumbai, India. It is one of a few studies that examined the effects of social support, spirituality as a coping mechanism and levels of autonomy on violence and CMD, and proposes a model for the factors that are significantly associated with them. The results provide valuable information on the factors that impinge on IPV and CMD in Indian women. The first chapter introduces the outline of the thesis, provides the background and rationale for the study, the aims, objectives and significance and gives a summary of the other chapters.

1.2 Rationale for the study

It is without doubt that violence against women is a common and wide spread public health issue that cuts across nations, cultures, religions, languages and socio-economic strata. In 1993, the United Nations General Assembly adopted the Declaration on the Elimination of Violence against Women which defines 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 in private life" (United Nations, 1993).

The most common type of violence against women is violence carried out by an intimate partner, and around the world women are at higher risk of violence in their home than anywhere else. IPV is a major contributor to ill health in women and results in a high social burden on society. Apart from deaths and injuries, IPV is associated with numerous adverse health outcomes which may be a direct result of the physical violence or are the result of the violence on the cardiovascular, gastrointestinal, endocrine and immune systems through chronic stress or other mechanisms (Black, 2011, Coker et al., 2002a). Victims of IPV – whether sexual, physical, or psychological are significantly more likely to suffer various psychological consequences such as depression, anxiety, suicide, and reproductive health issues such as unwanted pregnancies and sexually transmitted infections. They are also more likely to display negative health behaviours such as substance abuse and alcoholism (Black, 2011, Coker et al., 2000, Ellsberg et al., 2008). It was estimated that IPV in 2002-2003 cost the American economy \$8.3 billion (Max et al., 2004) and in 2007 cost the Australian economy \$13.6 billion (Braaf and Barrett-Meyering, 2011), with the largest contributors being pain, suffering and premature mortality, followed by health care costs which can persist as long as 15 years after the cessation of abuse (Rivara et al., 2007).

The World Health Organization (WHO) Multi Country Study found that the lifetime prevalence rate of physical and/or sexual violence ranged from 15% in Japan to 71% in Ethiopia with the other countries falling between 23% and 49% (WHO, 2005). More than half of physically abused women surveyed (between 55% and 95%) had not told anybody about the violence and had never sought help from any formal agency (e.g. health services, legal advice, shelter, police, women's nongovernmental organizations, local or religious leaders), the interviewer often being the first person the women disclosed their experiences of violence to (WHO, 2005).

Researching IPV is challenging as its parameters are not always well defined, severity of violence is subjective and the mental health consequences are linked to physical events in complex ways. Under reporting of IPV due to stigma and shame associated with the acts of violence also make researching this issue more difficult. Thus there is an urgent and growing need for robust and reliable epidemiological data to establish whether the patterns, risk factors and consequences of IPV in India are similar to other studies.

In 2004, when this study commenced, there were few research studies investigating the prevalence and incidence of IPV in India (Jeyaseelan et al., 2004, Jain et al., 2004, Hassan et al., 2004, Martin et al., 2002, Network, 2000, ICRW, 2000, Martin et al., 1999, Jejeebhoy, 1998, Rao, 1997, Jejeebhoy and Cook, 1997), and even fewer that focused on the relationship between IPV and mental health, in particular depression (Patel et al., 1998, Patil et al., 2002, WHO, 2002).

Since then, a few more studies have investigated the relationship between violence and mental health (Chandra et al., 2009, Kumar et al., 2005, Vizcarra et al., 2004, Nayak et al., 2010, Patel et al., 2006b). This study strengthens the sparse evidence base that supports the association between IPV and CMD in India.

Another aspect that has not been studied in detail in India and the Indian context, but has received some focus in industrialised nations, is the role of social support and autonomy on IPV and on the women's mental health status. Studies, mainly from the USA, have shown that social support plays an important role in moderating the effects of IPV and may protect against the development of depression and Post Traumatic Stress Disorder (PTSD) in women who are abused (Carlson et al., 2002, Coker et al., 2002b, Coker et al., 2003, Fowler and Hill, 2004, Holt and Espelage, 2005, Kaslow et al., 1998, Kocot and Goodman, 2003, Mitchell and Hodson, 1983, Rose et al., 2000, Thompson et al., 2000).

In contrast, the researcher was unable to find any studies from India that investigate social and family support with respect to IPV or mental health that were published before methodology development and data collection occurred in early 2005. There are several studies that investigate the role of social support in relation to work-family stress in middle and upper class working women (Aziz, 2004, Rajadhyaksha, 2006, Daga and Husain, 2001) and the role of social support for people with HIV/AIDS (Mittal et al., 2006, Kohli et al., 2005). The results of this research provide new information and insights on the relationship between social support and CMD in Indian women.

Spirituality is another variable of interest in this study. Spirituality, defined as religious beliefs and practices, has in the past been linked to various mental issues such as neuroses and psychotic delusions, however recent research has shown that spirituality and mental health are positively associated (Koenig, 2009, Baetz and J, 2009). Other research, including a meta-analysis of 147 studies have found that spirituality acted as a buffer to the negative effects of stress, with greater spirituality and religiosity associated with less depressive symptoms, even after controlling for other coping strategies (Smith et al., 2003, Kim and Seidlitz, 2002, Young et al., 2000).

In India, Anjana (2003) found that people that recite the Bhagavad Gita (the holy book of the Hindus) were less likely to show symptoms of depression and anxiety and were more effective in the management of adjustment problems than non-reciters. Other studies from India investigated the use of spirituality in coping with disasters (Rajkumar et al., 2008) or with terminal illness (Thombre et al., 2010), and found that spirituality was significantly associated with better outcomes. This study examined whether there was a similar association between spirituality and CMD in women who are experiencing IPV.

Autonomy is generally defined as the ability or capacity of women to make choices and decisions within their household relative to their husbands (Anderson and Eswaran, 2009). Autonomy within the sphere of IPV, reproductive health and nutrition has been investigated in depth on the Indian subcontinent and other developing countries (Spektor, 2010, Ghosh, 2007, Brunson et al., 2009, Hadley et al., 2010, Jejeebhoy, 2002, Senarath and Gunawardena, 2009, Acharya et al., 2010, Dyson and Moore, 1983, Vyas and Watts, 2009, Jejeebhoy and Sathar, 2001, Patel et al., 2006a, Hindin and Adair, 2002), however there is a dearth of literature on autonomy and CMD in Indian women (Kermode et al., 2007, Patel et al., 2005, Patel et al., 1998). The current study contributes new knowledge to previous research that attempts to explain the relationship between autonomy, IPV and CMD.

1.3 IPV and mental health – an overview

Research on the potential health consequences of IPV, particularly in the United States and other industrialised countries, increased dramatically in the 1990s. The early focus was on injury as the primary health consequence, but broadened to encompass a range of other health related conditions associated with violence against women such as chronic pain, reproductive issues, alcohol and drug abuse and mental health problems (Campbell, 2002, Campbell et al., 2002, Golding, 1996, Golding, 1999). This research indicated that in addition to the immediate physical sequelae, IPV increased women's risk of future ill health, leading to violence being viewed as a risk factor in the development of a number of diseases and conditions (Golding, 1999).

Mental health problems such as depression, anxiety and PTSD have consistently been associated with experiences of IPV both in industrialised and developing countries (Golding, 1999, Gururaj et al., 2004, Houry et al., 2006, Humphreys and Thiara, 2003, Ishida et al., 2010, Koss et al., 2003, Kumar et al., 2005, Nurius et al., 2003, Resnick et al., 1997, Robertiello, 2006, Roberts and Lawrence, 1998, Tiwari et al., 2008, Vizcarra et al., 2004). These studies show that abused women are 3 to 5

times more likely to suffer from depression, 3.7 times more likely to have PTSD and 3.8 times more likely to attempt suicide than non-abused women (Bonomi et al., 2006, Ellsberg et al., 2008, Golding, 1999). In addition, mental health symptoms are strongly correlated with the severity and length of violence experienced, with recent and severe abuse leading to more severe symptoms (Pico-Alfonso, 2005).

Studies from all India have also found consistently high rates of IPV, ranging from 18% to 70%, with the variation attributed to differences in study methodology (Babu and Kar, 2009, Chandra et al., 2009, ICRW, 2000, Jejeebhoy, 1998, Kumar et al., 2005, Martin et al., 1999, Rao, 1997). More recently, research from India has examined the impact of violence on women's health and the findings are consistent with those from western countries, namely higher odds of physical, reproductive and mental health problems in women experiencing IPV (Begum et al., 2010, Chowdhary and Patel, 2008, D'Costa et al., 2007, Kumar et al., 2005, Patel et al., 2006b).

1.4 Background to the study and researcher's interest

This study arose out of the researcher's interest in women's issues in particular mental health, her personal experiences in the Indian society and the desire to make a difference. Having witnessed and experienced some of the restrictions placed on Indian women due to gender inequality and cultural traditions such as movement restrictions, being highly educated but not being allowed to work and female identity dependent on the male in the family (father from birth and then husband after marriage), the question arose on the effect of these limitations on women's mental health. Tentative investigation of this issue indicated that in developing countries increasing literacy and education levels in women was considered the key to improved health, increased income, and ultimately empowerment and gender equality.

Interestingly the situation of women in Kerala raised even more questions. Kerala, one of the southern-most states of India, has the highest rate of female literacy in India (95%), however it also has one of the highest rates of stress related mental disorders and attempted suicide for women in the country (Eapen and Kodoth, 2003). While the rates of reported IPV in Kerala are not the highest in the country, (19.8 % vs 39.7% all India average) what was strange is that states with much lower levels of literacy had lower levels of IPV (International Institute for Population Sciences and ORC Macro International, 2007). For example, the states of Meghalaya and Himachal Pradesh have IPV rates of 15.0% and 6.9% respectively and literacy rates of 67% and 80% respectively, compared to Kerala's literacy rate of 95% (International Institute for Population Sciences and ORC Macro International, 2007). Other studies have also shown that despite high levels of education, women in Kerala still suffer gender inequality as demonstrated by increasing numbers of dowry deaths, ongoing restrictions on employment outside the home and high rates of IPV and sexual abuse (Eapen and Kodoth, 2003, Mukhopadhyay, 2007).

In particular, the researcher wanted to investigate the effects of IPV on the mental health of women, how women cope and what factors moderate or mediate resilience. Thus it was decided to focus on IPV and mental health as the subject of the study.

This study commenced in 2004, with approval and development of the PhD candidacy proposal, the project planning and literature review. The main data collection in Mumbai, India was undertaken in 2005. Between 2005 and 2012, the research study was undertaken in part time format. During this period there was a sudden increase in the number of publications on the issue of IPV in India and other developing countries especially the WHO multi country studies, the International Clinical Epidemiology Network (INCLEN) WorldSAFE--World Studies of Abuse in Family Environments and Vikram Patel's work in Goa. Thus while the thesis includes

current literature, the methodology and data collection aspects were based on literature available only up to 2004.

1.5 Research questions, aims and objectives

The research questions for this study arose from the researcher's interest in IPV and its effects and her close relationship with India and Indian people. As discussed earlier, studies from Western countries have shown IPV prevalence rates to range from 10-15%, and have also shown that women who are abused suffer from much higher rates of depression, anxiety and PTSD than non-abused women, with rates ranging from 50-80% (Abbott and Williamson, 1999, Acierno et al., 1997, Carlson et al., 2002, Cascardi et al., 1999). The little research into IPV prevalence from the Indian subcontinent when this study was started showed that prevalence rates ranged from 20-70% depending on the type of study (cross sectional or in depth interviews) and sample characteristics (urban, rural, low socio-economic or middle class) (Khosla et al., 2005, Ahmed-Ghosh, 2004, Babu and Kar, 2009, Babu and Kar, 2010, Bangdiwala et al., 2004, Chandra et al., 2009).

The question then arose that if findings from Western studies on the association between IPV and mental health issues were extrapolated to the Indian population, it could suggest that up to 50% of all women in India are depressed, anxious and have PTSD as a result of IPV. However this is obviously not the case and the researcher wondered if the Indian belief in karma could be a protective factor in the sense that women believe that the violence is retribution for past misdeeds and thus they relinquish responsibility for its causation as well as accept the violence as a way to atone and obtain good karma in the next life. Furthermore by doing this attribution of the violence to external causes and the belief that acceptance of this fate will result in a positive outcome may protect the mental health of Indian women and cause less mental health problems.

The overarching aim of this quantitative study was to investigate IPV, CMD and associated psychosocial issues experienced by women from a low socio-economic community in Mumbai, India. Mumbai was chosen due to an existing relationship between the Centre for International Health, Curtin University and KJ Somaiya Trust representatives who offered support to the researcher in carrying out the study.

1. The first objective of the study was to determine the lifetime and previous 12 months prevalence of intimate partner violence [IPV or domestic violence (DV)] in a low socio-economic Indian community. Previous studies have shown that IPV rates in Indian populations are high, but values vary widely due to methodological differences, so it was imperative to determine the rates of violence experienced by the women in this study using a more standardised methodological approach.
2. The second objective was to investigate the prevalence and co-prevalence of CMD in the study population. To date few studies have specifically looked at the relationship between different types of IPV (emotional, physical and sexual) and common mental disorders (CMD) in Indian women.
3. The third objective of this study was to document and investigate the association between the extent of women's social support network and their experiences of IPV and CMD.
4. Fourthly, the study aimed to examine and compare the effects of using spirituality to cope with stressful situations on levels of CMD between women who experience IPV and those that do not.
5. Lastly, the fifth objective of this study was to compare the effects of autonomy on CMD between women who experience IPV and those that do not.

1.6 The research site

1.6.1 Overview of India

India is one of the most populous countries in the world and is situated in Southern Asia, bordering the Arabian Sea and the Bay of Bengal, between Burma and Pakistan, see Figure 1.1. Being a large country (approximate land area of 3.3 million km²), India's climate varies from tropical monsoon in south to temperate in north, and is prone to a number of natural hazards such as droughts, flash floods, as well as widespread and destructive flooding from monsoonal rains, severe thunderstorms and earthquakes which are exacerbated by overcrowding and overpopulation driven soil erosion and deforestation.



Figure 1.1. Political map of India (www.maps.com)

India became an independent republic in 1947 and is made up of 28 states and 7 union territories with a population of approximately 1.21 billion people with a

median age of 25.1 years and a life expectancy of 64 years (National Census of India, 2011, UNICEF, 2011). The major ethnic groups in India are Indo-Aryan (72%), Dravidian (25%) and Mongoloid and other (3%) and in 2007 the main religions were Hindu (81.6%), Muslim (12.5%), Christian (2.7%), Sikh (1.6%) and others (1.9%) (National Census of India, 2011).

Hindi is the national language spoken by a large proportion of the population (41%) but there are 14 other official languages spoken and hundreds more unofficial languages and dialects (National Census of India, 2011). Seventy four percent of the population are literate, with more men than women being literate (78.1% vs 58.5%) and this varies dramatically from state to state, for example in the state of Rajasthan, the literacy rate for women is 53% whereas in Kerala it is over 91% (Kishor and Gupta, 2009). Overall, India is considered a developing country, with a Gross National Income per capita in 2009 of US \$1170 although there are significant regional disparities, and with 42% of the population living below the poverty line, on less than US\$ 1.25 per day (UNICEF, 2011). Despite impressive gains in economic outlay and output, India faces serious problems such as significant overpopulation, environmental degradation, extensive poverty, and ethnic and religious strife (World Bank, 2011).

1.6.2 Overview of Mumbai

Mumbai, formerly known as Bombay, is the capital of the state of Maharashtra and is India's economic, financial and cultural capital. Located on the northern portion of India's western coastline, the Konkan coast, Mumbai has a deep natural harbour. Positioned near the Arabian Sea in a tropical zone, Mumbai's climate has two main seasons: the wet season with monsoonal downpours and high temperatures and the dry season with cooler drier weather. In fact, data collection for this project was stopped for three months in 2005, due to floods caused by 944 millimetres of rain on 26 July 2005, which was the highest ever recorded rainfall in a single day. The city consists of two distinct regions: Mumbai City district and Mumbai suburban

district which together cover a total area of 603 km² and have a population of approximately 13 million (Department of Relief and Rehabilitation, 2012) making it the most populous city in India and second most populous city in the world although unofficial figure list the population at over 20 million (see Figure 1.2).



Figure 1.2 Map of Mumbai (www.mapsofmumbai.com)

★ Approximate location of Pratikshanagar

The population density is estimated to be about 20,500 persons per square kilometre; by comparison London has a population density of 5100 people per square kilometre. According to the latest census, more than 54% of the city's population lives in slums (National Census of India, 2011). The sex ratio is 848 females per 1,000 males in Mumbai, lower than the national average of 914 females per 1,000 males and this is partly because of the large number of male migrants

who come to the city to work (National Census of India, 2011). The overall literacy rate in Mumbai is over 94.7%, which is higher than the national average of 74%, and interestingly, with a literacy rate of 69%, the slums in Mumbai are the most literate in India and possibly the world (National Census of India, 2011).

Marathi is the official language of Maharashtra state but there are other languages that are widely spoken in Mumbai such as Hindi, Gujarati & English. Religious breakdown in Mumbai is slightly different to that for the whole of India, due to the migrant influx of cultures and people from all over the country with Hindus (67.4%), Muslims (18.6%), Buddhists (5.2%), Jains (4%) and Christians (3.7%), and Sikhs, Parsis and Jews making up the rest of the population (National Census of India, 2011).

Mumbai is also the financial, commercial and economic capital of the country and many of India's conglomerates and companies as well as foreign financial institutions and corporations are based there (Swaminathan and Goyal, 2006). A large proportion of the city's workforce is made up of state and central government employees, but there are large numbers of unskilled and semi-skilled self-employed people who work as hawkers, taxi drivers, mechanics and in other blue collar professions, in the massive shipping industry or in the media industry. Dharavi, in central Mumbai, which is Asia's second biggest slum and has over 800,000 inhabitants, has a large recycling industry, processing recyclable waste from other parts of the city (UNDP, 2009).

The economic, financial and information technology (IT) boom of the 1990s and the associated employment opportunities continue to draw many migrants to the city exacerbating the already existing urbanisation problems such as widespread poverty and unemployment, poor public health and poor civic and educational standards for a large section of the population.

1.6.3 KJ Somaiya Trust and Pratikshanagar slum

This study was made possible through the collaboration of the enrolling institution (Centre for International Health, Curtin University) and the KJ Somaiya Trust, which started in 2004. The K J Somaiya Trust was founded by Pujya Shriman Karamshibhai Jethabhai Somaiya, who was committed to the ideal "*what you receive from society give back multifold*" (Somaiya Trust Webpage, 2011). In 1991, the KJ Somaiya Trust built a medical college and free hospital located on a 22 acre campus in the heart of Mumbai at Sion (Ayurvihar Complex) (Somaiya Medical Trust, 2011). The hospital and medical centre were built to serve a number of nearby slum communities including the community of Pratikshanagar where the participants of this study reside (Somaiya Medical Trust, 2011).

Pratikshanagar covers an area of approximately 2 km² and has a population of approximately 50,000 people. The residents of this community are recipients of the Somaiya Action for HIV/AIDS Support (SAHAS) program run by the hospital that offers psychological counselling, training in management of the disease with nutritional counselling, nutritional supplements, training of caregivers, and skill development for income generation. Furthermore local people are recruited and trained as community health workers who then visit the slum communities to survey the needs of families and to provide information about the Somaiya Hospital services. The researcher, under the auspices of the SAHAS program, was given the opportunity to conduct this study in the slum community nearest to the K J Somaiya Hospital.

1.7 Study design and methodology

This study used a predominantly quantitative design, which has its roots in positivism meaning that there is an objective reality which can be examined and measured or quantified in some way (Seers and Critelton, 2001). It is an observational study in that it describes the issue of IPV and CMD in a group of

women from a low socio-economic community in Mumbai, without attempting to intervene or change the outcome.

The cross-sectional survey design using systematic sampling was chosen as it is the most appropriate method of describing the prevalence of IPV and the characteristics of the women who experience it. This design is useful at identifying associations and can be used to infer causation (Follingstad et al., 1990). This design also allows the researcher to investigate the relationship between characteristics of the study participants and the variables of interest within the limited time frame and budget constraints of a PhD program.

The researcher employed several approaches to reduce common method variance and causal inference and enhance the validity of the survey through item construction, reliability assessment and construct validation (Rindfleisch et al., 2008), and these are described in more detail in the Chapter 4, the Methodology chapter.

The participants in this study were married women who resided in the Pratikshanagar slum next to the KJ Somaiya Hospital in Sion-Chunabatti area of Mumbai. The researcher took all possible steps to ensure that the study was conducted according to the WHO and National Health and Medical Research Council (NHMRC) ethical and safety recommendations for IPV research and that study participants were not harmed, put at risk or distressed by the data collection nor identified or singled out (Ellsberg and Heise, 2002). These included employing and training local health care workers to carry out the data collection as the researcher, being a white female, attracted undue attention whenever she visited the slums. Data was collected in privacy and anonymously and interviewers were instructed to refer to local support services if necessary. Furthermore, preliminary results from the survey were provided to staff at KJ Somaiya Hospital to allow for follow up activities to address IPV to be carried out in the community.

1.8 Findings of the study

A total of 907 women were surveyed and the majority of respondents were Hindu or Buddhist and belonged to the Backward Castes and Scheduled Tribes. Over a quarter of the women in this sample (28.7%) reported experiencing IPV and a similar proportion of women (28.2%) were also clinically depressed.

As expected there was a large degree of overlap between all three forms of IPV (emotional, physical and sexual) with 1 in 10 women experiencing all three forms of IPV. Rates of CMD increased with co-prevalence of emotional IPV, physical IPV and sexual IPV in that particular order. The results suggest that CMD and physical health may be mediated by experiences of IPV.

Statistical modeling explained the odds of women in this sample experiencing various forms of IPV and CMD but surprisingly there were no common determinants for all three types of IPV. Husband's controlling behaviour, his frequency of drunkenness, and a woman's level of autonomy were significant risk factors for two types of IPV and CMD. Social support and the use of spirituality as a coping mechanism were not significantly associated with any of the variables of interest. These findings are presented in chapters 5 and 6.

1.9 Brief limitations of the study

Being a research project within the context of a PhD, this study has several limitations.

- Firstly, being based on a cross sectional survey, the results provide a 'snapshot in time' of the relationship between CMD, certain other factors and the likelihood of experiencing IPV. As such these relationships cannot be interpreted as causal where one factor causes another to occur (Rindfleisch et al., 2008, Heilman, 2010). Secondly, like most studies that measure IPV, this study tends to underreport the true prevalence of IPV in this community.

- Thirdly, financial and time considerations associated with being a postgraduate student on a scholarship limited the time allocated to fieldwork and data collection, and this inevitably has impacted on the results, with less than the required number of surveys collected. This may have limitations on the generalizability or applicability of the results.
- Finally, the researcher had to rely on the abilities of the staff at KJ Somaiya Hospital, as well as the community health workers for the collection of survey data and this is acknowledged as a potential limitation.

Further, a more detailed exposition of the methodological limitations is presented in the methodology chapter. The limitations are expanded upon in the concluding chapter.

1.10 Overview of the thesis

This thesis is presented in 8 chapters.

The current chapter (**Chapter 1**) provides a brief overview of the entire thesis, including the professional context of the researcher, the prevalence and context of IPV and CMD in India, the aims and objectives as well as the study setting, rationale and significance are included.

Chapter 2 examines the issue of gender inequality and provides an overview of gender inequality and how it affects women. It discusses the most well-known theories of causation of IPV from a Western perspective, as well as the mental and physical effects that violence has on victims, finishing with a specific look at IPV in India.

In **Chapter 3**, the theories of stress and coping are discussed from a Western perspective in particular as they relate to IPV. The relationship between stress and CMD is examined as well as moderating factors such as social support. The final

section of this chapter discusses the cross cultural variation of defining stress and coping and in particular stress and coping from a traditional Indian perspective.

Chapter 4 describes the methodology of the study, in three parts, namely the pre-data collection, data collection and the analysis of results sections. The pre-data collection section contains the methodology for carrying out the literature review and the development and translation of the instrument, the data collection section includes the pilot testing of the questionnaire as well as the actual data collection, and the analysis of results section gives details of the statistical tests and the anthropological analysis used. The limitations, methodological issues encountered and steps taken to ensure validity and reliability of the study are also included.

Chapter 5 presents and discusses the results of descriptive analysis with respect to the existing literature. It includes the socio-demographic characteristics of the participants, the experiences of decision making power within the household, experiences of IPV and general health characteristics.

In **Chapter 6** the results of the inferential analysis are presented and discussed, particularly the correlation between IPV and CMD, autonomy and violence and autonomy and CMD. The lack of significant association between social support, spirituality and CMD are discussed and the best model for IPV is presented and discussed.

Chapter 7 summarises and discusses the implications of the results of the study, a discussion of response to the research objectives, the limitations and generalisability of the findings and proposes a list of recommendations and a concluding comment.

CHAPTER 2

INTIMATE PARTNER VIOLENCE – CAUSES AND EFFECTS

“Violence is the last refuge of the incompetent.” –

Isaac Asimov

2.1 Introduction to the chapter

This chapter discusses the issue of gender inequality which is the underlying cause of Intimate Partner Violence (IPV) the world over. The chapter provides an overview of gender inequality internationally and how it affects women. It discusses some well-known theories of causation of IPV from a Western perspective, the prevalence and risk factors of IPV, as well as the mental and physical effects that violence has on victims. The chapter concludes with a specific look at IPV in India.

2.2 Gender norms and gender inequality

Gender is a social and cultural construct that defines what it means to be male or female, and is assigned based on the biological sex at birth (Anderson, 2005, Russo and Pirlott, 2006). It encompasses many other elements including gendered behaviours, values, expectations, roles and environments which are culturally dependent and can change over time and over a life course (McCloskey et al., 2005). For example what is expected of a young unmarried woman is different from what is expected from a married mother, and these expectations are different in different cultures.

In India, young unmarried women are supposed to live with their parents, are not supposed to engage in premarital sexual relationships and are expected to marry someone of their parents’ choice. Married Indian women are expected to live with their husband and often their in-laws, are responsible for raising children and expected to be understanding wives that hold the family together (Cho, 2012).

Gender also determines the social position and role of a person in society, and usually gives women less power and resources than men (Russo and Pirlott, 2006). Gender norms are the prevailing attitudes and values that ascribe and define the social roles and behaviours associated with both genders. These are firmly entrenched in every culture's social structures (Keleher and Franklin, 2008, Lott, 2011) and there is no country in the world where women are equal to men legally, socially and economically, not even in the most equalitarian societies in Scandinavia (WHO, 2005). Gender norms are used to organise and maintain social relations and order at individual, community and institutional levels, and transgressions or challenging these norms often result in sanctions or punishment (Sen and Östlin, 2008, Keleher and Franklin, 2008). The norms are present at all levels of society, from household and family level to neighbourhoods, communities and wider society and are perpetuated by social customs and establishments that produce legislation and codes of conduct that maintain gender inequities (Keleher and Franklin, 2008).

All countries, but in particular developing countries, experience tensions related to the conflict between the changing roles of women in society with the traditional concepts of women's domains (Keleher and Franklin, 2008). Implicated in these interactions between systems trying to maintain the gender norms and those trying to change or modify them is the concept of relative power, control over and access to resources (Keleher and Franklin, 2008, Lott, 2011). The outcomes of these interactions are usually unequal, as the inequitable dynamics expose women and girls to numerous risks such as violence, discrimination, denial of education, poverty, social and economic injustices, exploitation, restrictions on mobility and political activity. At the same time gender inequality reinforces male behaviours that affect women such as sexual violence and unsafe sexual practices, denial of women's rights and support for males to maintain control over their female partners (Keleher and Franklin, 2008).

Nobel laureate Amartya Sen divides gender inequality in India into seven types:

1. **Mortality inequality:** In India this is demonstrated by the higher rates of female mortality due to gender specific causes.
2. **Natality inequality:** The preference for male children leads to sex-selective abortion and female infanticide.
3. **Basic facilities inequality** occurs through the unequal provision of nutrition, healthcare and education between males and females.
4. **Special opportunity inequality** observed through gender imbalance in opportunities for higher education and professional training.
5. **Professional inequality** through decreased opportunities for employment, promotion as well as restrictions on occupation type.
6. **Ownership inequality** is expressed through unequal inheritance and ownership laws and traditions.
7. **Household inequality** is demonstrated through the asymmetrical division of labour within the household and a lack of decision-making power by females within their own homes (Sen, 2001).

Gender inequality limits women's access to and control over resources, in economic opportunities, in power and political voice which in turn systematically empower men to the detriment of women who become socially, economically and politically dominated (WHO, 2005).

Of the majority of people living in poverty today globally over 70% are women and children, and women as a group work in the most poorly paid occupations, in jobs with less status and pay than men (Steel and Kabashima, 2008, Lott, 2011). Despite women making up half the world's population and being a third of its workforce they own only 1% of the world's property and earn only 10% of its income (Lott, 2011, WHO, 2011).

Disparities in access to education between boys and girls means that two thirds of the world's illiterate people are women, which in turn limits their access to employment, independence, health care and nutrition impacting on the next generation in a vicious cycle (WHO, 2011).

In the political realm, gender inequality is clearly evident with only 17% of national parliamentary seats worldwide being occupied by women, although in some countries such as Rwanda, 55% of the lower house of parliament seats are occupied by women (Lott, 2011, Hughes, 2009). Some attribute this latter trend to civil conflicts which have exposed women's suffering and increased their participation in human rights movements leading to a change in traditional gender roles. However political equality in these cases was achieved despite continuing gender inequality in the social and economic spheres (Hughes, 2009).

The persistence of gender inequality, even in countries like those in Scandinavia that have the most gender equal policies in the world, is attributed to the universal division of domestic labour relating to child care. It is a universal assumption that mothers bear more responsibility for the care and welfare of children, thus devoting far more energy and time to these tasks than men (Brighouse and Wright, 2008). Furthermore, these unequal parenting responsibilities are reinforced in public and institutional forms which then contribute to those within the family and vice versa.

The interplay between gender systems and structural processes is an important determinant of health and the effects of gender inequality are most noticeable in the disparity in health status between men and women all over the world, but especially in developing countries where women suffer more from chronic diseases than men (Sen and Östlin, 2008). For example the proportion of total DALYs (Disability Adjusted Life Years) lost due to reproductive ill health in women of reproductive age in the world is 21.9% compared to that of men at 3.12% (WHO, 2005). Even after removing ill health due to maternal causes, women still lose more

than twice as many DALYs to reproductive ill health as men (7.43% compared to 3.12%) (WHO, 2005).

Research also indicates that women are disproportionately affected by common mental disorders such as depression and anxiety and gender inequality (Chandra and Satyanarayana, 2010, WHO, 2011). For example, Patel and colleagues (2002), have shown that economic hardship and marital unhappiness were significant contributing factors to the incidence of chronic depression in women and demonstrated a positive relationship between poverty and the risk of common mental disorders (Patel and Kleinman, 2003). They also found correlates of gender inequality such as marital sexual violence, lack of autonomy and severe economic difficulties to be independently associated with the risk of common mental disorders (Patel et al., 2006b).

Poverty and food insecurity are the strongest and most consistent predictors of CMD in women and gender inequality exacerbates this further with physical and sexual abuse, societal pressures to conform to traditional gender roles, and inequitable access to health care make women vulnerable to mental disorders and contribute to its severity and chronicity (Chandra and Satyanarayana, 2010).

In conclusion, both gender and gender inequality are major factors contributing to the higher burden of ill health for women in the world and research findings support this theory (Sugarman and Frankel, 1996, Jejeebhoy and Sathar, 2001, Hassouneh-Phillips, 2001, Patel and Kleinman, 2003, Brighthouse and Wright, 2008, Rohde et al., 2008, Chandra and Satyanarayana, 2010). The mechanisms of action of gender based inequality are complex and varied and to a large extent dictated by the cultural norms of a particular society that define the distinct roles, values and behaviours of women.

Societies where patriarchy is dominant, where women lack social, political and economic autonomy and where their identity is defined by marriage, gender inequality and discrimination are the norm (Sugarman and Frankel, 1996, Schuler et al., 1996, Jejeebhoy and Sathar, 2001, Asthana, 1996, Beer, 2009, Hunnicutt, 2009). These societies also have the highest rates of female morbidity and mortality and lowest life expectancy for females (Beer, 2009, Hunnicutt, 2009, WHO, 2011).

2.3 Gender based violence

One of the major contributing factors to, as well as a result of gender inequality is gender based violence or violence against women (Bott et al., 2005). Gender based violence encompasses any violence that is caused by gender roles and gender status in society. The United Nations General Assembly's Declaration on the Elimination of Violence against Women [CEDAW, (1993)] defines violence against women, or gender based violence as "any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life." This definition includes

"physical, sexual and psychological violence occurring in the family and in the general community, including battering, sexual abuse of children, dowry-related violence, rape, female genital mutilation and other traditional practices harmful to women, non-spousal violence and violence related to exploitation, sexual harassment and intimidation at work, in educational institutions and elsewhere, trafficking in women, forced prostitution, and violence perpetrated or condoned by the state" (WHO, 2005).

It is well accepted that women commit violence against men as well and research from the US has shown that there is little difference by gender in the prevalence rates of common acts such as shoving and hitting (Russo and Pirlott, 2006). While men also experience higher overall levels of violence than women due to armed

conflicts, gang and street violence, women are more likely to be suffering violence and death at the hands of family members and intimate partners (Krug et al., 2002b, Bott et al., 2005).

Violence is also used by men as a means to punish women for perceived transgressions of gender norms, to show authority or power and to save honour, for example honour killings and dowry deaths, Furthermore, in many societies, the use of violence against women by husbands and immediate family members is considered acceptable and is often justified by the broader society and the victims are blamed and stigmatized instead of the perpetrator (Bott et al., 2005).

However to understand the complexity of gender based violence one needs to focus on how gender defines the dynamics, the predictors and the results of violence for both males and females. Specifically important for this study is an understanding of the culturally entrenched traditions, attitudes laws and institutions that condone, justify and enforce gender based violence, objectify women and sexualise violence against them (Bott et al., 2005, Heise et al., 2002).

Gender based violence can be conceptualised through the ecological framework that explores the relationships between the personal, situational and sociocultural factors and envisages violence as a result of many factors influencing behaviour, see Figure 2.1 below (Krug et al., 2002a, Heise et al., 2002).

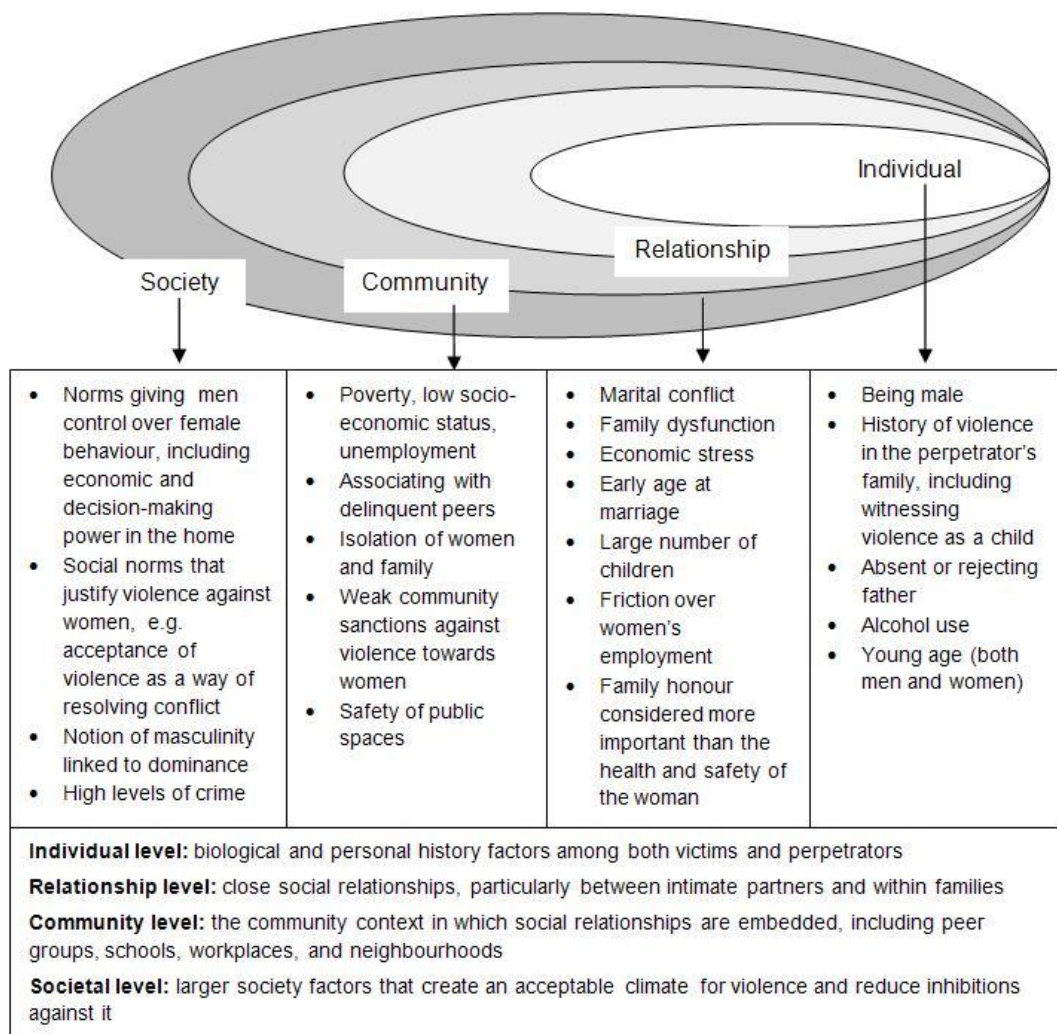


Figure 2.1 Ecological model of factors associated with IPV

Source: Interagency Gender Working Group,

http://www.igwg.org/igwg_media/gbv/ecological-model.pdf

At the individual level, the model identifies biological and personal characteristics that increase the likelihood of being a victim or a perpetrator of violence. These include low literacy levels, witnessing or being abused as a child (Krug et al., 2002a, Krug et al., 2002b, Heise et al., 2002) as well as drug and alcohol use (Stanley, 2008, Graham et al., 2011).

At the family and relationship level the close social and familial relationships are explored and how these can increase the risk of violence. At this level, characteristics such as female lack of autonomy and decision making power within

the household and marital conflict have been found to be strong predictors of violence (Heise et al., 2002).

At the community level the model considers community characteristics such as neighbourhoods, schools and workplaces to identify factors associated with increased risk of violence. High residential mobility, high population density, high levels of unemployment and social problems such as drug use have all been shown to increase the risk of violence (Heise et al., 2002). Cross cultural studies have also shown that communities where women are isolated or lack social support and where male violence is condoned also predict higher rates of violence (Koenig et al., 2003).

The final societal level of the ecological model scrutinizes the societal factors that affect gender based violence such as cultural norms that promote male dominance and 'ownership' of women (through bride price), rigidly enforced gender roles and tolerance of the use of violence to solve disputes (Heise et al., 2002, Russo and Pirlott, 2006). Also included in this level are policies and legislation, such as inequitable inheritance laws that favour males and that maintain high levels of social and economic inequality in a society thus contributing to increased risk of gender based violence.

The ecological framework provides an overview of the complex pathways and causative factors that work together at all levels to increase risk of violence and how this risk changes throughout the different stages of life of a person. Furthermore, the framework highlights the fact that there are a number of factors that are common to all types of gender based violence for example cultural norms, poverty and alcohol and drug abuse are risk factors for more than one type of violence. Thus women can often be exposed to more than one type of violence at a time, for example women at risk of physical violence by a partner are also at risk of sexual violence.

Women can also be exposed to different types of violence depending on their age, for example young girls in many parts of the world undergo female genital mutilation and may then be abused by her partner during her marriage (Purdon and Tettero, 2008). The most common type of gender based violence in the world is Intimate Partner Violence (IPV).

2.4 Intimate partner violence

Violence carried out by a male partner is also known as IPV and it encompasses physical, psychological and sexual abuse. According to research conducted in 24 countries on four continents, between 8% and 76% of the women interviewed reported that they suffered physical abuse from their male partners with prevalence rates varying from 8-14% in western countries to 40-76% in developing countries (Campbell, 2002, Martin et al., 1999).

A recent WHO conducted multi-country study on IPV has found prevalence of physical and/or sexual violence ranged from a low 15% in Ethiopia to 71% in Japan (Abramsky et al., 2011) while the lifetime prevalence of physical violence among African married women ranged from 17% to 48% and from 40% to 52% in South American women (Coker and Richter, 1998, Ellsberg et al., 2008, Jewkes et al., 2002, Jeyaseelan et al., 2007, Jeyaseelan et al., 2004, Kishor and Johnson, 2004). Furthermore, IPV was the eighth leading cause of death in women in the 15-44 age groups in 2004, and recent studies suggest that this type of violence is a growing public health concern (McAuliffe, 2007).

IPV is part of a pattern of abusive behaviour and control and includes repeated physical assault such as hitting, kicking, beating; repeated or ongoing psychological abuse such as intimidation and humiliation; and coercive or forced sexual intercourse (Alhabib et al., 2010, Simister and Makowiec, 2008, Ellsberg et al., 2008, Garcia-Moreno et al., 2006, Jewkes et al., 2002). It may also include behaviours

such as isolating and monitoring the victim's movements, and restricting her access to resources (Garcia-Moreno et al., 2006, Heise et al., 1999, Jewkes, 2002).

2.5 Theories of IPV

In the western world there have been many theories developed over the years to account for and provide a conceptual understanding of violence and IPV. To date most explanations of the causation of violence remain partial and incomplete, emphasize different yet connected aspects of violence, but do not provide a comprehensive explanation or framework that explains the entire range of interpersonal, institutional, and structural violence (Brown, 2006). These can be categorised into frameworks put forward by sociologists (see Dobash and Dobash's work) and frameworks put forward by psychologists (see Dwyer and Gondolf's work) (Knight and Hatty, 1987). The frameworks developed in the field of sociology place IPV in a macro model of society, while the frameworks developed by the field of psychology account for IPV at a micro level.

The theories that evolved from a sociological perspective attribute IPV to social and cultural factors, whereas the psychologically derived theories attribute IPV to individual factors such as aggressiveness and psychopathology (Anderson, 2005, Straus, 1980). Each of these theories are supported to a certain extent by empirical evidence, however they also have shortcomings, particularly around their ability to explain all episodes of IPV and to have a significant impact in the prevention and treatment of IPV (Bell and Naugle, 2008). The most well-known theories are discussed in the coming sections.

2.5.1 Feminist theory

Feminist theory consists of a number of different 'schools' of feminist theories, for example white radical feminism which locates the root cause of women's oppression in patriarchal gender relations, or socialist feminism which attributes it to class conflict (Dominelli, 2008). What the different strands of feminism have in

common is that they all speak out against the unfairness of the patriarchy. Seminal works by Dobash and Dobash, Yllo, and Walker explain IPV as a result of sexism and female inequality that exists in patriarchal societies (Dobash and Dobash, 1979, Yllo, 1988, Walker, 1984). The gender roles that are defined by the patriarchal society place more value on males and their needs and wants and thus put males in a position of power over women. Supporters of these theories propose that it is the socially defined gender roles that lead to and sanction victimization of women as men use various tactics including IPV to control and exert their dominance while at the same time socialising women to be non-violent (Dobash and Dobash, 1979, Walker, 1984).

There have been three waves of paradigm shifts in feminist theories over the last century. The first wave was the suffragette movement that fought for basic citizenship rights, such as the right to vote, to own property and have custodial rights over their children (Bulbeck, 1997, Jeffreys, 1997). Their background was upper and middle class and they opposed the idea of women being the 'weaker sex'.

The second wave occurred between mid-1960s and mid-1980s and built on the groundwork done by the first wave expanding on the agenda of sexual inequality and focus, and was aimed at social issues in society, such as IPV and sexual abuse (McPhail et al., 2007, Pease, 1996). What separated the second wave from the first were its theoretical foundation and the inclusion of women from less privileged backgrounds (Fraser and McMaster, 2009).

Some of the issues addressed by the second wave included women's possibility to maintain a career after marriage and the ability to get a personal home loan. During this time they also managed to make rape in marriage illegal based on the fact that it was a social and cultural problem, not merely an individual or interpersonal issue (Segal, 1999a, Herman, 1992, Greer, 1972, Connell, 1995, Anatas, 2007). Adjacent

with the second wave of feminism was the rise of the pro-feminist movement, and what has developed into a men's movement, who sought to change the perception of traditional gender roles as well as challenge men's violence against women (Pease, 1997, Pease, 1996, Mayo, 2005, Jenkins, 1990).

The third wave of feminist movement began in the 1980s and has progressed into current date, is characterised by significant financial and socio-political change and this has had a mixed impact upon different subgroups of women (Segal, 1999a, Fraser and McMaster, 2009). The main focus of this wave was the more subtle forms of power in society and its impact on women. Empirical support for this theory comes from studies that have shown a positive correlation between rates of IPV and men's patriarchal beliefs, that is when men hold traditional gender-role attitudes they are more likely to perpetrate IPV (Yllo and Straus, 1984).

Furthermore, feminist theory acknowledges that women can also perpetrate IPV; however this is not considered as serious a social problem as men's violence against women mainly due to the fact that women, due to their smaller physical size and strength, tend not to inflict as much physical harm as male perpetrators (Kurz, 1997). Limitations of feminist theory revolve around its failure to explain violence between same sex lesbian couples and violence perpetrated by women outside the framework of retaliation and self-defence, as well as its limited impact on prevention and treatment of IPV (Bell and Naugle, 2008).

2.5.2 Resource theory

This perspective of IPV was first iterated by Goode in 1971 and has been further developed over the years by Makepeace and Teichman and Teichman (Goode 1971; Makepeace 1987; Teichman and Teichman 1989). According to the resource theory, force and violence are resources which can be used to resolve conflict and members of a family, which is viewed as a stratified power system, compel other members to

behave according to their wishes by the use of force, including violence (Goode 1971).

The fundamental principle of this theory stipulates that the distribution of resources is the main reason for violence between men and women. When the balance of resources is in favour of the woman, men tend to respond with violence. In other words, men that lack resources, relative to their female counterpart, compensate with violence (Atkinson et al, 2005; Anderson, 1997; Hotaling & Sugarman, 1986; McCloskey, 1996).

One shortcoming of this theory is that it largely ignores the impact of socio-cultural aspects on women's lives. Instead, it builds its reasoning on the assumption that men want to be the breadwinner in the family and act in accordance with traditional gender roles. As a response to this, there are suggestions that gender ideology is a vital component to understanding IPV, and the effect of relative resources appears to be moderated by the husband's gender ideology (Atkinson et al., 2005). There is a growing body of research to support the notion that antecedents, consequences and interpretation of IPV are strongly correlated to gender ideology.

2.5.3 Social learning theory

The social learning theory has its roots in the well-known work of Albert Bandura (Bandura, 1977, Bandura, 1986) and posits that IPV is acquired through the modelling of violent behaviours observed during childhood. The theory grew out of the inability of classical and operant conditioning to provide satisfactory explanations for learning, for example, gender roles or social skills. The general notion behind social learning theory is that gender-linked behaviour is assimilated by children observing and imitating actions by people in their surroundings and whether those actions are being punished or rewarded. The most direct observations occur through parenting, but parenting alone, and the way boys and

girls are treated differently, are not sufficient to fully explain gendered behaviour (Lytton and Romney, 1991).

Research has found that even when parents directly discourage traditional gender roles, or gender typing, children still organise themselves into separate worlds depending on whether they are boys or girls, each directed by 'rules' for what boys and girls do (Meyers, 2005). But social learning does not stop as people grow out of childhood; it is an ongoing process and part of assimilation into society, with people active participants in their own learning (Ronen, 2008).

Bandura (1986) began studying gender modelling in the late 1950s and in 1986 he published *Social Foundations of Thought and Action: a Social Cognitive Theory*. In the 1960s Bandura conducted the Bobo Doll Experiment (Bandura et al., 1961) where he studied the influence of violent behaviour on children and what he found was that violence among children was acquired through the modelling of violent behaviour, something that can transform into IPV later in life. The impacts of exposure to violence affect males and females differently. Females exposed to violence in childhood are more likely to be victimized later in life than males exposed to violence in childhood are of becoming offenders (Mihalic and Elliott, 1997).

The theory provides an explanation for the development and transmission of intergenerational family violence in response to early exposure to IPV in the family or origin. Furthermore, Straus (1980) found that some children who have been victims of abuse learn to use violence as a value rather than turn against it. Limitations of Social Learning Theory include the fact that it ignores the potential moderating role of emotion in IPV, and that it does not account for the use of violence by people that have not been exposed to it in their own families and in early social interactions (Schunk, 2012).

2.5.4 Personality theory

The personality theory is one that is commonly used for the justification of IPV, namely that the perpetrator has certain negative characteristics which make him more prone to violence. This theory has been supported by some clinical data and population surveys, and there are some general personality characteristics that can separate male perpetrators of IPV from the general population such as low self-esteem and high levels of anxiety (Walker, 1979, Barnes et al., 1991, Goldstein and Rosenbaum, 1985). Some researchers suggest that psychopathology and other personality disorders as well as being abused as a child can make some men more violent as adults as demonstrated by the high incidence of psychopathy among abusers (Fugate et al., 2005, Krishnan et al., 2012).

Some psychiatric disorders such as borderline personality disorder and antisocial personality disorder, are sometimes associated with IPV and it is estimated that approximately one third of all perpetrators have some type of mental illness (Siemieniuk et al., 2010, Lee and Hadeed, 2009). A major limitation of this theory is that other researchers have found that less than 10% of perpetrators fit into this category and Gelles (1990) argues that social factors are more important, with personality traits, mental illness, or psychopathy being less important (Muldoon et al., 2011).

This snapshot of causation theories of IPV demonstrates that none of the theories by themselves can adequately and completely explain the occurrence of violence in intimate relationships but they have provided a unique perspective on the issue. However a paradigm shift occurred when Johnson (1995, 2010) argued that there are three different types of IPV namely intimate terrorism, situational couple violence and violent resistance, with different causes and developmental paths and different consequences that need to be analysed through different models.

- **Intimate terrorism** is the attempt to control a partner using coercive and control tactics such as physical and sexual violence, emotional abuse, isolation,

using children, using male privilege, economic control and is usually associated with the more common term 'IPV'. Gender inequality plays a central role in intimate terrorism and it is mainly perpetrated by men against their female partners (Johnson, 1995, Johnson, 2005, Johnson, 2010, Kelly and Johnson, 2008).

- **Situational couple violence** is not rooted in patriarchy or in the need to control another person, and consists of conflicts 'getting out of hand' where one partner uses violence to take control of a specific situation (Johnson, 1995). The violence can be perpetrated by either partner, tends not to escalate and the violence is less severe (Johnson, 1995).
- The third type of IPV is the **violent resistance** and this refers to violent actions carried out in self-defence, such as hitting back, with the perpetrator usually being a woman (Johnson, 2005, Johnson, 2010).

Johnson's typology of violence was substantiated by research carried out in the UK and USA across different population samples (Graham-Kevan and Archer, 2003, Johnson and Leone, 2005) and was used by Menon (2007, 2008) to analyse types of controls in IPV in India. Johnson's framework of IPV is the lens through which I have analysed the issue of IPV in this study. In western societies risk factors for IPV can be categorized into four major groups: poverty, masculine identity, relationship conflict, alcohol and drug abuse (Jewkes et al., 2002). In contrast, in countries with patriarchal societies like India, risk factors for violence against women can be divided into seven groups as follows: perceived male superiority, low status of women in society, poverty, alcohol abuse, presence of in-laws, absence of a male child and possibly inadequate dowry (Rao, 1997, Jewkes et al., 2002, Fikree and Bhatti, 1999).

2.6 Effects of IPV

Violence against women has adverse consequences in the short and long term, on women's health, on the health system and on the community and economy. It has

significant economic consequences, reducing family income and increasing health care costs, job absenteeism, reduced productivity, and costs related to law enforcement. Worldwide, IPV causes as much death and disability in women aged 15–49 years as cancer, and causes more ill health than malaria and traffic accidents combined (WorldBank, 1993). Research has shown that women who have been abused tend to use health services more often than women who have not been abused (WHO, 2005, Resnick et al., 1997, Ellsberg et al., 1999b).

Ellsberg has also shown that abused women earned 46% less than their non-abused counterparts, even after controlling for all other factors affecting earning power (Ellsberg et al., 1999b). Costs of IPV to the community are also high. For example the direct economic cost of all forms of violence against women in Australia in 2002-3 was \$8.1 billion, and in 2008-09 it was \$13.6 billion (Access Economics, 2004, Braaf and Barrett-Meyering, 2011). In Denmark, it was found that the health care costs of victims of violence were €1,800 higher per year than for non-victims, due mostly to higher psychiatric costs and numerous visits to health care facilities due to the violence (Kruse et al., 2011).

In developing countries there are few formal support services for victims of violence and few women seek help from formal services but because of the high prevalence of violence the economic costs associated with IPV are significant. For example in Guatemala, the costs of IPV in 2004 amounted to the equivalent of 7.3% of Gross Domestic Product (GDP) while in Fiji, in 2002 the annual estimated cost was US\$135.8 million or 7% of the GDP (United Nations, 2006). The overall social costs of IPV are significant but difficult to measure accurately (World Health Organisation, 2010). Ongoing violence against women limits efforts to reduce poverty by limiting women's participation in productive employment, it undermines women's access to education, and affects the welfare and education of children in the family (World Health Organisation, 2010).

2.6.1 Short term physical and mental effects

Short term non-fatal physical effects of intimate partner abuse include bruising, cuts, lacerations, fractures, sexually transmitted diseases and acute stress manifested as altered heart and respiration rates and abdominal aches (Shay-Zapfen and Bullock, 2010, Campbell, 2002, Hassan et al., 2004, Sarkar, 2008, Pico-Alfonso et al., 2006, Graham-Bermann et al., 2011, Bonomi et al., 2006, Acierno et al., 1997, Coker et al., 2000, Ellsberg et al., 2000, Kilpatrick et al., 1997, Resnick et al., 1997, Jeyaseelan et al., 2007). Pregnant women who experience violence have an increased risk of miscarriage, premature delivery and giving birth to low birth weight babies (Sarkar, 2008, Shay-Zapfen and Bullock, 2010, Murphy et al., 2001, Janssen et al., 2003).

2.6.2 Long term physical and mental effects

Long term physical health effects of IPV include organ damage, unwanted pregnancies and adverse pregnancy outcomes, chronic infections and systemic disorders due to a depressed immune system from HPV & HIV, gastrointestinal disorders and other chronic conditions such as hypertension, diabetes and asthma (Pallitto and O'Campo, 2005, Campbell, 2002, Coker et al., 2000, Ellsberg et al., 2008, Tjaden and Thoennes, 2000, Decker et al., 2009, Silverman et al., 2008). Violence also contributes to ill health by increasing the negative behaviour of the victims, such as smoking, excessive alcohol and drug use (self-medication) (Schuck and Widom, 2003, Sullivan et al., 2010, Golding, 1999, Bhatt, 1998, Abbott and Williamson, 1999, Walker et al., 1999).

Victims of IPV are also more likely to suffer long-term mental and emotional health problems, including persistent fear, low self-esteem, chronic stress, depression, posttraumatic stress syndrome and suicide. Short term mental health consequences of violence include acute stress, fear and anxiety, which with ongoing violence often become chronic conditions leading to depression, anxiety, obsessive compulsive disorders, eating disorders, post-traumatic stress disorders and suicidal ideation

(Pico-Alfonso et al., 2006, Dutton, 2009, Gururaj et al., 2004, Bradley et al., 2005, Ellsberg et al., 2008, Kaslow et al., 1998, Ishida et al., 2010, Devries et al., 2011).

Studies in India, Bangladesh, USA, Papua New Guinea and Peru show a high correlation between IPV and suicide rates with abused women 12 times more likely to attempt suicide than non-abused women (PANOS, 1998). The WHO multi country study also found that the most consistent risk factor associated with attempted suicide and suicidal ideation, after controlling for demographic variables, was IPV (Devries et al., 2011). See Figure 2.2 for a diagrammatic representation of a hypothetical model explaining the development of violence related common mental health disorders.

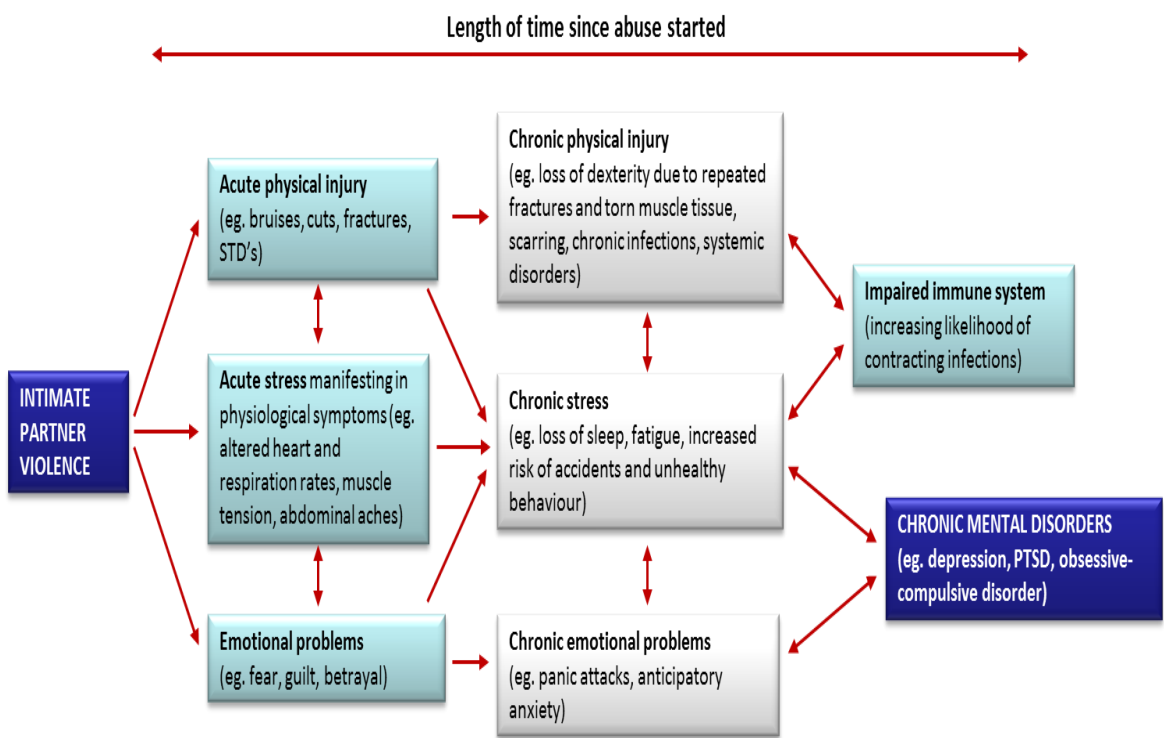


Figure 2.2 Hypothetical model for the development of common mental health disorders. (Source Resnick, Acierno and Kilpatrick, 1997)

2.7 IPV - the Indian perspective

India is a patriarchal, patrilocal and patrilineal society where culture, customs and traditions play a vital role in legitimising, obscuring, and denying the existence of wife abuse. The strong belief in family and marriage as a sacred institution permits violence within its boundaries to be viewed as a private affair, and as such it is often above public scrutiny (Subadra, 1999, Panchanadeswaran and Koverola, 2005). Gender inequality in India is rooted in centuries old religious texts, customs and social norms that class women as socially inferior to men, husbands 'own' their wives and have the right to dictate and dominate every part of her life, including disciplining her (Panchanadeswaran and Koverola, 2005, Martin et al., 2002, Jejeebhoy and Cook, 1997, Rao, 1997).

India's economic restructuring began in the early 1990s, and has undergone dramatic transformations since then with new avenues for prosperity and mobility (social and physical), and new technologies, media and services which have affected the lives of rural and urban Indians in novel ways. At the same time, the patterns of poverty and social exclusion along the lines of caste, class, region and gender continue to exist and thrive within the overall patterns of economic transformation.

The feminist movement in the 1970s and 1980s has brought the issue of IPV to the forefront of Indian national discourse, and effected changes in legislation culminating in the Protection of Women from Domestic Violence Act in 2005. The state and national policies against IPV are informed by the international conventions and India is committed to the Beijing Platform for Action and a signatory to CEDAW. Despite this, responses to IPV in India are marked by the dichotomy between modernity and tradition. Institutions such as the police, the legal system and the health sector are underwritten by modern laws and policies yet are embedded in traditional structures of patriarchy that are influenced by society. These institutions are furthermore largely populated by individuals who

rather than transform the patriarchal structures through their actions tend to perpetuate them instead (Jacobsen et al., 2012).

Jacobsen et al (2012) argue that the context of rapid socio-economic and cultural transformation reinforces the modernity-tradition dichotomy in responses to IPV a view supported by other researchers who found that changes in norms and roles for women have been minimal (Subadra, 1999, Parashar, 2008, Panchanadeswaran and Koverola, 2005). Thus Indian society condones the use of violence against women in certain circumstances for example, wife's alleged sexual infidelity, neglect of household duties, disobedience of husband's dictates and disputes over dowry (Jejeebhoy and Cook, 1997, Jewkes, 2002, Rao, 1997), and when IPV occurs within certain boundaries of severity as set by the community (Jewkes, 2002, Rao, 1997).

Furthermore, violence against women in the martial home is viewed as acceptable by many women, lending support to the theory of 'system justification' which states that subordinate groups tend to embrace ideologies promulgated by dominant groups that justify their own inferiority (Vindhya, 2007). For example Jejeebhoy (1998) found that more than three quarters of women held attitudes that supported and justified the use of violence by husbands against their wives in certain instances, while another study found that 65% of women from South India agreed that a man may hit his wife if she does not do as he says and 36% agreed that a man may force his wife to have sex when she refuses (Krishnan, 2005). However, long term trend analysis of attitudes of men and women to violence has shown a dramatic change for both groups between 1992 and 2007, with significantly more men and women finding violence unacceptable (Simister and Mehta, 2010).

This particular study (Simister and Mehta, 2010) investigated long-term trends in Indian rates of IPV and attitudes to such violence using data from several large scale Indian household surveys that span from 1990 to 2007. The results suggest that

Indian women are becoming more liberated as indicated by increasing trends in attitudes that do not justify violence from partners, but at the same time incidence of IPV have increased. The authors argue that there is evidence to suggest that some of the IPV is a male response to the increasingly modern attitudes of Indian women and this increase may be temporary, as India transitions to a more modern society.

Specific to the Indian subcontinent is the existence of extended or joint families that prescribes rigid and hierarchical norms and roles for all its members promoting group needs above individual needs and age associated status, fostering conformity and interdependence within the family and upholding male domination and female subordination (Segal, 1999b, Srinivas, 1957, Dyson and Moore, 1983). Thus three or more generations and two or more family groupings of the same generation may live together as sons bring their wives into the parental home, although in urban areas, the nuclear family consisting of husband and wife and their children, is becoming more common. In this context, women are expected to be emotionally and socially dependent all their lives, first on their father, then on their husband and in old age on their eldest son (Segal, 1999b, Srinivas, 1957, Dyson and Moore, 1983).

At marriage, which is usually arranged by the parents, women leave their natal family and join their husband's family. This tradition has reinforced women's position as a burden, not valued enough to expend food, education and other resources on as she belongs to her husband's family. Dowry, although illegal for many decades, is still given and demanded at marriage time, and reinforces women's low status in India. In fact, dowry deaths, where women are murdered by their husbands and/or his family because of inadequate dowry has emerged as a worrying trend in recent decades, with thousands of women killed this way every year (Segal, 1999b). These norms are maintained and exacerbated by inheritance,

property and divorce laws that favour men who continue to dominate in the economic, social and sexual spheres of the household (Go et al., 2003).

For abused Indian women, leaving their husbands and/or pressing charges is not a viable option, and most women are aware that their identity is almost exclusively linked to their marital status whilst their socio-economic factors do not provide viable alternatives to the life of violence (Jejeebhoy and Cook, 1997, Jejeebhoy and Sathar, 2001). While there is legislation in place to protect women against 'all types of violence' those responsible for upholding the law, the police, and the justice system are hampered by excessive bureaucracy and corruption, discouraging help seeking by victims of violence (Schuler et al., 2008). Women are reluctant to press charges or imprison their husband because the husband can often bribe his way out of the charges, the process is too costly, and the women fear reprisals by his family or believe he will divorce them and take the children upon his release (Cho, 2012).

Lohia (1998) describes the true story of a newly married pregnant girl whose family was unable to pay the bridegroom's request for dowry, and who was later found dead in the garbage tank with her hands tied behind her back, and her legs and mouth taped. Her family registered a complaint with the police accusing the husband of murder, but the police ruled the act as suicide. Other studies of battered women show that seeking help from the police, community elders or from their natal families did not help the women achieve safety nor prevented the violence, and in some cases the violence increased (ICRW, 2000).

The law is often used in a biased way against women when it comes to assets, for example, it does not protect a woman's right to the matrimonial home, while shelters, legal aid and other organizations that have the potential to help battered women are scarce in India. Moreover the victim is usually ignored or disowned by her relatives for bringing shame on the natal family and she has to cope with the immense stigma attached to being divorced or unmarried. This in turn may cause

the woman and her children to become social outcasts furthermore ostracizing her and making her life even more difficult if not impossible (Lohia, 1998, Subadra, 1999).

In the last decade there has been a significant increase in the number of research studies focusing on violence experienced by Indian women at the hands of their husbands and his family (Speizer and Pearson, 2011, Mogford, 2011, Mahapatro et al., 2011, Babu and Babu, 2011, Raj et al., 2010, Krishnan et al., 2010, Kaur and Garg, 2010, Heilman, 2010, Begum et al., 2010). Common themes emerging from these studies are that violence against women is very prevalent even in pregnancy, the in-laws, particularly the mother-in-law, are often instigators or abusers as well, women have limited recourse and the violence has significant effects on the women's physical and mental health.

2.8 Review of research on IPV in India

In the past decade, the literature on IPV in India has expanded from a few publications that dealt with small, specific sample groups (Jejeebhoy and Cook, 1997, Rao, 1997, Jejeebhoy, 1998, Martin et al., 1999, Segal, 1999b) to numerous publications on various aspects of IPV, its consequences and risk factors based on analysis of national data sets from the National Family and Health Surveys (NFHS). The following section summarises the findings from these studies and discusses some of the more important risk factors for IPV in India.

2.8.1 Prevalence of IPV

In the earliest studies on the lifetime prevalence of physical violence in India, Jejeebhoy and Cook (1997, 1998) found that 40% of women in Tamil Nadu and Uttar Pradesh had been beaten by their husbands, with somewhat higher rates found in the northern state of Uttar Pradesh. Rao (1997) in a sample of 163 women found a prevalence rate of 22% however he cautioned that this figure was significantly under reported. Martin et al (1999) investigated physical and sexual

abuse in five geographic districts of North India using representative samples of male respondents and found that both ranged from 18% to 45%. Between 4%-9% of the men in this sample also admitted that they physically forced their wives to have sexual intercourse (Martin et al., 1999).

In the 1998-1999 National Family Health survey one fifth of ever married women reported experiencing physical abuse, with rates ranging from 6% to 40% in different states (International Institute for Population Sciences and Macro International, 2000). A survey of 1279 men and 553 women from a slum in Mumbai found that 43% of women reported ever being physically abused by their husbands, but only 21% of men admitted to ever abusing their wives (Verma and Collumbien, 2003). Prevalence of violence in the 12 months prior to the survey was similar to both men and women at 11.5% (Verma and Collumbien, 2003).

The WorldSAFE study found lifetime prevalence of any physical IPV to range from a low of 31% in Vellore to a high of 43.1% in Trivandrum with more than 10% of women experiencing current physical violence (Hassan et al., 2004). In the same study sample, the lifetime prevalence of psychological and verbal violence ranged from 18.8% in Vellore to 46.3% in Trivandrum (Ramiro et al., 2004). Another study in Maharashtra, Western India, documented a lifetime prevalence of physical abuse of 46.9%, including during pregnancy, with almost one quarter reporting abuse in the 6 months prior to the study (Jain et al., 2004).

Furthermore, 38% of the women also reported psychological and verbal abuse, 18% were threatened with harm, and 12% of women actually having kerosene poured on them in order to set them on fire (Jain et al., 2004). A study on pregnant women in North India found that approximately a third experienced physical abuse during their pregnancy, and in 48% of cases the abuse was perpetrated by the husband, in 61% of cases the mother-in-law and in 30% of cases by other members of the husband's family (Khosla et al., 2005).

In 2005, a South Indian study documented that 34% of women reported being physically abused, while 12% reported that their husband forced them to have sex against their will (Krishnan, 2005). In another study from North India, 34% of men admitted to ever being physically violent against their wives, with 25% occurring in the year prior to the study, and 32% reported ever having committed sexual violence against them, 30% in the year prior to the study (Koenig et al., 2006). A large scale study investigating men's actions against their wives found that 37% of the 3,642 men had committed one or more acts of physical or sexual violence in the 12 months prior to the study (Stephenson et al., 2006).

More recently, a study investigating physical, psychological, sexual and any type of violence among women from Eastern India found the lifetime prevalence of each type of violence to be 16%, 52%, 25% and 56% respectively (Babu and Kar, 2009). By contrast, the men in the same study reported higher rates of all types of violence except sexual, at 22%, 59%, 17% and 59.5% respectively (Babu and Kar, 2009). Data from the most recent National Family Health Survey NFHS-3 covering the 29 states of India indicated an all India average prevalence of emotional violence of 14%, less severe physical violence such as slapping or hitting of 31%, severe physical violence such as punching or using a weapon of 10%, and sexual violence of 8% (Dalal and Lindqvist, 2010). However there were large differences between the states, for example in Himanchal Pradesh the prevalence of all types of violence was 6.2% while in Bihar it was 59.9% (Heilman, 2010).

Similar to research from developed countries, the lifetime and current prevalence of all types of violence were higher in smaller studies and those carried out in health facilities (Chaudhary et al., 2009, Chandra et al., 2009) than in larger scale population studies (International Institute for Population Sciences and ORC Macro International, 2007). A breakdown of prevalence of violence by religion using the NFHS-3 data shows that rates are highest in the Muslim community (43%) followed

by the Hindu community (39.7%), the Christian (33.6%) and the Sikh (25.3%) (Heilman, 2010).

Finally, analysis carried out to examine long term trends in Indian society regarding IPV shows that between 1995 and 2007 there was a significant increase in the prevalence of cruelty such as verbal humiliation and some physical violence by husbands against wives, however the authors suggest that some of this violence is in response to changes in attitudes and behaviour among women and may only be a temporary increase (Simister and Mehta, 2010).

2.8.2 Risk factors for IPV

It is clear that gender based power dynamics and patriarchal norms underlie women's susceptibility to IPV however studies from developed and developing countries including India have investigated numerous socio-cultural and individual factors that may either pose a risk or protect against IPV. Some factors not only increase the likelihood of IPV but are also an outcome of it, for example economic inequality, and many interact in complex ways, complicating the issue further. In the coming sections, risk factors are discussed using the ecological framework developed by Heise and Garcia-Moreno (2002) but combining community and societal factors into one category as several factors are common to both groups.

2.8.2.1 Individual level factors

a. Education

Education is one of the factors that has shown a consistent and significant relationship to IPV, for perpetrators as well as victims. Both international and Indian studies have shown that IPV decreases with increasing education (World Health Organisation, 2005, Abramsky et al., 2011, Bott et al., 2005, Coker and Richter, 1998, Dalal and Lindqvist, 2010, Hassan et al., 2004, Hien and Ruglass, 2009, Hindin and Adair, 2002, International Institute for Population Sciences and Macro International, 2000, International Institute for Population Sciences and ORC Macro

International, 2007). Being educated gives a woman higher status in their household, and thus make them less vulnerable to abuse (Vyas and Watts, 2009).

In Bangladesh and India, the likelihood of recent physical violence was significantly lower among more educated husbands and wives (7 or more years of schooling) compared to those with no education at all (Koenig et al., 2003, Koenig et al., 2006).

The WHO Multi Country study found that attainment of primary level education by women is somewhat protective against violence, with the highest level of protection occurring when both the male and female have attained secondary education (Abramsky et al., 2011). The most recent NFHS-3 data shows a linear association between education level and probability of experiencing violence, with four times as many illiterate women experiencing violence as those with the highest level of education (49% vs 12%) (Heilman, 2010, International Institute for Population Sciences and ORC Macro International, 2007). Inequality in educational level, particularly where the woman is more educated than the man also increased a woman's risk of experiencing IPV, although the association was found to be weak (Abramsky et al., 2011).

b. Age

A woman's age and her age at marriage are strongly associated with their risk of violence, with younger women and women married at a younger age more likely to experience IPV. The WHO Multi country study, covering 11 developed and developing countries found that younger age of women was strongly associated with recent risk of IPV with women in the 15-19 age group being 5 times more likely to experience violence compared to women over 35 years (Abramsky et al., 2011). Other studies found that risk of abuse decreases with increasing age, suggesting that in India younger women may lack the experience to avoid situations that trigger abuse, or lack social support during integration process into the husband's household (Sambisa et al., 2011).

Age at marriage is an important risk factor in India, and although the legal age is 18, one fifth of respondents in the NFHS-3 were married by the age of fourteen and 86% were married by the age of twenty (International Institute for Population Sciences and ORC Macro International, 2007). Indian studies have found that women who are married at a younger age are at increased risk of IPV (ICRW, 2000, Kishor and Johnson, 2004). Almost half (46%) of women married under the age of 15 have experienced physical or sexual violence compared to one fifth of women who were married at 20 years old (International Institute for Population Sciences and ORC Macro International, 2007).

c. Witnessing violence

Intergenerational transference of violence is not a new concept, and studies have found that a child's exposure to violence between adults in the home was the strongest risk factor for committing violent acts as adults, with children adopting the roles they witness in their homes, as either perpetrator or victim (Seltzer and Kalmuss, 1988, Turcotte-Seabury, 2010, Skaperdas et al., 2009, Stith et al., 2000). Kishore and Johnson (2004) in a study across nine countries found that women who witnessed violence between their parents were twice as likely to experience abuse themselves.

In the NFHS-3, one fifth of the respondents had witnessed violence perpetrated by their father on their mother as children, and the prevalence of IPV among these women was 63%, or twice as high as among women who had not witnessed childhood violence (Heilman, 2010, International Institute for Population Sciences and ORC Macro International, 2007). Among the men surveyed in the NFHS-3 study, a third had witnessed their father beating their mother in childhood, and 46% of these men went on to commit IPV compared to 35% who did not (Heilman, 2010, International Institute for Population Sciences and ORC Macro International, 2007).

Thus in India it appears that women's experiences of childhood violence are more predictive of future IPV than those of men.

d. Drug and alcohol misuse

Alcohol and drug misuse are correlated with many relationship issues, including increased rates of family and IPV and the violence is more frequent and severe (Stanley, 2008, Graham et al., 2011). While there is no conclusive evidence that alcohol misuse definitively causes IPV, alcohol has repeatedly been found to be a risk factor. Studies found that women whose partners misused alcohol were 3 to 3.6 times more likely to experience IPV compared to other women (Stanley, 2008, Demetrios et al., 1999). Bennett et al (1994) found that men who perpetrated IPV tended to be younger, consumed more alcohol frequently and had more alcohol related problems (Bennett et al., 1994).

In India, a husband's alcohol consumption was significantly associated with IPV, regardless of caste and economic status, and more than half of women whose husbands consume alcohol reported experiencing violence (Krishnan, 2005, ICRW, 2000). In the NFHS-3, 39% of men reported consuming alcohol and over half (54%) of the women whose husbands used alcohol reported some kind of IPV (Heilman, 2010, International Institute for Population Sciences and ORC Macro International, 2007). It is clear that alcohol is a major risk factor for IPV in India (Kaur and Garg, 2010, Babu and Kar, 2010, Pandey et al., 2009, Jacob et al., 2009, Chaudhary et al., 2009).

Illicit drug use is also a major risk factor in IPV; however it has not been widely studied in India. Studies from developed countries show that women who use illicit drugs are 2-4 times more likely to be victims of IPV (El-Bassel et al., 2005). Another study found that half of the males that commit IPV in the US also use illicit drugs, compared to 18% of males that do not abuse (Lipsky and Caetano, 2011). In Bangladesh use of marijuana was the social variable with the strongest relationship

to violence, with users more than twice as likely to also have perpetrated violence against their spouses in the past year (Johnson and Das, 2009).

The only national household survey on illicit drug use in India was published by the United Nations Office of Drugs and Crime (UNODC) and found that in 2004 ten million Indians were chronically dependent on alcohol, 2.3 million on cannabis and 0.5 million on opiates (United Nations Office of Drugs and Crime (UNODC), 2005). This translates in India's population having twice the global average prevalence of illicit opiate consumption as well as similarly high rates of illicit drug related violence and crime including IPV (United Nations Office of Drugs and Crime (UNODC), 2005).

e. Children

Generally studies from developed and developing countries have found that the risk of IPV increases with the number of children, for example in the US, a woman who has at least one child is twice as likely to be abused than one without children, whereas in India and Bangladesh, the odds of abuse significantly increase if a woman has three or more children (Vest et al., 2002, Panda and Agarwal, 2005, Sambisa et al., 2011, Peedicayil et al., 2004). In Pakistan, a study found that women with five or more children were almost three times more likely to have experienced physical and sexual violence by an intimate partner.

However this may also be an indication that women that experience frequent physical and sexual violence are more likely to have more children due to their lack of decision making power regarding contraceptives (Kapadia et al., 2010). Comparable findings from numerous studies in developing countries suggest that having children can potentiate IPV by exacerbating factors such as poverty related issues e.g. lack of space and resources (Vest et al., 2002, Panda and Agarwal, 2005, Sambisa et al., 2011).

Data from the NFHS-3 supports these conclusions, with results that show that women that do not have a child, have significantly reduced odds of experiencing physical and emotional IPV but not sexual violence (International Institute for Population Sciences and ORC Macro International, 2007). Heilman (2010) posits that the ability to decide not to have children may be one indicator of autonomy that reduces a woman's risk of experiencing physical and emotional violence.

Male child preference, which has a prevalence of 20-25% among Indian men and women, is associated with negative attitudes towards women and increased risk of IPV (Vindhya, 2007, Raj et al., 2010, Raj et al., 2006, Diamond-Smith et al., 2008, Santhya et al., 2007). A lack of a male child or the existence of only girl children increases a woman's risk of experiencing IPV but also the risk of violence by in-laws, and the existence of a male son has been found to be protective against violence in only a few studies (Vindhya, 2007, Raj et al., 2010, International Institute for Population Sciences and ORC Macro International, 2007, Schuler et al., 1996, Rao, 1997).

2.8.2.2 Family and relationship level factors

a. Socio-economic status

Wealth of a household was found to be a protective factor with significant or non-significant protective relationships to IPV (Vyas and Watts, 2009). IPV occurs in all socio-economic groups, however it has been repeatedly found to be more prevalent and more severe in poorer communities in countries as diverse as USA, Bangladesh, Nicaragua and South Africa (Bates et al., 2004, Ellsberg et al., 1999b, Jewkes et al., 2002). The NFHS-3 supports this finding in India, showing that women in the poorest quintile were 30% more likely to experience violence compared to women in the richest quintile (Heilman, 2010). Furthermore, a south Indian study found that violence was less likely in richer families because they could afford to pay higher dowries, thus protecting their daughter from violence (Srinivasan and Bedi, 2007).

b. Employment and independent income

A woman's employment status and the ability to contribute to household resources show a mixed effect on risk of IPV. Studies investigating women's employment status and risk of violence found that in Egypt being employed was associated with significantly lower violence however in India and Bangladesh it was associated with higher physical violence and in the Dominican Republic and Nicaragua with higher physical and/or sexual violence (Kishor and Johnson, 2004, Vyas and Watts, 2009). On the other hand, in Albania an unemployed woman had significantly lower risk of violence when compared with women in white collar employment (Vyas and Watts, 2009). In India, women that owned land had significantly lower risk of intimate partner physical violence compared to women that did not own land (Panda and Agarwal, 2005). It seems that the ability to bring an income offers a higher status to a woman and lessens the risk of violence, but, depending on the country context ,it can also challenge traditional gender roles and power balance in the family and increase her risk of violence (Vyas and Watts, 2009).

c. Membership in micro-credit or women's community groups

Of particular interest in India and South Asia generally is the effect of women's membership in a micro-credit organisation or women's group on the risk of IPV. Such organisations are very popular and have high levels of membership, and are promoted to increase women's status and autonomy by making her life more visible and by increasing her perceived value in the family (Bates et al., 2004). To date the evidence on the direction of the nature and relationship between women's membership in savings and credit groups and IPV is uncertain (Koenig et al., 2003). For example Schuler et al (1996) found that membership in micro credit and savings programs was associated with two thirds lower risks of violence and that these protective effects extended to non-members living in villages with credit programs (Schuler et al., 1996).

Other studies have found the opposite with 70% of women indicating that violence had increased following their membership in such a group, and only 20% reporting a decrease in violence (Rahman, 1999). Koenig et al (2003) found that effects of micro credit and women's group membership on risk of violence depended on the cultural context of the community. That is, in more traditional and culturally conservative communities, membership in a savings scheme and consequent empowerment escalated the prevalence of IPV, while in less conservative and traditional communities, membership had no effect on the risk of violence (Koenig et al., 2003). Koenig et al propose that this escalation in violence is only temporary and in response to women's changing roles, but after "women's individual and collective empowerment and autonomy gain acceptance and become commonplace" a decrease in the risk of violence will be observed (Koenig et al., 2003).

d. Autonomy

Dyson and Moore (1983) defined autonomy as the extent to which women can promote their self-interests and that of their children and described several measures of autonomy relevant to developing societies including level of mobility outside the home, choice of partner and marital arrangements that do not estrange women from their natal family, inheritance rights related to property and some control of reproductive rights (Dyson and Moore, 1983). Govindasamy and Malhotra (1996) redefined autonomy to include culturally specific and relevant concepts such as women's ability to negotiate and measured women's position in society through variables such as input into household decision-making, and control of household resources (Govindasamy and Malhotra, 1996). Because studies use proxy measures for autonomy such as level of mobility outside the home, reproductive choices and opportunity to make household decisions, it is difficult to determine conclusively the relationship between autonomy and the risk of violence, particularly as the effects of individual and contextual aspects vary significantly according to sociocultural conditions (Koenig et al., 2003).

Some studies found that autonomy increases with age (Acharya et al., 2010), and increasing age is negatively associated with risk of IPV although the causative relationship is not clear. In a south Indian study (Krishnan, 2005), employment and control over income were used as proxy measures for autonomy, and found that for those women who worked for and had control over their income were more than twice as likely to experience IPV than other women. Koenig et al (2003) posits that in conservative settings increased female autonomy may be considered provocative and actions related to the expression of autonomy increase the risk of IPV.

e. Family structure

Family structure such as living with in-laws or as a nuclear family is a factor that has mixed effects on the risk of IPV. Several South Asian studies have found that living in extended families increases the risk of IPV, and this violence occurs in the context of broader family violence with women already abused by their husband being 5.3 times more likely to be abused by their in-laws as well (Raj et al., 2010, Raj et al., 2006, Chan et al., 2009). On the other hand, a study from Bangladesh found that women residing in extended families had a significantly lower risk of violence compared to women living in nuclear families (Koenig et al., 2003). Menon and Johnson (2007), using NFHS-2 data found that the odds of a woman experiencing violence was less if she lived in an extended family or if others in the family were responsible for household decisions. In south India and Cambodia, living with a member of the wife's family was also related to significantly lower rates of IPV (Rao, 1997, Koenig et al., 2003).

2.8.2.3 Socio-cultural and community level factors

a. Rurality

The WHO Multi Country Study on Domestic Violence has found that in all countries of the study, the prevalence of IPV was higher in rural areas compared to urban areas (World Health Organisation, 2005). This finding holds true for India as well

(International Institute for Population Sciences and ORC Macro International, 2007, Kishor and Johnson, 2004) although one study found that prevalence rates in urban slums are even higher than in rural areas of India (ICRW, 2000). India's population is predominantly rural, with only 11% living in large cities, 22% in small towns and the rest in rural areas (International Institute for Population Sciences and ORC Macro International, 2007). The NFHS-3 data shows that rurality increases the likelihood of experiencing IPV with 42.9% of women from rural areas reporting violence compared to 28.7% of women who reside in an urban area (Heilman, 2010, International Institute for Population Sciences and ORC Macro International, 2007).

b. Cultural and community norms

Anthropological studies have shown that community level cultural and contextual factors influence the levels of IPV in various cultures and in particular that community level sanctions against severe violence were an important factor in restricting levels of violence against women (Koenig et al., 2003, Counts et al., 1992). Furthermore, societies undergoing social changes that challenge traditional gender roles were found to have higher rates of IPV (Hindin and Adair, 2002, Koenig et al., 2003, Koenig et al., 2006). By comparison, more traditional societies where women conform to traditional gender norms have lower rates of violence than societies in which women are more empowered (Campbell and Soeken, 1999, Koenig et al., 2003, Schuler et al., 1996). Other studies found that communities with higher patriarchal ideologies had higher rates of IPV, and violence was more common among men who held strong patriarchal beliefs (Pallitto and O'Campo, 2005, Yllo and Straus, 1984).

Menon (2008) on the other hand found strong evidence that in highly patriarchal societies the risks of violence may be reduced because the family structure (i.e. joint or extended) limits women's attempts at transgressing against traditional gender norms and that violence may be used as a last resort, after all other control mechanisms have failed (Menon, 2008). In the NFHS-3, a proxy measure for

patriarchy and traditional gender norms was husbands' controlling attitudes. Results show that the likelihood of violence by a husband that tries to control his wife is twice as high as that of a husband that does not try to control his wife, 56% vs. 27% respectively (Heilman, 2010, International Institute for Population Sciences and ORC Macro International, 2007).

c. Attitudes to and tolerance of violence

Communities in which there is a tolerance for the use of violence to solve disputes, such as societies in active conflict or post conflict, and/or in which the members hold attitudes that justify the use of violence against women have been shown to have significantly higher rates of IPV (Segal, 1999b, Ahmad et al., 2004, Ahmed-Ghosh, 2004, Dobash and Dobash, 1979, Yllo and Straus, 1984). In the WHO Multi Country Study, women who justified a man's use of violence against his wife were more likely to have experienced IPV themselves (WHO, 2005). Heilman (2010) found similar results in India, with 45.6% of women who justified partner violence having been victims themselves compared to 32.4% of women who did not justify violence. Similarly, 43.4% of Indian males that justified violence against women were also violent towards their wives compared with 34% who were not (Heilman, 2010). In conclusion, there are many risk factors that need to be taken into consideration when investigating IPV, and the above sections describe the main ones that affect Indian women.

2.9 Summary of the chapter

IPV is one of the visible and most pervasive signs of gender inequality. There are many theories that try to explain how and why IPV exists but none of them provide a complete explanation or way to rectify the issue. IPV occurs in all countries but it is more likely to occur in patriarchal societies. The effects of IPV are well documented and include short term physical injuries as well as long term mental health problems. In India, recent studies have shown that approximately 1 in 3

women suffer IPV which is accompanied by sexual, physical and mental health issues. The next chapter discusses stress and coping in victims of IPV.

CHAPTER 3

STRESS AND COPING

“Life is not always a matter of holding good cards, but sometimes, playing a poor hand well.” – Robert L Stevenson quoted in Sacred Journey of the Peaceful Warrior (1991) by Dan Millman, p. 78

3.1 Introduction to the chapter

To enable a better understanding of the processes surrounding IPV and its relationship to common mental disorders, the theories of stress and coping are discussed and IPV, and all it encompasses, is categorised as a stressor. Before continuing any further, it needs to be emphasised that the topics of stress, stress response and coping in humans and how these affect health, and in particular mental health, are immensely complex processes that have been studied for a relatively short time (since mid-last century). As such the interactions between stress, coping and ill health are not completely understood or explained especially in relation to such a multifaceted issue as IPV.

The theoretical foundations discussed in this chapter have been developed from a Western middle class perspective, based on research carried out by Western scientists on Western participants and thus generalization to other cultures needs caution. There is a dearth of research on the processes of stress and coping from an Indian perspective, and the final section of this chapter discusses Laungani’s work (2002) on the cross cultural variation of defining stress and coping and Palsane and Lam’s work (1996) on stress and coping from a traditional Indian perspective.

3.2 Theories of stress

This study is grounded in the seminal works of Lazarus (1984, 1991), Bandura (1986, 1992) and Hobfoll (1988, 1989). In the cognitive-relational theory, Lazarus and Folkman (1984) define stress as:

“Stress is a particular relationship between the person and the environment that is appraised by the person as taxing or exceeding his or her resources and endangering his or her well-being” (p. 19).

This theory has been further expanded to a meta-theoretical concept of emotion and coping processes (Lazarus, 1993) whereby these complex processes are made up of:

- Causal antecedents or person related variables such as beliefs and commitments and environmental variables such as situational limitations and requirements;
- Mediating processes such as mental assessment of the requirements of the situation as well as the required coping strategies (problem and/or emotional focused);
- Effects including short term physiological changes and long term psychological and physical health.

Cognitively, initial exposure to a stressor can be assessed and classified as challenging, threatening or harmful. Challenging situations involve physical and psychological activity; the person has an opportunity for personal growth and the situation is usually experienced positively, for example participating in a race. In a threatening situation the person perceives being in danger and expects future harm or loss and this can be both physical and/or emotional. The level of threat experienced is related to the difference between perceived coping capacity and the potential level of harm of the situation.

Although the situation is experienced negatively the individual involved attempts to engage strategies to take control of the situation, for example being followed while walking alone on a dark street. Finally, in a harmful situation the person has experienced some kind of damage, be that physical injury, loss of important

person(s) or item(s), loss of confidence or social standing. In such a situation, instead of trying to implement strategies to take control of the situation, the person is overwhelmed by a feeling of helplessness and gives up. Concurrently with this initial assessment, a person exposed to a stressor undertakes a secondary assessment or appraisal and evaluates their available coping options including physical strength, social support and material or other resources to effect a change in the situation in order to remove or minimize the stressor (Lazarus, 1993).

Folkman (2008) further revised and modified the theory of stress to include the role of positive as well as negative emotions in the process of stress. She discussed recent research evidence that highlighted the restorative roles of positive emotions in relation to psychological, physiological and social coping resources. Outcomes include benefit finding and reminding (e.g. the silver lining in every cloud), adaptive goal processes (e.g. relinquishing unattainable goals and re-engaging in alternative goals), reordering priorities (e.g. focusing on what is important) and giving ordinary events positive meaning.

While the mechanisms of action are complex and not always straight forward, the consequences of these positive emotions include restoration of self-confidence, reinstatement of feeling of control, sense of mastery and renewed sense of purpose all of which assist with coping processes and moderate negative outcomes such as depression and anxiety (Cronbach and Shavelson, 2004).

Hobfoll (1989) expanded the definition of stress into the model of conservation of resources which is based on the assumption that *“people strive to retain, protect, and build resources and that what is threatening to them is the potential or actual loss of these valued resources”* (p.513). The model of conservation of resources builds on Maslow’s *hierarchy of needs* theory (Maslow, 1968) and Bandura’s *social learning theory* which states that people interact with their surroundings in order to increase the chances of obtaining positive reinforcement (Bandura, 1977).

Thus according to Hobfoll the definition of psychological stress is a response to a situation where there is the perceived threat of or actual loss of resources or a lack of resource gain after the investment of resources (Hobfoll, 1989). Furthermore, even the perception of a loss or lack of gain of resources is enough to produce stress. In this case, resources are defined as any objects, personal characteristics, traits or anything else that is of value to a person or provide a way to obtain these objects, personal characteristics, traits (Hobfoll, 1989). Similar to Lazarus and Folkman's (1984) stress-coping model which states that people try to limit stress when exposed to it, the *conservation of resources* model predicts that people will attempt to minimize loss of resources when exposed to stressors. People also strive to increase their resources by investing resources they already have or are available in their environment, for example, giving love and affection in return for the same.

The ecological model of stress in violent relationships takes into account the individual, interpersonal and systemic factors which affect partner perpetrated violence (Gondolf, 2004, Heise, 1998). Individual factors include the personal history of the woman, such as witnessing abuse between parents while growing up, literacy level as well as culture specific notions of stigma attached to disclosure of violence and socialization to feel shame and guilt if a woman seeks help (Cho, 2012). Intermediate factors consist of the immediate context where the violence occurs such as the marital or other relationship, as well as allocation of control over income and family wealth to the male.

Systemic factors in this model consider the formal and informal social structures external to the relationship such as extended family, neighbourhood, work, the state and other institutions. It also includes the community attitudes to gender roles, female ownership of assets, normalisation of violence and male aggression (Cho, 2012). Culture specific notions in systemic factors include rigid gender role stereotyping, acceptance of female abuse in society, a subculture that normalizes

male privilege and dominance, lack of services to victims of violence due to patriarchal values within the police, legal and health sectors which promote stigma and lack of legitimacy for the issue of violence (Cho, 2012).

In conclusion, the process of stress and coping has a transactional nature, the person interacts with the stressor and the environment in an attempt to minimize or remove the stress, while at the same time the environment and the stressor influence the person, and each other, in a process of constant change (Green and Baxen, 2002). Furthermore, Aldwin states that stress, coping and health are lifelong processes, have a multidisciplinary perspective reflecting the roles of cellular, organismic, personal and systemic interactions, reflect past or current contextual factors such as socioeconomic status and are influenced by individual differences such as decisions on whether and how to react to a stressor (Green and Baxen, 2002).

3.3 Biology of stress and disease causation

An important aspect that needs to be examined at this point is the biology of stress, namely what happens in the human body during and after exposure to stress, and in particular exposure to long term or chronic stress such as when living in a violent relationship. A short overview of the most recent evidence on the pathways linking stress to disease is also provided. Methodological reasons have led to the study of the effects of stress on the endocrine, immune, haemostatic and nervous systems as individual or separate systems, however in reality these systems are closely integrated and constantly communicate with each other via complex pathways and feedback mechanisms (Marmot, 2005). The biology of stress response is an extremely complex process and beyond the scope of this study and thus only a generalised and short synopsis is provided herewith.

3.3.1 Biology of short term stress response

Ideally the body aims for a state of metabolic equilibrium called homeostasis where the stimulating and calming chemicals in the body are balanced. The process by which the body achieves equilibrium is called allostasis (Brunner and Marmot, 2005). The sympathetic nervous system (SNS), which stimulates the body, and the parasympathetic nervous system (PNS), which is responsible for the relaxation response, use hormones to carry out their functions. The hypothalamic-pituitary-adrenal (HPA) system is activated first in a stress response (Marmot, 2005).

Exposure to a one off stressful event, such as one violent incident by the husband, results in the sympathetic nervous system engaging the endocrine glands to initiate several metabolic processes which collectively are known as the flight or fight response. During this period the HPA system activates the production and release of corticosteroids including cortisol, and neurotransmitters such as dopamine, norepinephrine, and epinephrine (also called adrenalin) (Marmot, 2005). These hormones activate a chemical cascade leading to increased breathing, heart rate and blood pressure. The aim of this process is to move the oxygen rich blood to the brain and the muscles at a faster rate in readiness for fighting or fleeing. The epinephrine also releases glucose and fatty acids into the blood for readily available energy while other hormones shut down functions that are not necessary for fighting or fleeing.

The physical activity of fighting or fleeing then metabolizes the stress hormones released as a result of the activation of the sympathetic nervous system allowing the body to return to homeostasis. However if there is no opportunity to fight or fly as may be the case of an abused wife, the hormones circulate in the body for a longer period as the parasympathetic nervous system works on decreasing the sympathetic nervous system activity and remove the hormones associated with the initial stress response (Cohen et al., 2007).

The fight or flight response is a defence system that has been hard wired in the human brain for over 40,000 years and was designed for short-term use to allow the body to deal with physical threats such as attack by wild animals, where the emergency resolves very quickly either by fleeing or staying and fighting. In the modern world however, the stressors that set off the fight or flight response tend to be psychological in origin and chronic, such as financial worries, health problems and relationship issues and cannot be resolved by fighting or fleeing. While the fight or flight response is adaptive in situations of acute stress, it is maladaptive in chronic stress situations (Sapolsky, 1993).

3.3.2 Biology of chronic stress response

Chronic stress is the worst culprit as it is most likely to result in long term or permanent changes in the psychological and behavioural responses that control susceptibility and course of disease (Cohen et al., 2007). If the stressor is not removed after the initial flight or fight response or if it occurs frequently enough such as in the case of a wife being abused regularly, the parasympathetic nervous system does not have the time to return the body to equilibrium and the body is in a state of chronic hyper-arousal. Eventually the sympathetic nervous system activity declines and neurotransmitter production decreases, but corticosteroid secretion continues at levels higher than normal. If the stress continues long term the fight or flight response can become overactive and the body can suffer allostatic load which is an impairment of the body's ability to return to equilibrium (McEwen, 1998).

This stage is characterised by elevated cortisol and suppressed serotonin levels.

- **Elevated cortisol effects** – Increased cortisol levels in the brain lead to destruction of neurons and inhibition of blood sugar uptake by the hippocampus, the brain's primary memory centre resulting in short term memory loss. The regulation of the endocrine system is also affected, becoming less responsive resulting in increased production of stress hormones causing more stress and damage to the brain in a self-harming

cycle. Cortisol affects the body's immune responses via numerous biochemical pathways, including decreasing cellular immunity and suppressing the body's natural response to a challenge, leading to inflammatory and autoimmune diseases and an increased susceptibility to infection and tumours (Cohen et al., 2007).

- **Decreased serotonin effects** – Serotonin regulates body temperature, blood pressure, immunity, pain, digestion, sleep, and circadian body rhythms. Decreased serotonin levels have been shown to result in increases in irritability, depression, suicide, alcohol and drug use, eating disorders and obsessive-compulsive disorder. Long term serotonin deficiency has also been implicated in the neurobiology of post-traumatic stress disorder (PTSD) (Brunner and Marmot, 2005, Marmot, 2005).

To summarise, the biological response to a stressor affects health by increasing vulnerability to an illness or acts as a trigger for acute events e.g. heart attack (Brunner and Marmot, 2005). Chronic stress increases the risk of cardiovascular disease, elevates the blood pressure, increases atherosclerosis, and increases the risk of heart attack. Through its complex effect on the neuroendocrine and immune systems chronic stress can affect the onset of, and susceptibility to disease, the progression or course of disease, even when there is another cause to the disease; and can affect one's recovery from disease (Brunner and Marmot, 2005, Marmot, 2005). Chronic stress has been linked to cancer, diabetes, obesity, and excessive alcohol and other drug- use.

The possible process through which chronic stress can increase vulnerability to an illness is by increasing the baseline levels of the neuroendocrine feedback controls (Steptoe and Marmot, 2002). This conclusion is supported by research that found altered functioning of the main neuroendocrine stress pathway in people with a low quality of life (social and environmental) even after controlling for confounding

variables (Sjögren et al., 2006, Kristenson et al., 1998). What has not been proven yet is whether the abnormal neuroendocrine functioning is responsible for future ill health, however findings from animal studies certainly point in that direction (Brunner and Marmot, 2005). Thus prolonged exposure to chronic stress, together with low levels of control over the situation and no possibility for resolution is associated with ill health via the biochemical pathways described above, making stress a major causative factor in the development of both physical and mental health issues (Bosma et al., 1997, Brunner and Marmot, 2005, Marmot, 2005, Cohen et al., 2007).

3.4 Stress and CMD

There is an abundance of robust empirical evidence that indicates a causative relationship between stress and depression (Hammen, 2005), with stressful events preceding major depressive episodes. For example in population samples 80% of depressed patients experience a major stressful event in their life prior to developing depression compared to non-depressed patients. This significant relationship has been confirmed by stringent testing and through the use of unplanned or fateful events as stressors such as disasters and unplanned death of family members and twin studies (Hammen, 2005). Whilst most of the research on the relationship between stress and depression has focused on stressful events that have a defined beginning and an end, Kendler et al (Kendler et al.) have shown that there is a linear association between the frequency and severity of stressful events and the probability of developing depression. The time frame that precedes the onset of major depression varies somewhat between studies but generally ranges from three to six months (Hammen, 2005).

3.5 Coping

Simply put, coping is any action that is taken to deal with a situation that is stressful or perceived to be stressful. Coping is a very individual and subjective process that is influenced by culture (Pargament, 1997) as well as constrained by it.

“Culturally derived values and beliefs serve as norms that determine when certain behaviours and feelings are appropriate and when they are not . . . even allowing for a wide range of situational and individual differences, culturally derived values, beliefs, and norms operate as important constraints” (Lazarus and Folkman, 1984 p165)

Coping modalities have been categorised into two groups by a number of researchers.

- **Problem-focused vs. emotion-focused coping** (Lazarus and Folkman, 1984) – where coping focuses on changing the problem so it becomes less stressful versus the use of emotional responses to cope with the stress caused by the problem.
- **Locus of control and responsibility** (Rotter, 1966) – where control and responsibility for a stressor are attributed to either internal or external factors, and coping mechanisms follow accordingly.
- **Assimilative vs. accommodative coping** (Brandtstädter, 1992) – where coping mechanisms try to restore the situation to pre-stressor state versus accepting the stressor as an unchangeable factor and coping consists of acceptance, priority setting, and cognitive restructuring.
- **Mastery vs. meaning coping** (Taylor, 1983) – where coping involves attempts to control the stressor and modify it versus finding meaning in the stressor and its consequences.
- **Primary control vs. secondary control coping** (Rothbaum et al., 1982) where primary control coping consist of attempts to change the stressful circumstances versus secondary control coping mechanisms that involve efforts to adjust to circumstances as they are.

The common denominator for each of these categories is that the first coping modality involves attempts by the individual to change the stressor in relation to

themselves while in the other modality the individual attempts change within themselves in relation to the stressor.

Coping is also time dependent, that is coping can occur before, during and after exposure to a stressor and was categorised by Beehr and McGrath (Beehr and McGrath, 1996) as follows:

- **Preventive coping** – occurs a significantly long time prior to a stressor; for example an overweight person losing weight to avoid the risk of diabetes
- **Anticipatory coping** – occurs when the stressor or stressful event is anticipated soon, for example someone afraid of flying taking a tranquillizer while waiting take-off.
- **Dynamic coping** – occurs while the stressor or stressful event is ongoing; for example, meditating to divert attention from pain during childbirth
- **Reactive coping** – occurs after exposure to a stressor or stressful event; for example, getting used to a wheelchair after a car accident.
- **Residual coping** – occurs long after exposure to the stressor or stressful event, by dealing with long term effects; for example, by not allowing oneself to think painful thoughts many years after a traumatic event.

Finally, coping is process oriented, strategies and actions change with time, experience and the nature of the stressor and the process is constantly assessed within the context of the stressful situation and the positive and negative emotions it raises (Lazarus and Folkman, 1984, Lazarus, 1993, Cronbach and Shavelson, 2004). The role of coping is to protect people from psychological harm related to stressful experiences, and this can occur by eliminating or minimizing the stressor, by mentally controlling or defining the meaning of the stressor in a way that is acceptable or by controlling or attempting to control the stress reactions and consequences (Pearlin and Schooler, 1978, Koenig, 2009).

3.5.1 Coping strategies in women experiencing IPV

Women who experience IPV use a combination of help seeking and coping strategies to deal with the physical and/or mental health effects of violence and to help secure safety, and it is proposed that help seeking resources are related to women's coping styles (Ambuel et al., 2011, American College of Obstetricians and Gynecologists, 2012). Contrary to common perception, the majority of women (up to 80%) in industrialised countries use formal or informal resources for coping with their partner's violence and its consequences, including health services, lawyers, police, shelters and clergy (American College of Obstetricians and Gynecologists, 2012). Goodman (2003) summarized these help seeking responses into:

- Informal networks (talking or staying with family, friends),
- Formal and legal networks (clergy, employers, domestic violence shelters, violence restraining orders),
- Safety planning (hiding money, improving safety),
- Resistance (fighting back, shouting, physical retaliation, leaving home), and
- Placating (keeping quiet and doing what is asked by the perpetrator).

As discussed earlier in this chapter, coping modalities can be dichotomized into problem-focused or emotion-focused (American College of Obstetricians and Gynecologists, 2012, Cronbach and Shavelson, 2004). For women in IPV situations problem-focused coping strategies include action oriented practices to manage stress such as changing the environment, attempts to resolve the problem, modifying their own behaviour to lessen the stress or taking action to change the source of stress (Lazarus and Folkman, 1984, Lazarus, 1993). By contrast, emotion-focused strategies aim to lessen the emotional distress arising from IPV and consist of techniques that modify emotions in the victim rather than change the stressor or environment (Lazarus and Folkman, 1984, Lazarus, 1993). It is theorized that initiation of formal and informal help seeking and the type of help sought are influenced by the coping styles used by the victim of IPV (Ambuel et al., 2011, American College of Obstetricians and Gynecologists, 2012).

Liang et al (2005) recommend that women's help seeking and coping strategies be examined within the broader social context as cultural values and norms about gender and class, religious affiliation, and attitudes toward the acceptability and use of violence can affect their perceptions of whether the violence is an issue, whether it is acceptable to seek help and whether services for victims of violence exist at all and are accessible (American Medical Association, 1996, American College of Obstetricians and Gynecologists, 2012). Pinnewala's work (2009) on the development of a new theoretical framework for South Asian women subjected to partner violence supports the view that women's help-seeking behaviours and coping mechanisms are determined by cultural factors and societal constructs of womanhood.

In South Asian cultures, patriarchy and all the associated factors tend to prevail and women are held responsible for the maintenance and development of the well-being of the family and its members even at a personal, emotional, and physical cost to themselves (Cho, 2012). Combined with factors such as the importance of collective identity, the societal construct of women as sacrificing, dutiful partners, wives, and mothers, inadequate legislation and lack of external support systems to assist victims of IPV, South Asian victims of IPV are in a more difficult situation than their Western counterparts (Cho, 2012, McNutt et al., 1999). Often, leaving the relationship is not a valid option, and South Asian women need to engage strategies that minimize the violence, and develop resilience to cope with trauma by utilising their cognitive resources and the limited community resources and support systems.

Similar to Western women's processes within the cycle of violence, South Asian women engage a variety of coping strategies and the process occurs in stages where the woman progresses and regresses through stages repeatedly as she

attempts to develop effective coping skills in response to violence (Cho, 2012, McNutt et al., 1999, Patel et al., 2007).

Initially, women may react to the violence by denial of the abuse or the extent of its consequences, and particularly in developing countries, they may be unaware that violence constitutes a legitimate issue. Then women tend to engage in emotion regulation, seeking support from informal sources and avoidance strategies due to issues such as stigma attached to disclosure and a lack of resources or alternatives. Emotion-focused or avoidance coping and the use of religion are more frequently used in non-Western cultures particularly in those that emphasize group benefit over individual benefit and have strict hierarchical concepts (Shepard and Pence, 1999).

Seeking informal support from friends, family, and other community members to resolve the violence is also favoured over accessing formal supports such as pursuing the legal process (ICRW, 2000). Active problem-solving through accessing external support systems, including crisis counselling tends to be a longer process particularly in places where external resources are minimal or difficult to access, and is thus one of the later stages of the coping process (Cho, 2012). In India and most other South Asian countries, the majority of women do not go beyond preparation to leave the abuser, and the few that do leave end up returning to the relationship due to societal pressure, economic dependence, inability to support their children, stigma, and lack of social support (Cho, 2012). This study focused on two specific factors that can moderate the effects of IPV on mental health, namely **social support** and **religiosity**, and these will be discussed in more detail in the coming sections.

3.6 Social support

Social support is defined as "resources provided by others" (Cohen and Syme, 1985), or as "coping assistance" (Thoits, 1983) and it is derived from the effects of

loss of relationships (Stansfeld, 2005). Definitions of social support can include the structure of individual social life such as group memberships, and existence of family ties, as well as the roles they may serve such as emotional support; (for a review see Cohen et al., 2000) (Minnesota Advocates for Human Rights, 2000). There is considerable evidence that social support has beneficial outcomes on both physical and mental health, and in relation to its benefits in lessening the effects of IPV (Madsen and Abell, 2010, Dutton and Greene, 2010, Alim et al., 2008, Zink et al., 2006, Bosch and Bergen, 2006, Holt and Espelage, 2005, Coker et al., 2002b, Carlson et al., 2002, Hurdle, 2001, Rose et al., 2000, Cohen and Wills, 1985). Uchino (2006) has summarised potential mechanisms through which social support affects health into two distinct but not necessarily independent pathways, see Figure 3.1 below.

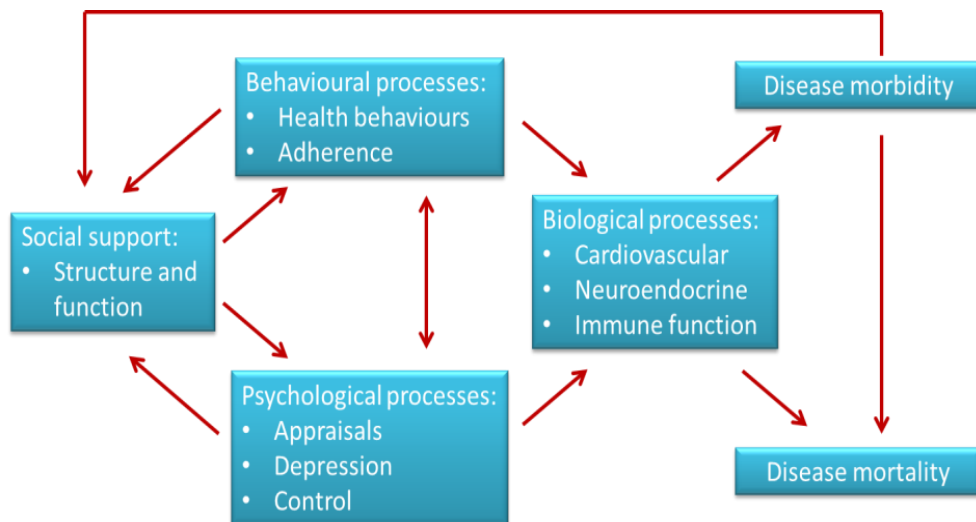


Figure 3.1: Potential pathways linking social support to health (Uchino, 2006)

According to this model, one pathway encompasses behavioural processes including health behaviours such as exercising, not smoking and eating right, as well as compliance with medical treatments (Stansfeld, 2005). By contrast, unsupportive social relationships can increase risky health behaviours such as alcohol and other drug use (Minnesota Advocates for Human Rights, 2000). The second potential pathway of action of social support is through psychological processes related to emotions or moods and feelings of control although to date, their mediating role on

health has not been proven conclusively. Furthermore, the two distinct pathways can also affect each other, for example, stress can increase negative health behaviours such as smoking while on the other hand exercise can reduce stress levels (Minnesota Advocates for Human Rights, 2000). Finally, Uchino proposes that the behavioural and psychological pathways can influence social support processes, for example, emotional distress affects perceptions of social support (Minnesota Advocates for Human Rights, 2000).

In relation to IPV, it is hypothesized that social support affects the link between violence and negative health outcomes; however there is disagreement on how this relationship should be conceptualized in the context of IPV (Rothman et al., 2003). Coker and colleagues (2003) proposed a model where social support partially mediates the relation between IPV and health, by directly affecting the social support of the victim. Aries and colleagues (1999) on the other hand proposed a model where social support acts as a moderator between IPV and health outcomes, indirectly modifying the extent of the relationship.

It is proposed that social support functions by increasing individual perceptions of control and self-worth which then improve well-being and immunity to disease (Rothman et al., 2003). Carlson and colleagues (2002) found that social support acts as a buffer by allowing the threat of the stressor to be reappraised through discussion with a supportive person and enabling the threat to be downgraded or avoided (Stansfeld, 2005). Social support in the form of practical help may also moderate the impact of the stressor enabling the person to deal with the consequences of the situation in a more appropriate manner (Stansfeld, 2005).

The evidence base supporting the beneficial effects of social support on depression and other common mental disorders in victims of IPV is quite extensive. A consistent finding is that abused women who report low social support are significantly more likely to be depressed than women who report high levels of

social support (Raistrick et al., 2006, Carlson et al., 2002, DeJonghe et al., 2008, Mburia-Mwalili et al., 2010). Similar outcomes were obtained in relation to PTSD, where tangible support and network size were found to moderate the relationship between violence and PTSD and psychological wellbeing (Kaner et al., 2007, Raistrick et al., 2006). The evidence base from India, while not as extensive as the one from Western countries also shows that the mental health status of women who report having good social support is better than women who report poor social support (Jeyaseelan et al., 2007, Kumar et al., 2005).

3.7 Spirituality

Religion has played an important role in the life of people for thousands of years, with evidence of religious rituals dating as far back as the Palaeolithic period over 500,000 years ago (Smart and Denny, 2007). Koenig (2009) argues that the purpose of religion, and the reason why it has survived this long, is to enable people to cope and make sense of suffering, provide a perception of control over situations that are outside their control and understanding and facilitate communal living and cooperation through promotion of social rules.

Until relatively recently, religious beliefs and practices were considered symptoms of mental illness, starting with Jean Charcot and Sigmund Freud who linked religion with neurosis, and even the DSM III, published in 1980 defined religious and spiritual experiences as examples of psychopathology. But recent research is of the view that religion and spirituality are used by people in crisis as resources to help them cope, and the importance of spirituality in mental health is now widely accepted (Thirhalli and Chand, 2009).

Religiosity and spirituality are defined in several ways depending on the context, but it is generally accepted that religiosity refers to the institutionalized form of faith and belief in a divine power, including practices. Spirituality on the other hand is something people define for themselves, it is largely free of rules, and can be understood as the process of searching and experiencing what is perceived as

sacred or divine (Verma et al., 2006). Studies show that most people define themselves to be both religious and spiritual, and there is a large degree of overlap between the two terms (Verma et al., 2006). In this study religiosity and spirituality are considered synonyms and used interchangeably.

Coping through the use of religion is very common across the world, particularly in times of great stress and Koenig (2009) explains why this is so:

“Religious beliefs provide a sense of meaning and purpose during difficult life circumstances that assist with psychological integration; they usually promote a positive world view that is optimistic and hopeful; they provide role models in sacred writings that facilitate acceptance of suffering; they give people a sense of indirect control over circumstances, reducing the need for personal control; and they offer a community of support, both human and divine, to help reduce isolation and loneliness.” p 285

Religious coping in response to illness has been extensively studied particularly among patients with cancer or HIV or other life threatening illnesses (for a review, see Sherman and Simonton, 2007) (World Bank, 2011, Koenig, 2009). Researchers have identified two types of religious coping, “positive religious coping” which provides comfort and reassurance and “negative religious coping” which consists of a sense of struggle or doubt (Babar et al., 2004). Interestingly, studies have found mixed results when investigating effects of positive religious coping on health outcomes, but have consistently found that negative religious coping is associated with poorer health outcomes (Carver et al., 1989).

Systematic research published in the mental health literature on the effects of religiosity on health and particularly mental health show that religious beliefs and practices aid in coping with the stresses of life and are beneficial to mental health (Thirhalli and Chand, 2009, World Bank, 2011, Koenig, 2009). The strongest and

most consistent association is found by comparing different degrees of religiousness or spirituality (from a non-religious to a deeply religious person) rather than between different religious denominations (World Bank, 2011).

A review of 100 studies, both cross sectional and longitudinal, that examined the relationship between religious practices and psychological well-being found that 79% of the studies found at least one significant positive correlation between the two variables (World Bank, 2011, Koenig, 2009). This association was consistent even after controlling for age, gender and socio-economic status and was similar across different countries, religions, races and ages.

Smith and colleagues (2003) carried out a meta-analysis on the association between religiousness and depressive symptoms in a large US cohort and found that religiousness had the same magnitude of association with lower rates of depressive symptoms as sex, which is a widely recognized factor that influences the prevalence of CMD. Furthermore they found that the association between religiosity and lower depression rates was twice as strong for people who were severely stressed compared to those who had minimal stress at the time of the survey suggesting that the protective effect of religiousness seems to be stronger for people under psychosocial stress (Department of Relief and Rehabilitation, 2012).

Similar results are obtained when investigating the effects of religiosity on suicide, anxiety, psychotic disorders and substance abuse, regardless of ethnicity, age or gender, for an in depth review of this research see Koenig (2009). Finally, it must be noted while many find comfort, hope, and meaning in religion, there are some for whom religious beliefs and practices emphasize neurotic predispositions, increase fears or guilt, and limit life rather than enhance it (World Bank, 2011, Koenig, 2009).

To date, the majority of research on stress and coping has been conducted in Western countries and little is known about how differences in cultural and

religious contexts shape these views in the developing world. In the next section, an overview of stress and coping from an Indian perspective is discussed.

3.8 Stress and coping: the Indian versus the Western perspective

One of the major issues for this study is the appropriateness of applying Western research findings and conclusions on stress and coping to an Indian population. The cultural and social differences between India and western societies are well documented, and have been discussed to some extent in earlier sections. Very briefly and simplified, western societies tend to be individualistic, have their religious roots in Judeo-Christianity, theoretically operate on an equalitarian social structure and the social systems and cultures promote competition and individual achievement (Palsane and Lam, 1996). By comparison, Indian society is collectivist and operates on a vertical social structure with caste and hereditary hierarchies defining the order of the society (Laungani, 2002, Henning and Klesges, 2002).

India has been shaped by thousand year old philosophies of life and religions that have provided stable social structures and values, and the association between religion and society is closely related (Palsane and Lam, 1996). Thus the meaning and purpose of life and all its encompassing experiences are viewed differently in the two societies.

Life in western societies is largely based on the social exchange principle of cost and benefit and individuals strive towards increasing their benefits sometimes even at the cost of others (Homans, 1958). It is achievement oriented and satisfaction is obtained only when there is the perception of gain or increased benefit, be that education, income, status etc. In such societies with highly competitive cultures the possibility of conflict and frustration are high which in turn lead to high levels of stress (Palsane and Lam, 1996). A concept closely related to stress in Western literature is 'locus of control'. Rotter (1966) categorised people into those that have an internal locus of control, that is the person believes they are the cause of an

outcome or that they can control an outcome, and those that have an external locus of control, where a person believes that an outcome is determined by outside forces like God, fate or chance or other people.

Rothbaum, Weisz and Snyder (Rothbaum et al., 1982) expanded on these concepts by classifying internal locus of control as 'primary control', where a person tries to change their world to suit them, and external locus of control as 'secondary control', where a person changes themselves to suit the external world. There is a strong need for control in Western societies, and loss of control is so abhorred that even when an outcome is controlled by chance or others it is still interpreted as control, albeit secondary (Rothbaum et al., 1982). Thus individual locus of control has implications for stress, the perception of stress and how stress is dealt with. In particular, in Western societies, stress and anxiety often arise when individuals feel that they have no control over what is happening to them i.e. external locus of control or secondary control (Sandler and Lakey, 1982, Fusilier et al., 1987).

People with an external locus of control tended to use fewer coping strategies, use strategies with poorer well-being outcomes and have greater psychological distress (Crisson and Keefe, 1988, Elfström and Kreuter, 2006). It can be theorised that in cases of IPV, the women are repeatedly told and end up believing that the violence is their fault, however in reality the locus of control is external, i.e., it is the abuser who is responsible. The women thus perceive themselves responsible for the violence but no matter what strategies they use, the violence continues making the women feel powerless leading to psychological distress and mental health issues (Dalgard, 2008).

By contrast, life as posited by traditional Indian philosophies is a cycle of birth, life, death and reincarnation. The ultimate aim of this cycle is to attain *moksha* or liberation from the perpetual chain of reincarnation and for this to occur a person must follow the interrelated concepts of:

1. *Dharma* – defined as ‘correct conduct’, not morally or ethically but in terms of keeping within the laws of nature, life and cultural existence
2. *Detachment* – meaning that one should not be too involved with the pursuit of positive or pleasurable experiences, nor get attached to material possessions or try to avoid negative experiences such as suffering
3. *Impulse control* – to obtain control over the body and the self by the use of practices such as fasting and abstinence
4. *Belief in rebirth and karma* – whereby the deeds of a person whether good or bad, accumulate and define their destiny in the next life and through the practices of *dharma* and detachment a person aims to bring the sum of these karma credits to zero.
5. *Transcendence* – found in most religions, literally means to ‘get out of something’ and in this case means to get out of the rebirth cycle but its most common meaning is belief in something supernatural. (Palsane and Lam, 1996).

Within this Indian view of life stress and coping are also conceptualised differently than in Western societies. In fact, in the languages of India there is no equivalent word for stress and the closest words that approximate the Western concept of stress are *klesha* and *dukha* (Laungani, 2002). Taken from Indian indigenous philosophies on which Hinduism, Buddhism and Jainism are based; *klesha* refers to the stressor aspect or the unavoidable experiences of life while *dukha* could be translated as sadness or unhappiness (Laungani, 2002).

One of the principal differences in the conceptualisation of stress between Eastern and Western thinking is that in Indian culture both *klesha* and *dukha* are considered an integral part of life and of being human (Shamasundar, 2008) and thus do not raise the same concerns in the Indian people as the word stress does among Westerners (Laungani, 2002).

By emphasizing the importance of *dharma* and *karma*, the Indian belief system assigns low significance to outcomes, people are encouraged to relinquish control to a higher being and even outcomes that are controlled by individuals tend to be attributed to a higher being (Palsane and Lam, 1996). Suffering is viewed as the outcome of misdeeds in previous lives (bad *karma*) and this attribution of the cause to factors beyond individual control provides relief from responsibility while at the same time accepting the suffering is a way to atone for past misdeeds and invoke good *karma* thus taking a step closer to liberation or *moksha* (Awasthi and Mishra, 2011). Dalal and Pande (1988) investigated the role of karmic beliefs in the psychological recovery of disabled accident victims in India, and found that psychological recovery of Hindu patients was significantly correlated with greater causal attribution to karma.

The literature reports that, the *karmic* doctrine offered these victims a sense of control, i.e., attributing their injury to events in their past lessened their sense of immediate personal burden but provided them with the motivation to gain control of their current lives by seeking treatment. Furnham (1999) found that an attribution of health and illness to supernatural causes provides defence against stress reactions and such beliefs are more prevalent in developing countries (Furnham et al., 1999). Other studies indicated that people that use coping strategies aimed at acceptance of a chronic disease had better psychological outcomes compared to people that tried to avoid or deny their chronic condition (Culver et al., 2004, Heijmans, 1999, Kershaw et al., 2004).

In the case of Indian women who experience IPV, the belief system may allow them to attribute the violence to an external force, view the pain as only a temporary condition that does not affect their inner self and by putting up with it or accepting it, the women believe that it will have a positive outcome in their next life (Vos et al., 2009), and this can lessen the psychological distress caused by the ongoing violence (Tsey et al., 2007).

3.9 Summary of chapter

This chapter provides an overview of the theories of stress and coping beginning with Lazarus and Folkman's seminal works on stress, appraisal and coping. The theory of stress is extended and discussed from an ecological framework perspective to include individual, neighbourhood and societal level factors that can influence women in an IPV situation, highlighting the differences between Western and Indian contexts. The biology of stress and in particular chronic stress is summarised and mechanisms of action of stress and health outcomes are provided, focusing on mental health wellbeing.

The second half of this chapter discussed coping strategies that victims of IPV may engage in, particularly social support which has been shown to have a protective effect against the development of common mental health disorders in victims of IPV. Spirituality or religiosity has also been shown to affect health outcomes but has not been studied in relation to IPV in India. The chapter concludes with an overview of the differences in Western and Indian perspectives on stress and coping. Chapter 4 discusses the research methods used for the study.

CHAPTER 4

METHODOLOGY

“Victory attained by violence is tantamount to a defeat, for it is momentary.” – Mahatma Gandhi

4.1 Introduction to the chapter

This chapter describes the methods used for this study. The methodology is divided into three parts, namely the pre-data collection phase, the data collection phase and the analysis of results sections. The pre-data collection section contains the methodology for carrying out the literature review and the development and translation of the instrument, the data collection section includes the pilot testing of the questionnaire as well as the actual data collection, and the analysis of results section gives details of the statistical tests and the anthropological analysis used.

4.2 Preparation for data collection

4.2.1 Literature review

The starting point for the study was a comprehensive literature review that included peer reviewed scientific articles, reviews and meta-analyses. Reports were also sourced from governmental, non-governmental, national, international and aid organisations. The literature review in this thesis considers peer reviewed journal articles, reports and books and book sections published up until December 2011 however instrument development and data collection occurred in 2004 and thus were informed by literature published only up to 2003.

The search for relevant literature began with an exploration of six, full-text scholarly electronic databases, namely Current Contents, Ovid, Medline, ProQuest 5000, EBSCOHost EJS, InfoTrack OneFile, Science Direct, Swetswise and Wiley InterScience. They were chosen as they publish works on the topics of interest. These databases were searched repeatedly and simultaneously using Curtin University’s gateway called Gecko. Informal search methods such as scrutinizing the

reference lists on collected articles and reviews and keyword search of the World Wide Web were also used to seek out relevant literature.

The keywords used for all modes of literature search were as follows: *violence against women, IPV, intimate partner violence, mental health, depression, post-traumatic stress disorder, PTSD, suicide, social support, coping mechanisms, autonomy, Indian women, India, Asia, South Asia and developing countries.*

A variety of search combinations were utilised to maximise the impact of the search and to narrow the articles down to those most essential for this particular study. The search was conducted until it was determined that the number of relevant articles was exhausted.

One major issue with the literature review up until 2004 was the paucity of peer reviewed scientific articles published in international journals on the topics of IPV and of the effects of IPV on the mental health of victims in India or other developing countries. To try and overcome this imbalance of information, reports from aid organisations and non-government organisations, as well as conference presentations such as poster abstracts by Indian researchers in the field were sought. Since these works were not peer reviewed, the student exercised caution when taking their results and findings into account. A bibliographic database for this study was created and maintained in EndNote X4.0.2. Once articles and reports were selected for review, a summary of the pertinent findings in each article was made for easy referencing and added to the bibliographic database.

4.2.2 Ethical considerations of the study

All research involving people has inherent risks, but the potentially threatening and traumatic nature of IPV research means that issues of safety, confidentiality, informed consent and interviewer skills and training are even more important than in many other forms of research.

The researcher endeavoured to address all the ethical considerations highlighted by the WHO guidelines for ethical IPV research (Ellsberg and Heise, 2002, Ellsberg and Heise, 2005, Ellsberg et al., 2001) as well as the Australian National Health and Medical Research Council's guidelines on Human Research Ethics. The WHO guidelines for ethical research have been developed to ensure that victims of IPV that participate in research about their experiences are not endangered or further victimised through:

- Poor study design and methodological issues,
- Lack of implementation of processes to ensure participant safety during and after data collection,
- Poorly trained data collectors,
- Lack of support services to refer participants to if necessary, and
- Inadequate dissemination of findings.

The study had approval from Curtin University Human Research Ethics Committee, and a copy of this approval is found in Appendix 1. This process ensured that the study had merit, and the researcher who carried out the research has integrity, indicating that the study was ethically justifiable. It also ensured that:

- i. The study had a scientific basis and the design was sound. As part of the ethics application, a literature review was carried out to demonstrate the need for this study. The proposed methodology was also assessed and found to be robust and appropriate for achieving the aims of the study.
- ii. Participants were provided with sufficient information in an appropriate format so they could make an informed and voluntary decision. A copy of the participant information sheet in English, Hindi and Marathi was provided to the ethics committee to enable evaluation of the information to be provided to participants.
- iii. Participants were assured of confidentiality and anonymity unless they decided to waive it. No names or any other identifying information was

recorded at the time of interview unless the participant specifically stated that they wanted to be contacted again, or wished to provide their name.

- iv. Harm to participants was minimised and processes were developed to minimise risks and provide support where necessary. The researcher ensured that all the necessary steps were taken to ensure minimal harm to participants by training the interviewers to follow the WHO guidelines to carrying out IPV research (Ellsberg and Heise, 2002, Ellsberg and Heise, 2005, Ellsberg et al., 2001). The researcher also established a process whereby KJ Somaiya Hospital staff would be available to provide counselling or support if the participant needed it. Furthermore, KJ Somaiya Hospital staff initiated follow up meetings at a later date with participants that requested for further support or information at the time of the interview and provided their contact details.
- v. Voluntary withdrawal of participants was allowed with the survey terminated if participants were likely to be injured or harmed. This information was conveyed to participants in the information sheet before an interview was started. Interviewers were also trained to ensure that all surveys were collected in privacy and at a time suitable to the participant.

The researcher attempted to obtain ethical approval for the study from the KJ Somaiya Trust as well but at that time the organisation did not have a formal ethics committee and informed the researcher that they would accept the ethics approval from Curtin University.

4.2.3 Development of survey instrument

The literature review provided a number of sources which the student used as a starting point for the development of the questionnaire for this study. For example, the WHO has numerous validated health related questionnaires such as the World Health Survey and World Mental Health (WMH) Survey that have been used in many countries (e.g. Egypt, Philippines and India) to survey and document

everything from reproductive health to economic development to mental health status. Other organisations which provide sample copies of questionnaires on their web sites include government organisations like the Centre for Disease Control and the National Institute of Health, USA, the United Nations and even some universities and individual scientists.

In the end, the overall structure of the Demographics and Health Survey (DHS) Household Questionnaire (version 8.9, April 2003) and the DHS Domestic Violence Module (2003) from ORC Macro's DHS+ website (<http://www.measuredhs.com/>) were considered the most appropriate for this study and were used by the student to develop the new questionnaire. The Demographic and Health Surveys (DHS) project is a worldwide research project initiated by the U.S. Agency for International Development (USAID) and is currently a joint venture between several scientific organizations including Macro International Inc., USAID's multi-project MEASURE program and Johns Hopkins University Bloomberg School of Public Health/Centre for Communication Programs (Hopkins CCP). The aim of this large program is to provide a wide range of monitoring and impact evaluation indicators in the areas of population, health, and nutrition of women and children in developing countries and access to and use of demographic and various health data on developing countries. This questionnaire was chosen because it covers the topics of interest for this study in detail; it has been translated into many languages and validated in many countries including India making it a reliable instrument that would allow the results of this study to be compared to other studies that used this instrument.

The original DHS Household Questionnaire consists of a household questionnaire and a women's questionnaire and is made up of modules addressing general characteristics such as demographics and nutritional status with special modules that are added to the questionnaires in order to collect specific information on other topics such as reproductive behaviour, contraception use and HIV/AIDS education. The questionnaire was modified to make it more appropriate for this

study however the formatting and many of the questions of the original DHS household questionnaire were retained to ensure the data collected would be valid and reliable as well as comparable to other studies.

The modified, revised and developed questionnaire consisted of seven sections, as follows:

- (1) Respondent's Background,
- (2) Reproduction and Contraceptives,
- (3) Health Care and Autonomy,
- (4) Husband's Background,
- (5) Woman's Work and Social Support,
- (6) General Health Questionnaire and
- (7) IPV.

These seven sections and their questions were chosen specifically not only to address the objectives of the study but to also provide the socio-cultural context in which the issue of IPV occurs. The new questionnaire contained a mixture of multiple choice and open ended questions, depending on the information sought. For example participants were given a number of items to choose from when asked which method of contraception they use, with an option to select 'other - specify' if the method they use is not available on the list. On the other hand, questions which collected information specific to that participant, such as the three most frequently encountered obstacles that prevent women from accessing health services, were open ended, with each woman asked to name the three obstacles that she believed affected women.

Section 1: Respondent's background

This section was developed to gather information about the participants' background, such as age, schooling, religion and living arrangements, and had a total of 12 questions. Some of the questions from this section of the original *DHS*

Household Questionnaire were deleted from the new questionnaire as they were considered irrelevant for the purposes of this study. Of the questions that were retained, some were adjusted to suit the Indian target population. For example, the question on the highest schooling achieved was changed to reflect the schooling system in India, rather than the western style schooling system.

A number of culturally specific questions were also added such as what is the caste or tribe of the participant, whether the participant had an arranged marriage or a love marriage and who else resides in her household. These questions were deemed necessary for inclusion in the questionnaire as the literature review, as well as the student's personal experiences showed these factors to be of relevance when investigating the issue of IPV.

Section 2: Reproduction and contraceptives

This section in the original *DHS Household Questionnaire* was extremely detailed and complex as it gathered information on lifetime reproduction and contraceptive use as well as specifics on each pregnancy and delivery. However for the purposes of this study only basic reproductive and contraceptive information was required, thus most questions from the original questionnaire were discarded, leaving only 14 questions in this section of the new questionnaire.

The formatting of the original, retained questions was kept, however as in the previous section, the wording in some questions were adjusted to make them relevant to the Indian population. For example, the list of contraceptive methods a participant may use contained items specific to the Indian society, such as copper T, the loop and abortion. Three new questions were also developed to address an issue often raised in the literature review as an important protective factor against IPV, namely the existence of a male offspring, especially a firstborn son.

Section 3: Health care and autonomy

Since it is well documented that physical ill health can have negative effects on the mental status of the subject, as well as be an indicator of psychosomatic issues, this section was developed to gather information on the general physical well-being of the women. Some examples of the questions in this section are whether or not the participant is suffering from any chronic illnesses, are these illnesses affecting her life, and are they being treated and who decides whether she can seek treatment for herself or her children.

This section also addressed another major factor linked to increased risk of IPV, namely autonomy. There were 15 questions in this section and some were developed by the student with the aim of measuring concepts specific to this study. In this section, there are also several questions regarding alcohol and drug use by the participants as both have been shown to be exacerbating factors for IPV.

Section 4: Husband's background and woman's work and autonomy

This section was developed to gather demographic information on the participant's husband, such as his age, education and employment status, as well as on the woman's employment status. Both these factors have been documented in the literature as having significant protective and/or exacerbating effects on a woman's experience of IPV. For example a woman who is employed outside the home may have more autonomy, a protective factor, whilst at the same time she may be accused of infidelity, an exacerbating factor. Once again, the questions have been adapted to the Indian socio-cultural context, as detailed for earlier sections.

The researcher also included several questions from the original DHS questionnaire, which inquired about the participant's autonomy and independence in the household. The autonomy measure in this survey was retained from the validated *Demographic and Health Survey* instruments (ORC Macro, 2003) and measures the

women's decision making power, their mobility and access to resources. The specific variables were

- Who makes decisions about your health?
- Who decides on the children's health when they are ill?
- Who decides on how the woman's income is spent?
- Who has final say on big household purchases?
- Who decides on what to cook on a daily basis?
- Who decides when the woman visits her family?

The possible responses to these questions were 'respondent', 'husband', 'jointly with husband', 'respondent jointly with others in the family' and 'others in the family'. Only the answer 'responded' was scored as 1, all the others were scored 0. The composite autonomy index ranges from 0 to 6 and was constructed by the summation of all the indicators in the scale. This section has a total of 18 questions.

Section 5: Social support and spirituality

Social support has been found to be a protective factor against the development of common mental health disorders in victims of IPV. Studies showed that increased social support was associated with significant reductions in a wide range of adverse mental health outcomes including depression, anxiety, post-traumatic stress disorder (PTSD) and suicidal ideation (Coker et al., 2002b, Coker et al., 2003, Kaslow et al., 1998).

This section of the questionnaire was developed to collect information on the extent of the participant's social support network, her perceived emotional and financial support and the coping strategies she uses to relieve stress and to relax. Since the meaning of emotional and social support is quite subjective, this section has an introductory part where the participant is asked to define her understanding of what emotional and social support is. If the content of the woman's response is the same as the pre-determined definition of social and emotional support, then

the interviewer proceeds to the first question. If the content of the woman's response differs from the pre-determined definition, the interviewer explains the definition used in the survey and only continues to the first question when there is agreement on the shared understanding of social and emotional support.

If the participant's understanding of social and emotional support is significantly different to the pre-determined meaning, then the interviewer informed the woman on what this section is measuring and specifies clearly the pre-determined definition of social and emotional support. The interview then proceeded to the first question only after the participant advises the interviewer that for the purposes of this questionnaire she shares the same understanding of social and emotional support as defined in the instrument.

Most of the questions in this section were developed by the researcher, however the *Arizona Social Support Interview Schedule* (Barrera, 1980) was used to guide item and theme development. The *Arizona Social Support Interview Schedule* is an instrument used to measure psychosocial functioning and perceived social support and has been previously used to study the social network in a group of migrant Asian students (Lorenzo et al., 1995). This instrument was chosen above other validated instruments such as the *Interpersonal Support Evaluation List* (Cohen et al., 1985), or the *Adult Social Support Questionnaire* (Bogat et al., 1983) because of the appropriateness of the questions to the Indian context. For example questions such as "There is no one I could call on if I needed to borrow a car for a few hours" (Cohen et al., 1985) were completely inappropriate in the Indian context particularly as the participants in this study were drawn from a very poor area where running water is considered a luxury, and nearly all participants in the study did not have many material possessions.

Spirituality in this study was defined as the personal sense of importance given to religion and spirituality. The rationale for using an open ended question was to

allow participants to identify the strategies they used to deal with anxiety and stress as at the time of survey design, there was no other culturally suitable measure found.

A one item measure consisting of an open ended question where respondents could list up to three strategies was used to measure the use of spirituality as a coping mechanism. During data entry, responses were coded manually into 6 categories determined by the researcher as:

- Social support – if responses included ‘visit family or friends’ ‘talk to husband’ or ‘spend time with kids’
- Spirituality – if responses included ‘pray’, ‘visit temple’ or ‘read holy book’
- Actively cope – if responses included ‘deal with it’ or ‘work out a solution’
- Distraction – if responses included ‘cook’, ‘watch TV’ or ‘go for a walk’
- Distress – if responses included ‘cry’ or ‘sleep’
- Other – all other responses

For analysis the categories were collapsed to a dichotomous variable where responses categorised as spirituality were scored as 1 and all others were scored as 0. The formatting of the original DHS questionnaire was carried through this newly developed module, to ensure consistency and flow. There are 12 questions in this section, the first question required an answer on a Lickert-like scale of 1 to 10 but most of the other questions are open ended and allowed the woman to express her own experiences and perception on the support she receives.

Section 6: General Health Questionnaire (Mental Health)

The *General Health Questionnaire* (GHQ) is a self-administered 32 item instrument developed to screen for psychiatric morbidity in primary care and for use in general population and in community surveys (Goldberg, 1972). The GHQ detects breakdown in normal functioning, namely it identifies the inability to carry out normal everyday functions and identifies stressful or distressing episodes in the

participant's recent past. The questions cover four main areas: depression, anxiety, social impairment and hypochondriasis. The 28- and 30-item *General Health Questionnaires (GHQ)* (Goldberg and Williams, 1988, Goldberg and Blackwell, 1970) have been validated in different languages and cultures and in various settings including India, in Hindi (Gautam et al., 1987).

For this study, the shortened version of the GHQ was used, containing 12 items (GHQ-12) (Tarnopolsky et al., 1979). The GHQ-12 has been validated in Hindi by Jacob et al (Jacob et al., 1997). For this study Goldberg's original scoring method was used, with the instrument scored bi-modally (i.e. - 0-0-1-1) with items 2, 5, 6, 9, 10, and 11 reverse scored (i.e. 1-1-0-0). The scores ranged from 0 to 12 with higher scores an indication of more problems. Where possible during analysis, the GHQ scores were kept categorical, however when dichotomous values were needed, a cut off score of 2/3 was used to separate between those with CMD and those without. This cut off threshold was found by Jacob et al (1997) to be the most reliable in the Indian context.

4.2.4 Translation of survey instrument

The wording of the English version of the instrument was examined and approved by an independent researcher with extensive experience in conducting research in Indian communities. Furthermore, the student consulted with a Mumbai based psychiatrist, from KJ Somaiya Hospital to ensure that the questions asked were not likely to cause psychological harm or distress to the participants.

The Indian constitution recognises 18 official Indian languages, even though there are over 200 different languages and dialects currently in use across the country. Hindi and Marathi belong to the Aryan language family which in turn is considered to have evolved from Sanskrit. Both languages use the Devanagari script, and are written from left to right. Special computer software, interface and fonts as well as a good working knowledge of the written languages are needed to write in

Devanagari script. Due to lack of availability of appropriate software in Perth, the questionnaire was translated by the student only into Anglicised Hindi. The wording was refined with assistance from two bilingual educators.

Upon arrival in Mumbai, the instrument was translated into Marathi by a trilingual translator with extensive knowledge of colloquial terminology related to the research topic, and with the assistance of several trilingual social workers and psychologists working in the research area. Further refinement of wording was carried out during the translation process, where grammatically and technically correct words and phrases were replaced with colloquial terms which were deemed more appropriate for use on the sample population. Both the Hindi and Marathi versions of the questionnaire were then transcribed into the Devanagari script.

Finally, during a focus group discussion which included the student, the translator and several trilingual psychologists and social workers working in the area of violence, the questionnaire was discussed and each question was back translated from Hindi and Marathi into English. Discussion continued until a consensus was reached on the meaning and wording of each question to ensure comparability of the language versions. A copy of the final version of the survey instrument is available in Appendix 3.

4.2.5 Pilot testing of survey instrument

Once the instrument was translated and back translated, the questionnaire was administered to a convenience sample of 10 women working at KJ Somaiya Hospital, and a re-test was carried out three weeks later on the same sample to ensure reliability of the instrument. The sample of women was chosen to be similar to the target population in age range, socio-economic status and education and income levels. Responses were analysed for consistency and internal validity.

4.2.6 Validation of survey instrument

The DHS questionnaire has been validated in many countries including India, and in many languages, including Hindi (DHS+ website, 2004). The questionnaire was administered to the 10 pilot study subjects in exactly the same way it was planned to be administered in the main study. The time taken to complete the questionnaire was also recorded for each subject to ensure that it was within reasonable limits. Participants were also asked to provide feedback or comment on any questions they found difficult or ambiguous. Interviewers were asked to note if participants had difficulties answering any questions, or if they encountered any other problems when administering the instrument. No changes were needed.

4.2.7 Ensuring validity and reliability of data

The researcher had prior knowledge and understanding of the economic, political and cultural setting in which the study was conducted, having lived and travelled through India numerous times in the past. However to ensure accurate contextualisation of the quantitative data as well as the responses to open ended questionnaires, the researcher held a focus group discussion with 8 key informants such as medical staff, social workers, local NGO staff and community leaders and explored the issues of community support/control for victims of violence, health care services for victims of violence and community perceptions regarding violence, effects of violence and needs of victims of violence. The researcher also lived and worked in the precise area to be studied for the duration of the data collection and had daily contact with the informants' world through shopping, leisure activities, celebrating holidays, and visiting parks. The researcher also proactively identified and put aside any preconceived ideas, beliefs and assumptions regarding the study subject and used a daily reflective diary to record thoughts and feelings.

4.3 Data collection

Data and participants from the pilot study were excluded from the main study because 'an essential feature of a pilot study is that the data are not used to test a

hypothesis or included with data from the actual study when the results are reported' (Peat et al. 2002:57)

4.3.1 Sample population and strategy

The sample population was drawn from a low socioeconomic area of Mumbai, situated near the KJ Somaiya Hospital and was made up of married women over the age of 14 years.

The population of interest in this study were women who experienced partner violence and were also depressed as diagnosed through the GHQ 12 questionnaire. To ensure the strength of the statistical relationships investigated, it was decided to use power analysis to calculate the sample size needed for a statistically significant result. At the time of designing this study, there were no Indian prevalence data on the relationship between IPV and CMD, it was decided to use existing data from western literature to calculate the sample size. It was also necessary to work backwards i.e., calculate the number of participants required in the group of interest, that is abused women with presence of CMD, and then determine the total sample size.

Drawing on results from western studies, it was decided to use a conservative prevalence rate of 60% for CMD in abused women with power analysis resulting in a sample size of 330 women. The sample size was calculated based on the available estimated prevalence of IPV from a review of previously published studies on prevalence of IPV in India. Based on this, with a confidence level of 95% and absolute precision of 0.05, the sample sizes required was calculated to be 970 women. To ensure that the required number of questionnaires was collected, it was decided that data collection continued until the required number was reached.

A systematic random sampling strategy with a sampling interval of 15 was adopted. This value was derived by dividing the number of households in the area serviced by

KJ Somaiya Hospital by the sample size $17,000/970=17.5$ (number of households was calculated by dividing the total population in the area – approximately 100,000 people – by 6, the average size of an Indian household, arriving at approximately 17,000 households). Thus every 18th household was visited and a respondent recruited who was invited to participate in a survey on women's health. In households with more than one eligible woman, only one was selected by choosing the one with the next closest birthday. If a potential respondent refused to participate, the next 18th household was selected.

4.3.2 Administration of survey

A qualified social worker fluent in Hindi, Marathi and English was trained extensively by the student in appropriate interview and support techniques and was provided with training on how to conduct these interviews to ensure their standardisation. The social worker was then entrusted with training and supervising 5 local women who worked as Community Health Workers (CHWs) and they collected the data. The social worker also carried out the translation of all open ended answers which the CHWs wrote on the instrument in the original language of the respondent. The CHWs were already visiting households in that area to provide education on HIV, so the interview for this project was added on to their existing program.

Interviews were conducted in the house of the respondent only if privacy could be assured and the husband or any other adult was not at home. If the husband or any other adult was at home, the woman was asked to visit KJ Somaiya Hospital for the interview and reimbursement for the transport to and from the hospital was offered. If this was not possible, the CHW moved on to the next house. All participants completed the survey in one sitting and each meeting lasted no longer than one hour including the HIV education.

Prior to seeking written consent, the main objectives of this study were explained verbally to the women and the information sheet was read out in its entirety by the interviewer in a language chosen by the respondent (Hindi or Marathi). Respondents also had access to a printed information sheet, in English, Hindi and Marathi, which informed them of the objectives, methods, level of participation and potential outcomes of the research. The women were informed of their right to withdraw at any time during the study without penalty. Any further questions or clarifications were provided prior to receiving consent. All participants were instructed that by completing the questionnaire they were giving consent for participation in the study.

To the researcher's knowledge no interviews were declined or abandoned however there were several women who requested further assistance and voluntarily provided their names and addresses for further contact. These details were forwarded to staff at the HIV cell at Somaiya Hospital who had previously agreed to provide ongoing support and counselling to any participants who needed it or asked for it.

4.4 Quantitative data analysis

All data was entered into IBM Statistical Package for Social Sciences (IBM SPSS) by the researcher. Prior to data analysis, all variables were scrutinized for accuracy of data entry and missing values. Random surveys were spot-checked for accuracy and the IBM SPSS software was used to check for outlying values, or incorrectly entered variables. CMD, IPV, autonomy, coping using spirituality and social support scores were added up and transformed into dichotomous variables which were used in further analyses. Distribution of the demographic data was assessed to ensure the data followed a normal distribution curve and was thus suitable for further statistical analysis.

For this study both descriptive and inferential statistics were used. Descriptive statistics were used to describe the characteristics of the sample population in detail, such as age distribution, religion, education level attained, marriage type, health and contraceptive use, incidence of CMD and IPV.

Chi square tests, correlations and partial correlations were carried out with the variables of interest (CMD, IPV, autonomy spirituality and social support) and some of the demographic variables (respondent and husband's ages and education levels, religion, type of marriage) to investigate if there were any significant associations which could be explored further. Variables which gave significant chi square and correlation results were then used to carry out multinomial logistic regression to determine the magnitude and significance of the association.

The aim of the inferential analysis was to make inferences on the research questions using the sample data. To do this, it was decided to investigate what attributes are associated with IPV and CMD, for example, income, age, religious affiliation, autonomy, social support or spirituality. Social support, controlling behaviour, autonomy of woman were all assessed as composite dichotomous 'yes' or 'no' variables made up of responses to a predetermined number of questions. Women who responded yes to one or several of the questions within each item formed one group of the dichotomy, and the women who responded 'no' to all the questions within each category formed the other group of the dichotomy. Similar scales have been used in other studies eg. Garcia-Moreno et al (2006).

The data were analysed with a multinomial logistic regression model. To assess the goodness of fit of a model, the log-likelihood ration test (LRT) was used. The LRT is used to measure how important a predictor variable is in the model. It is a measure of how much of the response variability is associated with the term of interest. To do this a forward stepwise model were fitted. A significant LRT p-value (PrLRT) indicates that the terms are important and should be retained in the analysis.

Predictor variables (woman's and husband's age, income, religion, education, type of marriage, whether they live in an extended household and female autonomy) were fitted into the model for psychological IPV, physical IPV, sexual IPV, any IPV and CMD to determine their significance. The odd ratio, 95% confidence interval and probability of error are reported for each association and results discussed.

4.5 Analysis of open ended questions

Responses to open ended questions were translated by the trilingual social worker and inscribed directly under the original answer on the survey instrument. Two to three word responses were recoded into one word responses which were entered as string characters into IBM SPSS. For example to the question "What are the three main obstacles that prevent you from accessing health care?" some of the responses were "don't have money" "too expensive" and "lack of money". All these responses were re-coded into "money" as the reason why these women did not access health care was due to financial reasons. Eventually these one word responses were re-coded into numerical values and analysed similarly to the qualitative data.

Responses that were longer and more complex in content were summarized and emerging themes were noted. Themes were then contextualised and classified according to particular topics. These results were entered into and analysed using SPSS Text Analysis for Surveys version 2.0, and add-on to IBM SPSS. Attempts were made to generate propositions from the classified topics and identify any other associations between the themes. The software also allowed some of the topics to be recoded into numerical variables and for these results to be analysed for associations with the qualitative data.

4.6 Summary of chapter

This chapter described the research methods used in the study including details on how the literature review was undertaken, the development, translation and pilot

testing of the questionnaire, administration of the questionnaire and the statistical tests used to analyse the collected data. The next chapter presents the descriptive results.

CHAPTER 5

DESCRIPTIVE RESULTS

“Educate one man and you educate one person, but educate one woman and you educate a whole civilisation.” – Mahatma Gandhi

5.1 Introduction to the chapter

This chapter contains the descriptive results of the research study and their implications are discussed with respect to the existing literature. A total of 907 women were interviewed over a period of 10 months from April 2005 to January 2006 in the Mumbai area of Pratikshanagar. From July 2005 to August 2005, interviews for this study were suspended due to devastating floods and consequent clean up that occurred when Mumbai received the highest ever recorded rainfall in one day. Although it was intended to continue sampling until the required number of respondents was reached, the natural disaster meant that the final number of survey respondents were 93.7% of the original sample size. The descriptive results below are reported on and supported with a systematic literature review to enhance the analysis.

5.2 Respondents' background

The mean age of the women in this sample was 30.2 \pm 6.3 years with the minimum being 16 years and the maximum being 65 years at the time of the interview. Mean length of time living at the current residence was 7.7 \pm 5.9 years with the minimum less than 1 year and the maximum being 50 years at the time of the interview. Just over half the respondents (52.6%) have lived in the city prior to their marriage, with the rest having moved to Mumbai from various rural locations.

Only one in 10 women was illiterate a figure that is much lower than the all India illiteracy rate of 41.6% but higher than Mumbai illiteracy rates of 5.3% (National Census of India, 2011). Of the literate women, a third (32.2%) completed primary school and almost half completed high school (45.2%).

Approximately half the respondents were Hindu (53.2%) and 42.2% was Buddhist. The remaining women were Sikh (1.9%), Muslim (1.7%) or Christian (0.9%), see Figure 5.1.

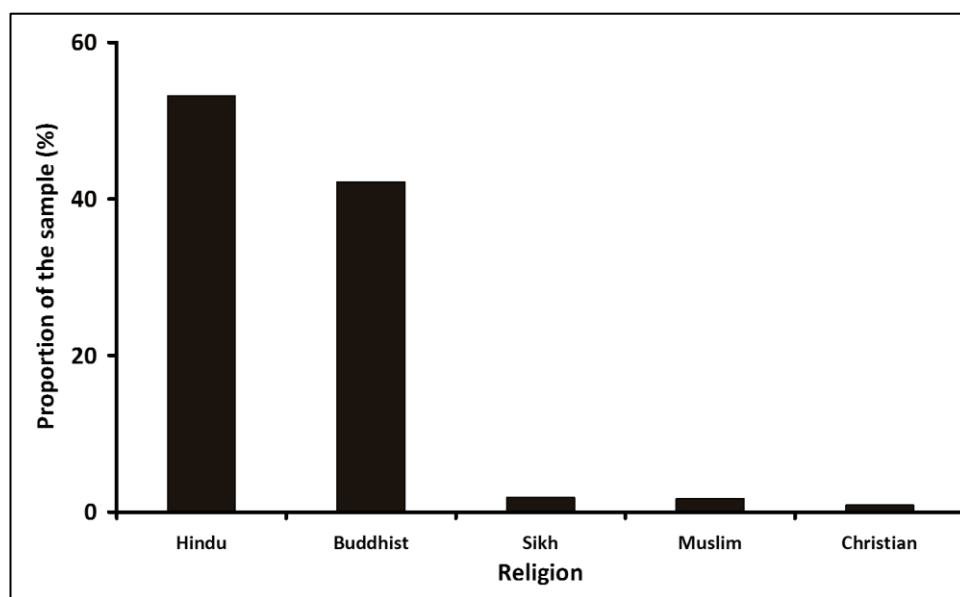


Figure 5.1: Religious affiliation of the women surveyed

The majority of respondents belonged to the backward castes (41%), Shudhra (33.2%) or other scheduled tribes (18.9%) or castes (4.6%) see Figure 5.2. The Indian caste system defines the social classes, as well as the restrictions, in the Indian society. This social structure consists of thousands of endogamous hereditary groups which are called *jātis* or castes. The caste system is usually associated with the Hindu religion but it is also prevalent in other religious groups such as Muslims and Christians (Dyson and Moore, 1983). In the Indian Constitution cast-based discrimination is now outlawed and in urban areas the caste system has lost its stronghold but it still persists in rural areas in various forms as a result of social

perceptions and divisive politics. There are five different levels of the caste system: Brahman, Kshatriya, Vaishya, Shudra, and Harijans and within each of these categories are the actual castes within which people are born, marry and die (Bayly, 1999, Srinivas, 1957, Sana, 1993).

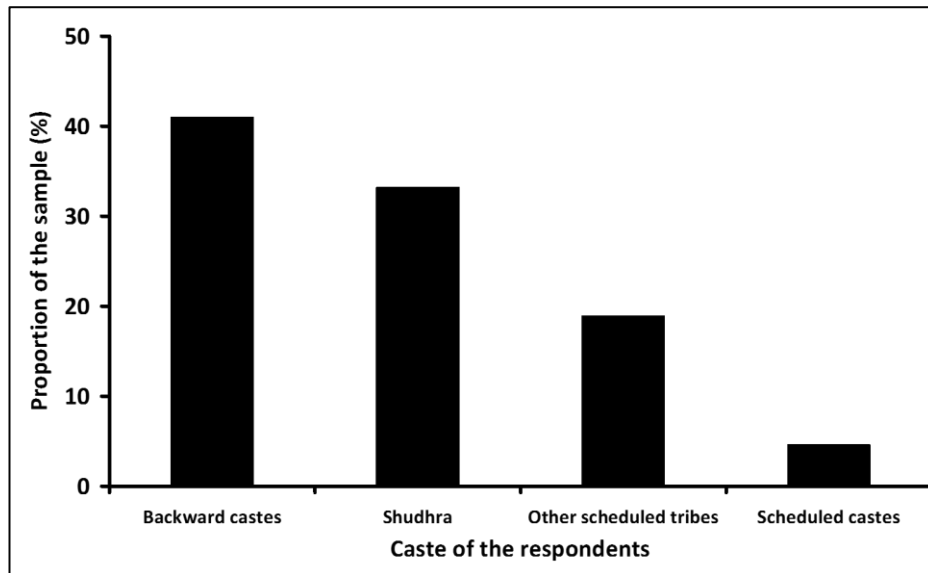


Figure 5.2: Caste breakdown of the women surveyed

All the women in the sample were married at the time of the interview. The mean age at marriage was 19.9 ± 2.8 years with 12 years being the youngest and 40 years being the oldest age at marriage. According to the 2001 National Census of India, the mean age at marriage for females, who married in the last five years, was 23.5 years for all of India, thus the women in this study had a lower mean age at marriage than the India average. The mean length of time of marriage was 10.5 ± 6.6 years with 81.1% having had an arranged marriage and the rest having a love marriage.

The majority of respondents (77.1%) lived with their husband and child/children, and 13% lived with their husband and parents-in-law with or without children. The rest lived with other family members such as brothers, sisters, parents or brothers/sisters in law. Indian society consists of an interwoven network of

communities and each community consists of numerous extended families joined by marital bonds, local neighbourhoods and cultural heritage. Thus the extended family has a significant impact on the social and moral values throughout a community and this differentiates it from most of the rest of the industrialised world. In this study nuclear family units were more prevalent than extended family networks however this can be explained by the fact that the location of the study has a very high proportion of migrants from rural areas that have come to the city seeking employment and left behind their extended family networks.

The 'nuclear family' in most industrialised countries consists traditionally of a couple and their children, but in Indian society the term 'family' is more dynamic and includes family members from several generations. For example, in one 'family' one may find several uncles, aunties, nephews, nieces and cousins living together under one roof (Dasgupta et al., 1999, Shah, 1998). Furthermore, in Indian society, regardless of religion, it is customary for women to leave their natal family and become part of or 'belong' to their husband's family upon marriage (Bayly, 1999, Srinivas, 1957, Sana, 1993). In this study younger women and those recently married tended to live with their in-laws while the older women and those married for longer tended to live in nuclear units. Women visited their natal families an average of 3.5 ± 3.4 times a year.

5.3 Reproduction and contraceptives

The majority of respondents (87.1%) had given birth and had an average of 2.2 ± 1.1 children and 9.5% of women were pregnant at the time of the interview. In the majority of cases (93.7%) the decision to become pregnant was made jointly with their husband. In the rest of the cases (6.4%) the husband decided by himself or jointly with the in-laws. The respondents had a total of 1814 children between them with over half the women (53.2%) having a daughter as a firstborn. Out of a total of 1814 children in the sample, 931 were boys and 882 were girls reflecting the generalised bias against girl children in India. Approximately one fifth (21.4%) of

women have had at least one miscarriage in their lifetime, a rate much higher than the reported all India average of 8.85% (Rajaram et al., 2009).

The use of contraceptives was divided into roughly equal parts with 43.7% of women using some form of contraception and 51.4% not using any. The most common form of contraception was tubal ligation (76.3%) followed by copper T/IUD/loop at 17.1% and the rest used condoms or the contraceptive pill. India has one of the most dynamic family planning programs with current efforts focusing on meeting the unmet needs for contraception, reducing infant and maternal mortality and assisting families to achieve their reproductive goals (WHOSEA, 2004). Despite this more than three quarters of those using contraceptives have access to a limited choice with an overwhelming majority relying on female sterilisation or the IUD. In 1971, abortion was legalised in India, and this is frequently used as a family planning method (Edmeades et al., 2010) and female foeticide, despite the fact that inadequate service provision leads to large numbers of unsafe abortions (Kohli, 2008).

Safe abortion rates were calculated at 10 abortions per 1000 women ages 15-44 in the 2003, however surveys estimate that two thirds of abortions are not performed at approved facilities suggesting that the overall abortion rate in India is about 30 per 1000 women (Sedgh et al., 2007). Barriers to family planning include high levels of illiteracy, poverty, poor access to correct information, gender inequality, limited and uncoordinated programs and resources and staff shortages and limitations (WHOSEA, 2004). Contraceptive use patterns in this study mirror the all India rates as demonstrated in Figure 5.3 below.

The majority of women (97.4%) said that the decision to use contraceptive was taken jointly with their husband, 2% decided by themselves and in 0.5% of cases the husband decided on his own. Of the women that were not using contraception, 93.7% took that decision jointly with their husband, 4.3% made the decision by

themselves, and in 1.9% of cases the husband decided by himself. Approximately half of the women not using contraception (46.7%) did so due to fertility related reasons such as infrequent or no sexual intercourse or because they wanted more children. A further 24.1% were opposed to using contraception, 19.8% had no knowledge of or source of contraception and the rest were method related reasons such as costs or fear of side effects or inconvenience.

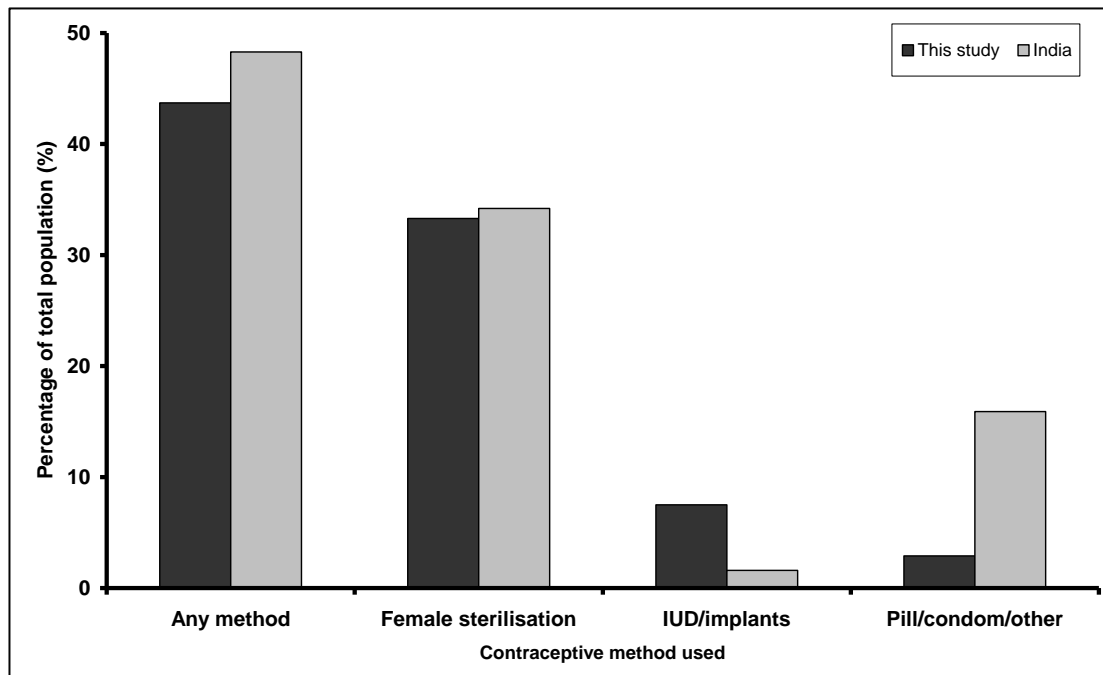


Figure 5.3: Comparison of contraceptive use rates by married women in the study population and in India (Data for India refers to the years 1999-2000, WHOSEA 2004)

5.4 Healthcare and autonomy

The majority of respondents (74%) rated their overall health as good, 22.5% rated it as fair and the rest of the women rated it as poor (3.5%). Over a third (36.3%) of those that rated their health as fair or poor complained of aches and pains mostly in the hands, feet or back, and one fifth (19%) had some serious illness such as tuberculosis, diabetes, gastro-intestinal (GI) problems, hormone problems or asthma. Another 17.3% had obstetrics and gynaecological problems such as morning sickness, irregular menstrual periods or other reproductive problems and

12.4% had blood pressure problems. The rest complained of fevers (5.8%), weakness and dizziness (4%) or other issues (5.3%).

The majority of women (87%) responded that the health problems impaired their ability to carry out day to day activities and almost all the women (93.1%) were seeking treatment for their health problems. The majority of respondents (89.4%) attended a western style, private or government owned medical facility to treat their health problems and 10.4% used an ayurvedic, homeopathic or religious/traditional healer. This result is most likely skewed in favour of the western style medical facility because KJ Somaiya hospital, a large, privately owned tertiary care facility is located at one of the main entrances to the Pratikshanagar slum and offers free services to the slum community members.

The majority of women (80%) reported that the final say on decisions concerning their health was made jointly with their husbands, and approximately 1 in 10 made that decision on their own (9%) or had that decision made on their behalf by their husband either on his own or jointly with his parents (11%).

Women were asked what the top three factors were that prevented women from getting medical advice or treatment for themselves. Considering the sample population was drawn from a slum area, it is not surprising that the most common factor that prevented them from accessing medical assistance was:

- Lack of money;
- Lack of time or the excessive time spent waiting in queues; and
- Issues with medicines such as unwanted side effects and length of treatment.

Other factors that prevented women from accessing health care were lack of autonomy, with women stating that it would cause tension at home or she was afraid of what the elders in the household would say, or the attitude of the

husband, presence of children and no one to take care of them while she accessed health care. These barriers have previously been identified as affecting women in developing countries disproportionately more than men. Proximate factors such as lower levels of education, literacy and socio economic status contribute to this disparity (Chang et al, 2008; Lewallen and Courtright, 2002).

However research has found that underlying these proximal factors is gender inequality expressed as inadequate social support within the household or community to allow women to access care, inadequate control over finances and low societal value that is, the value placed on a woman's worth by her husband and family determines whether they allow her or support her access to health care (Lewallen and Courtright, 2000).

In the majority of the cases (80.4%), the respondent jointly with her husband decides on when and how to get treatment for their child/children when they are ill. Approximately 1 in 10 responded that they solely are responsible for making decisions regarding their children's health (12.1%) and the rest (7.5%) responded that they had no say in their children's treatment seeking with the husband, in laws or the husband jointly with the in laws being responsible for the decision.

Very few women in the sample consumed alcohol (1.4%) or drugs (5.9%), and of those that responded in the affirmative to the question about drug taking defined drugs as medicine rather than illicit substances. This result is comparable to other findings that show alcohol use rates among women to be less than 3% and illicit drug abuse rates even lower (WHO, 2004).

5.5 Husbands' background and women's work

The mean age of the husbands in the sample was 35.7±7.4 years. Over half (56.8%) completed high school, one fifth (20.3%) completed junior college and 4% completed a degree college. On the other hand, 4.6% were illiterate and 14.3%

completed only primary school. In the majority of the cases (94.4%) the husbands provided their wives with money for living expenses and roughly the same proportion (93.7%) also worked on a regular basis. The husbands' average monthly income was INR 4161±2646 (AUS \$100.3±63.7). The large standard deviation in the husbands' income was due to a small number of men that earned much larger amounts than the rest of the husbands.

Over a third of respondents (39.7%) said they had paid work, with 33% of those working from home mainly doing small sewing or beading jobs while the rest worked away from home in jobs such as sorting rubbish to sell, as domestic servants or community health care workers. Of the 60.3% that did not work a third (34.2%) listed looking after children or having young children as the reason, approximately another third (27.5%) said their husband or in laws did not allow them or did not like them working, and 14.2% said they had too much housework. Other reasons that prevented women from working were work related factors (8.5%) such as 'no need to work' or 'cannot find a job', illness (6.9) and pregnancy (3.5%).

The women's average monthly income was INR 1432±1587 (AUS \$34.5±38.3) and the majority of respondents (92.6%) disclosed their full income to their husbands. The large standard deviation in monthly income was due to a very low number of women being college educated and having much higher incomes than the median income of the women in the slum which was INR 1000. In fact 62.3% of the women that earned an income, the monthly amount was INR 1000 or under, 31.2% earned between INR 1001 and INR 4000 per month, 20 women (5.8%) earned between INR 4001 ad INR 6000 and two women earned INR 15,000 and 20,000 per month respectively, see Figure 5.4 below.

In about half the cases (49.0%) the women alone were responsible for deciding how their income is spent and in another 47.3% of cases the women make that decision jointly with their husbands. In a minority of cases (3.7%) the husband or husband

together with the in laws or the in laws only decide how her income should be spent.

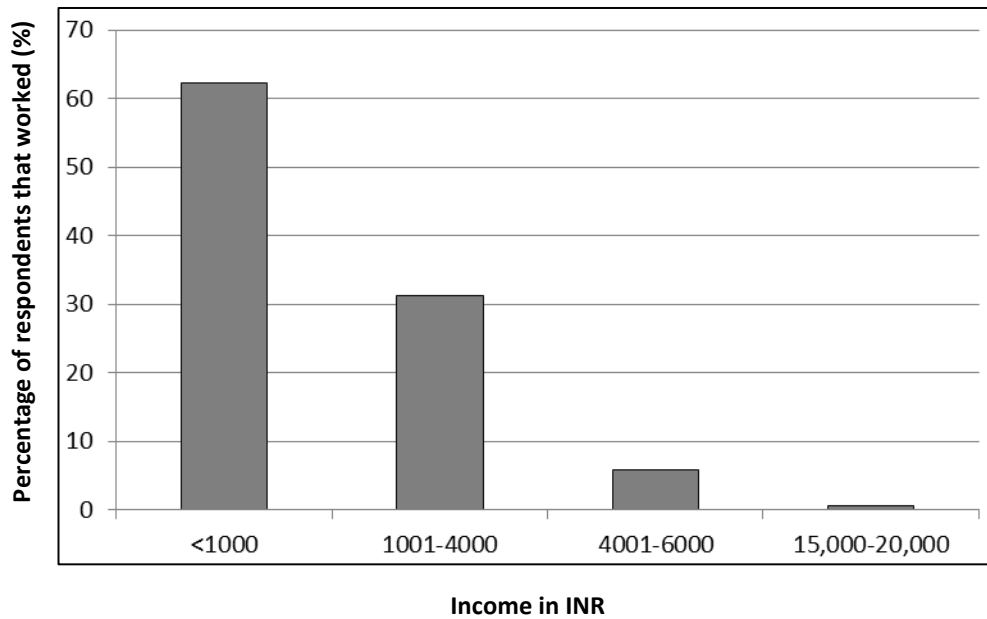


Figure 5.4: Distribution and amount of income

Decisions regarding large household purchases such as a radio, TV or furniture were made jointly with the husband in the majority of the cases (65.9%), by the husband alone or in conjunction with the in laws in approximately a quarter of the cases, and only 1 in 10 women had the final say on such decisions. Purchases for daily needs were made jointly with the husband in almost half the cases (47.3%), by the woman alone in 38.5% of the cases and in the rest of the cases the decisions were made by the husband with or without the in laws. Women had a greater say in decisions on what food was cooked on a daily basis, with 82.1% of respondents being solely responsible for that decision, while less than 1 in 10 made that decision jointly with the husband, and the rest had that decision made for them by the husband with or without the in laws.

Over three quarters of the women (78.5%) reported that decisions on whether and when they can visit their natal family were made jointly with their husbands, 11.7%

were solely responsible for those decisions and the rest had those decisions made for them by their husband with or without the in laws.

An autonomy score or sum was calculated for each woman. The following six questions were deemed to measure autonomy:

1. Generally speaking, who in your family has the final say on decisions concerning your own health care?
2. Generally speaking, when your child is ill, who decides whether or not the child should be taken for medical treatment?
3. Generally speaking, who in your family has the final say on decisions concerning large household purchases?
4. Generally speaking, who in your family has the final say on decisions concerning household purchases for daily needs?
5. Generally speaking, who in your family has the final say on decisions concerning what food should be cooked each day?
6. Generally speaking, who in your family has the final say on decisions concerning visits to YOUR family or relatives?

Responses indicating high autonomy, that is the respondent makes the decisions by herself (Questions 1,2 and 6) or in conjunction with her husband (Question 3, 4 and 5), were given 1. All other responses indicated low autonomy and were given 0. Each woman’s autonomy score was calculated by summing the individual scores to each of the 6 questions. The distribution of scores is found in Table 5.1 below.

Table 5.1 Distribution of autonomy scores

Autonomy score	Frequency	Percent (%)
0	122	13.5
1	374	41.2
2	263	26.0
3	98	10.8
4	38	4.2
5	24	2.6
6	15	1.7

In this study, autonomy was converted to a dichotomous variable, with scores of 1 or below defined as low autonomy and anything 2 and above defined as high autonomy. 54.7% of women had low autonomy and the rest had high autonomy.

5.6 Social support

Women were asked to rate their satisfaction with the emotional support they receive on a scale of 1 to 10 with 1 being not satisfied at all and 10 being completely satisfied. In this case emotional support was defined as having someone to talk to when they are upset or sad or having someone to do things for them to make them feel better. Most of the respondents (69.1%) were overall dissatisfied with the emotional support they received with 21.5% being slightly dissatisfied, 19.5% being dissatisfied, 10.8% being very dissatisfied and 17.3% being completely unsatisfied. Of the rest of the women, 16.8% were neither satisfied nor dissatisfied with their emotional support, while only 14.1% reported being overall satisfied, with most being only slightly satisfied (8.1%).

Just over a third of the women in the sample (30.1%) were members of a "*mahila mandal*". "*Mahila mandals*" meaning women's organisations arose in the 1970s among the poorest groups of self-employed to challenge existing middle class women's organisations and the existing patriarchal trade union structures (Abbot, 1997). There are a number of different types of such grass roots organisations, the Self Employed Women's Association, for example, represents all types of self-employed poor women and has a similar function to a union, whereas Annapurna Mahila Mandal represents poor women engaged in a single type of self-employment activity (meal makers) and its primary concern is credit facilitation for its members (Abbot, 1997). Despite the differences in functions, these grass roots organisations work to improve their member's lives through individual and community empowerment (Abbot, 1997).

Respondents in the study sample that were not members of a *mahila mandal* gave as reasons lack of time (32.0%), a dislike of the organisation (14.8%), living in rented accommodation (11.8%) and husband not allowing them or discouraging them from attending (10.7%). Of those that were members of a *mahila mandal*, a resounding majority (90.6%) reported that the group provided them with support when needed, in the form of emotional support (72.8%), both financial and emotional support (21.1%), or financial support (5.2%).

As expected significantly more women that were members of *mahila mandal* had high autonomy, $\chi^2(1, N = 904) = 15.14, p = 0.000$. On the downside, membership in the *mahila mandal* was significantly associated with increased rates of CMD and all types of IPV see Table 5.2 below. It is possible that this relationship is mediated by high autonomy rather than direct association between the membership in the *mahila mandal* and increased rates of CMD and IPV.

Table 5.2 Evidence of association between *mahila mandal* membership and IPV

	df	N	χ^2	p-value
CMD	1	901	36.95	0.000
Emotional IPV	1	904	17.67	0.000
Physical IPV	1	904	14.48	0.000
Sexual IPV	1	904	35.54	0.000
Any IPV	1	904	34.14	0.000

The majority of women (86.3%) had one person to provide them with emotional support but 11.9% had no one. Of those that had at least one support person, in over a quarter of the cases it consisted of a female friend or neighbour (29.3%), a sister or sister in law (27.6%), the husband (22.4%) or the parents (16.0%). The husband was listed as person of support only by women who were not abused.

Just over half the women had someone to help out with the housework when they were sick (55.4%) but 44.6% did not have anyone. The people most likely to help out were the husband (28.7%), the mother in law (27.7%) a daughter (26.3%) or a sister in law (14.1%). When the women were in financial trouble, 68.1% had someone to turn to for assistance, but 31.0% had no one to turn to. The people most likely to help out financially were brothers (26.7%), female friends or sisters (26%) parents (19.1%) or a money lender (9.7%).

Approximately half the women (49.8%) reported having at least one person causing her anxiety or making her upset. Husbands caused the most anxiety in almost half the cases (45.0%), followed by parents or parents in law (23.6%) and children (10.0%). Significantly more women that had at least one person causing them anxiety also had CMD, $\chi^2(1, N = 903) = 70.31, p = 0.000$, and reported poor health $\chi^2(1, N = 903) = 6.68, p < 0.010$.

The respondents were asked to list what activities they do to relax or re-energise themselves, and sleep was the most common activity (45.2%), followed by visiting family (11.4%) or some kind of personal activity such as reading (9.5%). The women were also asked to list mechanisms used to cope or deal with stressful situations or when they are upset. Almost a third (30.4%) listed spirituality in the form of praying, going to the temple or reading the Bhagavad-Gita (religious book), followed by going out of the house (21.4%) or sleeping (10.8%).

It is clear from this response that the majority of women in this study used emotion focused behaviour as opposed to action or problem focused behaviours such as initiating direct action to halt the stressor (Carver et al., 1989, Lazarus and Folkman, 1984). Carver et al (1989) classify coping behaviours such as sleeping, watching TV, and going out as 'mental disengagement' strategies that are used to take one's mind off a problem but it often impedes adaptive coping. In fact disengagement behaviour to cope with a stressor is considered maladaptive and results in poor long

term coping outcomes (Carver et al., 1989, Lazarus and Folkman, 1984). It is likely that the cultural and social structures that exist in Indian society prevent women from using active coping behaviours such as making plans and taking steps to leave the perpetrator and force women to resort to ineffective coping behaviours such as sleeping (Dyson and Moore, 1983, Menon, 2008, Menon, 2009, Pargament, 1997).

Chi-square tests were performed to test the association between type of coping, CMD, autonomy and IPV. While no significant association was found, within the group of women that never experienced any IPV, a smaller proportion of women that used spirituality as a coping mechanism had CMD, 20% vs. 25.3% respectively. This was somewhat unexpected especially as a quarter of women used spirituality as a coping mechanism for stressful situations. This result is discussed at length in the Discussion, Chapter 7.

5.7 General Health Questionnaire - GHQ 12

Based on the results of this screening questionnaire, over a quarter of the women in the sample (28.2%) were clinically depressed at the time of the interview. By comparison, other studies in India found CMD rates to range from 8.2% (Nayak et al., 2010) to 31% (Chandra et al., 2009) and 38% (Kumar et al., 2005). The differences in methodology, sample size and different geographical locations of the study populations probably account for the difference in CMD rates. For example sample sizes in the previous studies varied from 105 to 9475 women, used population surveys and primary care attendants and included urban, rural, slum and non-slum populations. The instruments used to diagnose CMD were also different e.g. Beck Depression Inventory, General Health Questionnaire and clinical interviews.

The co-prevalence of CMD with IPV and autonomy was investigated and the results are presented in Table 5.3 below. It can clearly be seen that both autonomy and CMD rates increase with the type of IPV with women that experience sexual IPV

having the highest rates of CMD as well as autonomy. In fact, having any IPV increases the rate of CMD two fold, and experiencing sexual IPV increases it almost three fold.

Table 5.3 Co-prevalence of CMD with IPV and autonomy

	No IPV	Any IPV	EIPV	PIPV	SIPV	All 3 IPV
High autonomy (%)	39.6	59.6	58.2	60.0	62.4	64.9
CMD (%)	21.0	46.3	44.0	44.1	55.0	52.6

EIPV = Emotional violence, PIPV=Physical violence, SIPV=sexual violence

5.8 Intimate partner violence

The following results would be better appreciated with the provision of an overview of some cultural aspects of Indian gender relations and the outcomes of the enactment of these relations. There are distinct sociocultural variations and a discrete dichotomy in gender relations and consequences in India that correlate to a broad geographical pattern. Low female autonomy and unfavourable consequences of unequal gender relations, as measured by low female literacy and high birth and death rates are prevalent in the north and relatively high female autonomy and favourable consequences are prevalent in the south (Dyson and Moore, 1983).

Despite these variations, there are commonalities in gender relations and women's status that are seen throughout the entire country and in fact the entire South Asian region. Indian culture is defined by a relatively strict social hierarchy and a tradition of joint family system characterized by patrilineal descent and patrilocal practices such as inheritance of family land can occur only through the male line and upon marriage a woman belongs to her husband's family not her natal family, that tend to exclude women (Jejeebhoy and Sathar, 2001). These practices result in low female autonomy with women having little control over their lives and health resulting in early marriages, high fertility, malnutrition, and other health and social issues (Dyson and Moore, 1983).

In recent years, particularly in urban areas, some of these practices have become more relaxed or have disappeared, and the nuclear family is becoming more common. This is particularly salient for migrants from rural areas who come to the city in search for work and leave behind their extended families. The male/female dynamic is consequently changing from traditional, often gender segregated practices to a more intimate one where the buffer and support of the extended family is absent. The traditional roles of the wife may also change, as she may need to leave the house to earn an income thus potentially creating tension or conflict within the marriage (Dyson and Moore, 1983).

This section has several groups of questions that investigate various aspects of the marital relationship. In India, conjugal bonds tend to be weak and younger married women tend to be marginalized (Gupta, 1995). The first four questions relate to whether the husband shows respect to his wife by spending free time with her, consulting her on household matters, is affectionate to her and whether he respects her wishes (Table 5.4).

Table 5.4 Frequency of respectful behaviour by the husband towards his wife (%)

	Frequently	Sometimes	Rarely	Never
He spends free time with her	35.8	58.6	2.3	3.3
Consults her on household matters	37.0	54.5	3.1	5.4
He is affectionate	51.3	41.9	2.9	4.0
He respects her wishes	49.3	42.2	2.5	6.0

Frequently = at least once a week; **sometimes** = 1-3 times a month; **rarely** = a few times a year

The next six questions investigate the husband's controlling behaviour such as whether he is jealous or angry if she talks to other men or limits her contact with family. This type of behaviour is common as the hierarchical relations within a family give the patriarch or his male relatives' authority over female family members (Jejeebhoy and Sathar, 2001). Levels of female autonomy are inversely

proportional with levels of control exhibited by the husband. Results are presented in Table 5.5 below.

Table 5.5 Frequency of controlling behaviour by the husband towards his wife (%)

	Frequently	Sometimes	Rarely	Never
He is jealous when she talks to other men	4.8	32.2	6.0	57.0
He accuses her of unfaithfulness	2.3	11.7	4.5	81.4
He does not permit her to meet friends	4.4	11.4	2.5	81.0
He tries to limit contact with her family	2.9	8.1	2.1	86.8
He insists on knowing her whereabouts	3.4	11.0	3.4	82.2
He does not trust her with money	5.3	9.0	9.6	76.0

Frequently = at least once a week; **sometimes** = 1-3 times a month; **rarely** = less than once a month or a few times a year

The above results are consistent with another study that used the same instrument as this one, which found that 36.5% of women reported at least one controlling act by their husband (Sudha and Morrison, 2011). Alcohol and illicit drugs can be exacerbating factors in IPV therefore the women were asked how often they have seen their husband drunk or under the influence of drugs in the past 12 months. Almost 1 in 10 women (7.1%) have seen their husbands drunk frequently or at least once a week, one third (31.7%) have seen them drunk sometimes or up to 3 times a month and 14.8% have seen them drunk rarely or a few times a year. The rest (46.2%) have not seen their husbands drunk in the year prior to the interview. More husbands in this study consumed alcohol at least once in the past year compared to Nayak et al (2010) who found any alcohol use prevalence rate of 35.7%. Over 1 in 10 women have seen their husbands use drugs in the year prior to the survey but clarification on the type of drug used showed that the drug of choice was usually tobacco or beetle nut rather than illicit drugs although in a few cases the women mentioned that their husbands used cannabis.

Significant associations were found between frequency of husband's drunkenness and CMD and all types of IPV, and this data is presented in Table 5.6 below. Based

on these results it was decided to include husband's alcohol use as one of the variables in the multinomial regression analysis in the next chapter.

Table 5.6 Significant associations with husband's frequency of drunkenness

	Frequency of drunkenness			Chi-square df 2, N = 904	
	Frequently	Sometimes	Rarely/never	χ^2	p-value
CMD	39.5%	23.7%	20.3%	36.21	0.000
Any IPV	45.1%	22.1%	16.9%	77.29	0.000
Psychological IPV	38.9%	14.8%	12.1%	83.48	0.000
Physical IPV	35.8%	10.4%	9.4%	92.30	0.000
Sexual IPV	25.6%	14.8%	7.2%	49.15	0.000
All 3 types of IPV	16.9%	5.2%	2.4%	53.73	0.000
High autonomy	51.0%	54.2%	37.2%	20.53	0.000

Frequently = at least once a week; **sometimes** = 1-3 times a month; **rarely/never** = less than a few times a year

Significantly more women whose husbands were drunk weekly or more frequently had CMD and experienced any and all types of IPV. Other studies found similar associations between husband's alcohol consumption and women's experiences of IPV (Stanley, 2008, Graham et al., 2011, D'Costa et al., 2007, Das et al., 2006, Jacob et al., 2009, Nayak et al., 2010). The association with high autonomy was a bit different.

Significantly more women whose husbands were drunk sometimes or frequently had high autonomy. It is possible that when a husband is drunk regularly, the wife is forced to start making decisions regarding household issues, children's health and so forth, or seek employment outside the home since the husband is unable to, thus increasing her level of autonomy out of necessity.

The next section deals with IPV itself, and the questions investigated whether a particular behaviour has ever occurred (lifetime prevalence) and if it did, how often it occurred in the 12 months prior to the survey and whether it occurred when the

husband was sober, drunk, under the influence of drugs or any combination herewith. The questions are also divided into three categories based on behaviours consistent with psychological and emotional abuse, physical abuse and sexual abuse. The lifetime prevalence of any kind of IPV was 28.7% and a breakdown by the three categories revealed that the lifetime prevalence for psychological and emotional violence was 22.9%, for physical violence it was 19.8% and for sexual violence it was 15.5%. Table 5.7 shows the breakdown by individual questions for all three categories of IPV.

In this study, lifetime prevalence rates and the incidence of IPV in the past 12 months were very similar, with 28.2% experiencing any IPV, 22.3% of women experiencing emotional and psychological IPV, 19.8% experiencing physical IPV and 14.8% experiencing sexual IPV. Other studies tend to find that prevalence rates are usually much higher than rates of IPV in the 12 months prior to the survey (Abramsky et al., 2011, Alhabib et al., 2010, Babu and Kar, 2009, Chowdhary and Patel, 2008, Garcia-Moreno et al., 2006).

Emotional IPV was the most frequently reported form of abuse and overlapped heavily with reports of other forms of abuse: 87.8% of women who experienced lifetime physical IPV also reported emotional IPV; 71.6% of women who experienced lifetime sexual IPV reported emotional IPV; and 51.7% of women who experienced lifetime physical IPV reported sexual abuse.

Table 5.7 Occurrence and frequency of specific abusive behaviours and presence of alcohol or drugs during the event (%)

	Lifetime prevalence	How often in occurred in the past year (Row percentages)			Abuse occurred when husband was: (Row percentages)				
		Frequently	Sometimes	Rarely	Sober	Drunk	Drugs	Sober or drunk	Sober or drugs
Psychological and emotional abuse									
<i>Says or does something to humiliate her</i>	17.6	9.0	87.7	2.6	28.1	65.1	0.0	6.2	0.7
<i>Threatens her with harm</i>	14.2	5.9	91.5	2.5	34.2	60.7	0.9	4.3	0.0
<i>Threatens to harm someone close to her</i>	4.0	6.7	93.3	0.0	12.5	84.4	0.0	3.1	0.0
<i>Threaten to leave or divorce her</i>	7.6	9.4	89.1	1.6	27.3	69.7	0.0	3.0	0.0
Physical abuse									
<i>Pushes, shakes her or throws something at her</i>	14.8	4.9	92.7	2.4	27.0	65.9	1.6	4.8	0.8
<i>Slap her or twist her arm</i>	13.8	3.4	93.2	3.4	34.2	59.0	1.7	5.1	0.0
<i>Punch her with his fist</i>	8.3	8.5	90.1	1.4	19.7	73.2	1.4	4.2	1.4
<i>Kick or drag her</i>	6.5	7.1	92.9	0.0	23.2	71.4	1.8	3.6	0.0
<i>Try to strangle or burn her*</i>	1.2	22.2	77.8	0.0	25.0	75.0	0.0	0.0	0.0
<i>Threatens her with a knife, gun or other weapon*</i>	1.0	25.0	62.5	12.5	33.3	66.7	0.0	0.0	0.0
<i>Attacks her with knife, gun or other weapon*</i>	0.4	33.3	33.3	33.3	0.0	100.0	0.0	0.0	0.0
Sexual abuse									
<i>Physically forces her to have sexual intercourse against her will</i>	14.6	8.1	88.7	3.2	35.5	53.2	0.0	10.5	0.8
<i>Forces her to perform other sexual acts she did not want to</i>	4.1	7.1	75.0	17.9	34.6	50.0	0.0	15.4	0.0

Frequently = at least once a week; **sometimes** = 1-3 times a month; **rarely** = a few times a year

*Low numbers of respondents (>11 women)

Approximately 1 in 10 women (9.2%) experienced all three types of IPV sometime in their lifetime. Similarly in past-year abuse, 85.6% of women who experienced physical IPV also reported emotional IPV; 70.9% of women that experienced sexual IPV also reported emotional IPV; 65.7% who experienced physical IPV also reported sexual IPV and 8.5% experienced all three in the past 12 months. These results are presented graphically in Figure 5.5.

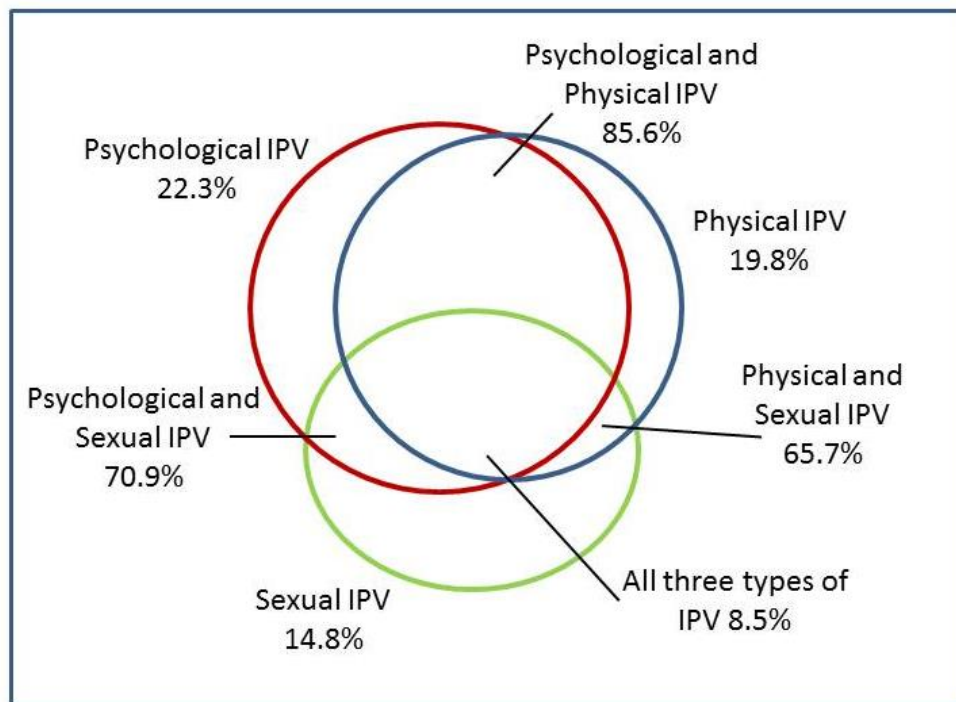


Figure 5.5 Overlap of IPV experiences in the 12 months prior to the survey

The majority of the women were not able to recall how soon after marriage the abuse began (53.8%) while in a little over a quarter of cases (27.6%) it started soon after the marriage.

Whilst the long term health consequences of IPV are difficult to diagnose with the use of a survey, the immediate physical effects of IPV were measured for this sample group and the results are in Table 5.8 below. A third of women who experienced IPV (33.5%) suffered bruises and aches as a direct consequence of violence by their husband. Almost a quarter of abused women (23.8%) had to visit a doctor or a health center, one in five (21.3%) suffered an injury or broken bone, and

17.6% had to spend at least one night in hospital due to their husband’s violence in the 12 months prior to the survey. Similar rates were found in Western studies, with approximately 26-30% of women who are injured as a result of IPV needing health care for their injuries (Tjaden and Thoennes, 2000, Yick, 2007).

Table 5.8 Lifetime prevalence of injuries related to IPV and their frequency of occurrence in abused women in the 12 months prior to the survey (%)

	Lifetime prevalence (frequency)	Frequently	Sometimes	Rarely
She had bruises and aches	8.8 (80)	11.4	63.6	25.0
She had a wound or broken bone	5.6 (51)	16.7	55.6	27.8
She had to go to a doctor or health center as a result of violence by the husband	6.3 (57)	9.1	86.4	4.5
She had to stay in hospital at least one night because of violence by the husband	4.6 (42)	0.0	20.0	80.0

Frequently = at least once a week; **sometimes** = 1-3 times a month; **rarely** = a few times a year

To investigate the level of violence in the marriage, women were asked whether they had ever hit, slapped or physically hurt their husband at a time when he was not already physically hurting them and 4.1% of respondents admitted to having done so. What is interesting though is that the majority (78.4%) of women who have ever hit their husband when he was not already hurting them were also victims of IPV. In fact women who suffered any type of abused were significantly more likely to have ever hit their husband than women who are not abused, see Table 5.9 for results.

Table 5.9. Likelihood of a woman ever hitting her husband when he was not already hurting her

Levels	Odds Ratio	95% CI	p value
No experience of violence	1		
Any type of IPV	11.393	5.130-25.304	0.000
Psychological and emotional violence	11.800	5.600-24.865	0.000
Physical violence	10.681	5.244-21.755	0.000
Sexual violence	5.580	2.839-10.968	0.000

Of all three types of abuse, women who were sexually abused were the least like to have ever hit their husband while women who were psychologically and emotionally abused were the most likely to do so compared to women who were not abused at all. One in ten women (11.4%) also reported being physically abused by people other than their husband, with over half (52.4%) reporting abuse in the previous 12 months. In the majority of cases those people were either a parent (45.8%) or a sibling (53.1%) (usually male). A small percentage of women (2.9%) reported being abused even when pregnant, and in all but one case (92.9%) the perpetrator was the mother or the father of the woman. This result is consistent with other studies (Ali et al., 2009, Devries et al., 2010, Khosla et al., 2005).

Only half of the abused women (55.2%) have ever told anyone about the abuse or tried to get help. Most of the women that sought help approached a parent (77.9%), the police (6.5%), a friend or neighbour (5.2%) or their in laws (5.2%). Reasons for not seeking help were that IPV is part of life or destiny (karma) (51.9%) or that it was of no use trying to get help (33.6%), the women were afraid of being divorced (9.9%) or were ashamed (6.1%). These results are similar to findings of other studies from India and other countries (Ahmed-Ghosh, 2004, Goel, 2005, Martin et al., 2002, Martin et al., 1999, Mogford, 2011, Panchanadeswaran and Koverola, 2005, Panda and Agarwal, 2005, Rao, 1997, Segal, 1999b, Sharma, 2005, Subadra, 1999). India's collectivist and patriarchal orientation emphasises values such as avoiding family shame at all costs, placing the needs of others first, conforming to stringent norms and expectations and resolving family problems privately (Yick, 2007, McAuliffe, 2007, Muldoon et al., 2011) which in turn discourage women from disclosing their experiences of IPV. In many patriarchal societies it is a husband's right to hit his wife, and women accept the violence as part of life or as punishment for something they did wrong, preventing them from telling even close family members about their IPV (Yick, 2007, Muldoon et al., 2011).

Not surprisingly a significant association was found between women that did not seek help for IPV because they believed it was their karma and women that used spirituality as coping, [$\chi^2(2, N = 140) = 9.03, p=0.011$], with 73.5% of women that used spirituality as a coping mechanism not seeking help for IPV because of the belief it was her destiny to suffer violence, compared to 40% of women that did not use spirituality to cope. Finally the women were asked whether they knew if their father ever hit their mother, and in a third of cases (31.0%) this was so. Violence between the parents was not associated with IPV experiences in the participants in this study.

5.9 Summary of the chapter

In this chapter the descriptive results are presented. A total of 907 women responded to the survey. The women in this study had high literacy levels, with almost half completing high school, and less than 10% being illiterate. Over a quarter of the women in this sample (28.7%) reported experiencing IPV and a similar proportion of women (28.2%) were also clinically depressed. There was a large degree of overlap between all three forms of IPV (emotional, physical and sexual) with 1 in 10 women experiencing all three.

Rates of CMD increased with co-prevalence of emotional IPV, physical IPV and sexual IPV in that particular order. Husband's frequency of drunkenness was a key causative factor of IPV with the majority of all types of IPV occurring when the husband was drunk. A woman's level of autonomy was also associated with the incidence of IPV and CMD, with women that had high autonomy significantly more likely to experience both. The next chapter reports the results of the inferential analysis.

CHAPTER 6 INFERENTIAL ANALYSIS AND MODELS TO EXPLAIN IPV AND CMD

*“Opinions founded on prejudice are always
sustained with the greatest of violence.” –
Francis Jeffrey*

6.1 Introduction to the chapter

In this chapter the results of the inferential analysis are presented. Inferential statistics use probability theory to deduce or infer properties of a larger population by analysis of sample data and is usually used to generalise findings. The best fit models for the various types of violence and for CMD are presented, as well as the estimated odds of violence due to the predictor variables.

6.2 Cronbach’s alpha

Cronbach’s alpha, a coefficient of reliability which is commonly used to measure the internal consistency or reliability of a survey instrument, was calculated for both scales used in this study. For the social support scale the Cronbach’s alpha was unacceptable (-0.1, on 3 items and a sample of 273), indicating that the internal consistency of the social support scale is low, and the items in the scale are not closely related as a group (Cronbach and Shavelson, 2004). This measure was not used in further analysis. On the other hand, the Cronbach’s alpha for autonomy based on a set of 6 questions was 0.79, which is acceptable.

6.3 Bivariate analysis on variables of interest

Bivariate analysis was carried out on variables of interest that showed significant association during initial Chi square analysis. After controlling for woman’s age, type of marriage (love or arranged), education level and CMD, significant but weak

bivariate correlation was found between autonomy and self-reported health, $r(892)=-0.07$, $p=0.036$. This result indicates that as autonomy increases self-reported health decreases, which is in contrast to several other studies that have found a positive association between autonomy and better health outcomes (Spektor, 2010, Hadley et al., 2010, Senarath and Gunawardena, 2009, Jejeebhoy and Sathar, 2001). Autonomy accounted for 4.9% of the variance in self-reported health outcomes. This correlation increased in strength and degree of significance when the analysis additionally controlled for any IPV, $r(892)=-0.08$, $p=0.014$, accounting for 6.4% of variance in self-reported health outcomes. IPV was not correlated with self-reported health outcomes.

Significant correlation was also found between high autonomy and CMD $r(900)=0.111$, $p=0.001$ indicating that with increasing autonomy there is an increase in CMD, and high autonomy accounts for 12.3% of the variance in CMD. High autonomy and controlling behaviour by the husband were also associated $r(900)=0.076$, $p=0.023$ even after controlling for IPV, with high autonomy accounting for 5.6% of the variance in husband's controlling behaviour.

Weak but significant correlation was obtained between autonomy and education after controlling for woman's age, type of marriage and CMD, with less educated women having higher autonomy, $r(892)=-0.1$, $p<0.01$, with education accounting for 10% of the variance in autonomy of women.

Weak but significant correlation was shown between length of time married and autonomy after controlling for woman's age, type of marriage, education level and CMD, with women married longer having more autonomy, $r(889)=0.1$, $p<0.01$. A woman's increasing age was also correlated to increasing autonomy, even after controlling for educational level, type of marriage, CMD and any IPV, with $r(886)=0.22$, $p<0.01$. This result is consistent with other studies that show that women's participation in decision making significantly increases with age (Senarath and Gunawardena, 2009). It is possible that the relationship between women's

length of being married and autonomy is mediated by the woman's age, so as her age increases so has the length of time she has been married.

The number of children a woman had did not significantly correlate with autonomy, but the number of sons she had did. After controlling for the woman's age, educational status, type of marriage and CMD, her level of autonomy increased with increasing number of sons, $r(805)=0.1$, $p<0.01$. In Indian society, having sons is considered good fortune and a number of other studies have found that in patriarchal societies having sons was associated with better husband-wife relationship, better relationship between the wife and the in laws, and it was protective against IPV (Koenig et al., 2003, Koenig et al., 2006, Rao, 1997, Schuler et al., 2008).

Independently, increasing income was negatively associated with all types of violence (psychological IPV $p=0.09$; physical IPV $p=0.027$; sexual IPV $p=0.023$) that is as income increased the likelihood of a woman experiencing IPV decreased. Multifactorial analysis of this variable resulted in loss of significance of association, however these results are still important to note and are similar to findings by other researchers (Abramsky et al., 2011, Graham et al., 2011, Spektor, 2010, Acharya et al., 2010, Vyas and Watts, 2009, Jacob et al., 2009, Babu and Kar, 2010). It is possible that due to the participants being from a similar low socio-economic background, with a relatively small range of income levels, this study did not find similar significant associations between income and IPV as other studies.

6.4 Model to explain psychological violence

A statistically significant overall relationship was found between the combination of independent variables and psychological IPV. The final model for psychological IPV is: PsychIPV- ~ husband's education + husband's respectful behaviour + husband's controlling behaviour + living in a nuclear family + physical IPV + sexual IPV, see Table 6.1 below.

Table 6.1. The estimated odds of psychological violence

	Coefficient	Std Error	p-value	OR	95% CI
Husband illiterate	-2.003	0.654	0.011	0.135	0.029-0.635
Husband high schooled	-0.811	0.316	0.010	0.445	0.239-0.826
Respectful behaviour	1.981	0.429	0.000	7.252	3.131-16.800
Controlling behaviour	-0.870	0.309	0.005	0.419	0.229-0.767
Live in nuclear family	1.565	0.566	0.006	4.783	1.577-14.505
Physical IPV	-4.069	0.310	0.000	0.017	0.009-0.031
Sexual IPV	-1.572	0.326	0.000	0.208	0.110-0.393

This suggests that the variability in the odds of psychological IPV can be “explained” by the different categories of the husband’s education, his respectful and controlling behaviours, living in a nuclear family and experience of sexual and physical IPV. There was no evidence of numerical problems in the solution, and the classification accuracy surpassed the proportional by chance accuracy criteria, supporting the utility of the model.

These odds are interpreted as follows:

- The estimated odds of psychological violence decrease with increasing educational level of the husband. Women with illiterate husbands were 7.4 times more likely to be psychologically abused and women with husbands that completed high school were 2.25 times more likely to be abused than women whose husbands had college education.
- The estimated odds of psychological violence for a woman whose husband does not display respectful behaviour towards her were 7.2 times the odds for a woman whose husband was respectful towards her.
- The estimated odds of psychological violence for a woman whose husband displays any controlling behaviours were 2.4 times the odds of women whose husbands did not display any controlling behaviours.
- The estimated odds of psychological violence for women living in a nuclear family (with only husband and with/without children) were 4.78 times the estimated odds for women living in an extended family (in laws and in law family members).

- The estimated odds of psychological violence for women that also experience physical IPV were 0.017 times the estimated odds for women that do not experience physical violence i.e. women that were already physically abused were more than 58 times more likely to also be psychologically abused.
- The estimated odds of psychological violence for women that also experience sexual IPV were 0.208 times the estimated odds for women that do not experience sexual violence i.e. women that were already sexually abused were 4.8 times more likely to also be psychologically abused.

It is clear that in this study physical and psychological IPV are highly associated, and where a woman experiences one type she also experiences the other type of IPV. There is a lack of literature on the associations between the different types of IPV, but it is possible that this association is so noticeable due to the relative 'ease' of carrying out these two types of abuse compared to sexual abuse. For example verbal humiliation or threat, and slapping or hitting can be carried out instantly by the husband to show his control over his wife and may only take a few seconds. Sexual assault however implies a need for some privacy, removal of at least some clothing items and takes somewhat longer to carry out than physical or psychological IPV.

The husband's increasing education decreased the risk of psychological violence and this finding is consistent with numerous other studies (Sambisa et al., 2011, Abramsky et al., 2011, Babu and Kar, 2010, Vyas and Watts, 2009, Boyle et al., 2009, Ackerson et al., 2008). Respectful behaviour by the husband reduced a woman's risk of psychological IPV while his controlling behaviour increased the risk, consistent with Dalal and Lindquist's (2010) findings. Living in extended family households was a protective factor for psychological IPV in this group of women consistent with the findings in Koenig et al study (2003) who found that the extended family residence was predictive of lower risks of violence.

6.5 Model to explain physical violence

A statistically significant overall relationship was found between the combination of independent variables and physical IPV. The final model for physical IPV is: PIPV- ~ husband's education + marriage type + husband's frequency of drunkenness + spirituality as a coping mechanism + sexual IPV + psychological IPV, presented in Table 6.2 below.

Table 6.2. The estimated odds of physical violence

	Coefficient	Std Error	p-value	OR	95% CI
Husband illiterate	2.003	0.664	0.003	7.414	2.017-27.251
Husband primary schooled	1.191	0.472	0.012	3.292	1.305-8.303
Husband high schooled	0.817	0.369	0.027	2.264	1.099-4.663
Arranged marriage	-0.845	0.372	0.023	0.429	0.207-0.890
Frequent drunkenness	0.673	0.314	0.032	1.961	1.059-3.632
Spirituality	-0.674	0.331	0.042	0.510	0.266-0.967
Psychological IPV	-4.268	0.314	0.000	0.014	0.008-0.026
Sexual IPV	-1.221	0.331	0.000	0.295	0.154-0.564

This suggests that the variability in the risk of PIPV can be “explained” by the different categories of the husband's education, the type of marriage, frequency of drunkenness of the husband, spirituality as a coping mechanism, sexual violence and psychological IPV. There was no evidence of numerical problems in the solution and the classification accuracy surpassed the proportional by chance accuracy criteria, supporting the utility of the model.

These odds are interpreted as follows:

- The estimated odds of psychological violence decrease with increasing educational level of the husband. Women with illiterate husbands were 7.4 times more likely to be psychologically abused; women whose husbands completed primary school were 3.2 time more likely and women with husbands that completed high school were 2.25 times more likely to be abused than women whose husbands had college education.

- The estimated odds of physical violence for women in love marriages were 2.33 times the odds for a woman in an arranged marriage, that is women in love marriages were almost two and a half times more likely to be physically abused than women in arranged marriages.
- The estimated odds of physical violence for women whose husbands are drunk frequently were 1.96 times the estimated odds of women whose husbands were seldom or never drunk.
- The estimated odds of physical violence in women that use spirituality as a coping mechanism were 0.51 times the odds of women using other coping mechanisms.
- The estimated odds of physical violence for women also experiencing psychological violence are 0.014 times the estimated odds of women with no psychological IPV i.e. women already suffering psychological abuse are 71 times more likely to also be physically abused.
- The estimated odds of physical violence for women that also experience sexual IPV are 0.295 times the estimated odds of women with no sexual IPV i.e. women that are already sexually abused are 3.34 times more likely to be physically abused than women without sexual abuse.

To summarise, in this study, the risk of physical IPV increased with decreasing educational level of the husband, in love marriages, when husbands were frequently drunk, in women that used spirituality as a coping mechanism and if women already experienced psychological or sexual violence.

6.6 Model to explain sexual violence

A statistically significant overall relationship was found between the combination of independent variables and sexual IPV. The final model for sexual violence is: SIPV ~ husband's controlling behaviour + psychological IPV + Physical IPV + CMD, see Table 6.3. This suggests that women are significantly more likely to experience sexual IPV if they have a husband that displays any controlling behaviours, experience psychological and physical IPV and have CMD. There was no evidence of

numerical problems in the solution. The classification accuracy surpassed the proportional by chance accuracy criteria thus supporting the utility of the model.

Table 6.3. The estimated odds of sexual violence

	Coefficient	Std Error	p-value	OR	95% CI
Controlling behaviour	-0.745	0.287	0.009	0.457	0.271-0.833
Psychological IPV	-1.534	0.316	0.000	0.216	0.116-0.401
Physical IPV	-1.264	0.313	0.000	0.283	0.153-0.522
CMD	-1.042	0.229	0.000	0.353	0.225-0.552

The above odds can be interpreted as follows:

- The estimated odds of sexual IPV in women whose husbands displayed any controlling behaviours were 2.2 times the odds of women whose husbands did not show controlling behaviour.
- Compared to women that did not suffer psychological IPV, women who experienced psychological IPV were 4.7 times more likely to experience sexual IPV as well.
- Compared to women that did not suffer physical IPV, women who experienced physical IPV were 3.5 times more likely to experience sexual IPV as well.
- Compared to women that did not have CMD, women who scored highly on the GHQ-12 were 2.8 times more likely to have experienced sexual IPV.

Husband's controlling behaviour, in women already experiencing psychological and physical IPV increased the odds of women experiencing sexual IPV. Women who had CMD were also more likely to experience sexual IPV, however since CMD was only associated with sexual IVP and not the other types of IPV, it is likely that women that experience sexual IPV are at increased risk of CMD compared to women that only experience the other types of IPV.

6.7 Model to explain any IPV (emotional, physical and sexual)

A statistically significant overall relationship was found between the combination of independent variables and any IPV. The final model for any violence is: any IPV- ~ autonomy + respectful behaviours + controlling behaviours + husband's frequent drunkenness + live with others + CMD, see Table 6.4. This suggests that the

experience any IPV can be ‘explained’ by the variables related to women’s autonomy, husbands respectful and controlling behaviours, frequency of husbands’ drunkenness, living in a nuclear family, and existence of CMD. There was no evidence of numerical problems in the solution. Moreover, the classification accuracy surpassed the proportional by chance accuracy criteria, supporting the utility of the model.

Table 6.4. The estimated odds of any violence

	Coefficient	Std Error	p-value	OR	95% CI
Autonomy	-0.454	0.175	0.010	0.635	0.450-0.096
Respectful behaviour	2.199	0.329	0.000	9.020	4.731-17.199
Controlling behaviour	-1.114	0.201	0.000	0.328	0.221-0.487
Frequent drunkenness	0.964	0.194	0.000	2.622	1.798-3.832
CMD	-0.633	0.186	0.001	0.531	0.369-0.764
Live in nuclear family	0.897	0.300	0.003	2.452	1.362-4.413

These odds can be interpreted as follows:

- The odds of experiencing any type of IPV for women with high autonomy increase by 1.6 times compared to women with low autonomy.
- The estimated odds of any IPV for a woman whose husband does not display respectful behaviour towards her were 9 times the odds for a woman whose husband was respectful towards her.
- The estimated odds of any type of violence for a woman whose husband displays any controlling behaviours were 3 times the odds of women whose husbands did not display any controlling behaviours.
- Compared to women whose husbands were drunk seldom or never, women whose husbands were drunk frequently were 2.7 times more likely to experience any violence.
- Compared to women that did not have CMD, women who scored highly on the GHQ-12 were 2.4 times more likely to have experienced any IPV.

- The estimated odds of any violence for women living in a nuclear family (with only husband and with/without children) were 2.4 times the estimated odds for women living in an extended family (in laws and in law family members).

In this study, women living in extended families, that had low levels of autonomy, whose husbands were respectful and not controlling, were seldom or never drunk and that did not have CMD were significantly less likely to have any kind of IPV.

6.8 Model to explain CMD

A statistically significant overall relationship was found between the combination of independent variables and CMD. The final model for CMD is: CMD- ~woman's age + husband's age + husband's respectful behaviour + husband's controlling behaviour + frequent drunkenness + sexual IPV as shown in Table 6.5.

Table 6.5. The estimated odds of CMD

	Coefficient	Std Error	p-value	OR	95% CI
Woman's age	-0.193	0.030	0.000	0.825	0.778-0.874
Husband's age	0.194	0.025	0.000	1.214	1.155-1.275
Respectful behaviour	0.615	0.279	0.027	1.849	1.071-3.194
Controlling behaviour	-0.964	0.195	0.000	0.382	0.260-0.560
Frequent drunkenness	0.468	0.191	0.014	1.597	1.099-2.323
Sexual IPV	-0.982	0.216	0.000	0.375	0.245-0.572

This suggests that the risk of CMD can be “explained” by the different categories of woman's age, husband's age, the husband's controlling and respectful behaviours, frequent drunkenness of the husband and sexual violence. There was no evidence of numerical problems in the solution. The classification accuracy surpassed the proportional by chance accuracy criteria, supporting the utility of the model.

These odds are interpreted as follows:

- A year increase in the husband's age has the effect of multiplying the estimated odds of CMD in the wife by 1.21.

- A year increase in the woman's age has the effect of multiplying her estimated odds of CMD by 0.826, that is for each year that she gets older a woman's likelihood of having CMD decreases by 1.2 times.
- The estimated odds of CMD for a woman whose husband does not display respectful behaviour towards her were 1.8 times the odds for a woman whose husband was respectful towards her.
- The estimated odds of CMD for a woman whose husband displays any controlling behaviours were 2.6 times the odds of women whose husbands did not display any controlling behaviours.
- The estimated odds of CMD for women whose husbands were drunk frequently were 1.6 times the estimated odds of women whose husbands were drunk seldom or never.
- The estimated odds of CMD for women that are sexually abused were 2.7 times the estimated odds for women that did not report sexual abuse.

Older women who were treated respectfully by their husbands, whose husbands did not display any controlling behaviours had decreased risks of CMD. Younger women who had an older husband and suffered any type of IPV were at higher risk of CMD. The use of spirituality as a coping mechanism was not significantly associated with CMD or other of the variables of interest in this study.

To clarify the relationship between CMD, IPV and other variables of interest, Chi-square analysis was carried out on women that did not report any IPV, and compared to women that experienced any IPV i.e. controlling for lifetime prevalence of any IPV. The variables included in the analysis were age of woman and her husband, autonomy, husband's alcohol use, respective and controlling behaviours, living arrangements and the use of spirituality for coping.

In women with no IPV, significantly more women whose husbands were drunk occasionally or frequently had CMD compared to women whose husbands were seldom or never drunk, $\chi^2(2, N = 640) = 18.308, p = 0.000$. Significantly more women whose husbands displayed any controlling behaviour had CMD, $\chi^2(1, N = 642) =$

23.893, $p = 0.000$. Furthermore, significantly more women with high levels of autonomy had CMD compared to women with low autonomy, $\chi^2 (1, N = 642) = 5.945, p = 0.015$. No association was found between CMD and self-reported physical health, which suggests that physical health in women that do not experience IPV is not mediated by CMD.

All the variables were then included in a multinomial regression analysis and the results are presented in Table 6.6 below.

Table 6.6. The estimated odds of CMD in women with no IPV

	Coefficient	Std Error	p-value	OR	95% CI
Woman's age	-0.227	0.038	0.000	0.797	0.740-0.859
Husband's age	0.219	0.032	0.000	1.245	1.169-1.325
Controlling behaviour	-0.829	0.226	0.000	0.437	0.280-0.680
Frequent drunkenness	0.685	0.242	0.005	1.985	1.235-3.190

These results can be interpreted as follows: In women with no IPV

- A year increase in the woman's age has the effect of multiplying her estimated odds of CMD by 0.797, that is for each year that she gets older a woman's likelihood of having CMD decreases by 1.25 times.
- A year increase in the husband's age has the effect of multiplying the estimated odds of CMD in the wife by 1.24.
- Women's whose husband's exhibited controlling behaviours were 2.3 times more likely to have CMD when compared to women whose husbands did not display any controlling behaviours.
- The estimated odds of CMD for women whose husbands were drunk frequently were 2 times the estimated odds of women whose husbands were drunk seldom or never.

The same analysis was carried out on women that reported any IPV. In this group CMD was not associated with husband's frequency of alcohol use, suggesting that CMD may be mediated by IPV rather than by the husband's drunkenness per se.

That is women are abused when their husbands are drunk, but it is the IPV that causes the CMD. Both controlling and respectful behaviours by the husband were significantly associated with CMD in this sub-group of women.

Significantly less women whose husbands engaged in respectful behaviours had CMD, $\chi^2(1, N = 257) = 8.119, p = 0.004$, but significantly more women whose husbands employed controlling behaviours had CMD, $\chi^2(1, N = 257) = 7.346, p = 0.007$. There was a twofold increase in the number of women that had high autonomy and CMD compared to women with low autonomy and CMD, $\chi^2(1, N = 257) = 4.818, p = 0.028$. Furthermore, significantly fewer women with CMD reported good physical health compared to women with no CMD, $\chi^2(1, N = 257) = 7.811, p = 0.005$ suggesting that physical health is mediated by IPV. Multinomial regression analysis result for women that experienced IPV are presented in table 6.7 below.

Table 6.7. The estimated odds of CMD in women with IPV

	Coefficient	Std Error	p-value	OR	95% CI
Woman's age	-0.132	0.046	0.001	0.876	0.798-0.926
Husband's age	0.145	0.040	0.000	1.155	1.064-1.255
Husband primary schooled	1.178	0.468	0.012	3.248	1.297-8.133
Self-reported health	0.746	0.327	0.022	2.110	1.112-4.002
Controlling behaviour	-1.119	0.423	0.008	0.327	0.143-0.748

These results can be interpreted as follows: In women with IPV

- A year increase in the woman's age has the effect of multiplying her estimated odds of CMD by 0.876, that is for each year that she gets older a woman's likelihood of having CMD decreases by 1.16 times.
- A year increase in the husband's age has the effect of multiplying the estimated odds of CMD in the wife by 1.17.
- The odds of CMD for a woman whose husband is illiterate or primary school educated only are 3.2 times the odds of a woman with college educated husband.
- The odds of CMD for a woman who reports poor physical health are 2.1 times the odds of a woman who reports good physical health.

- The odds of CMD for women whose husbands are controlling are 3.27 times the odds of women whose husbands do not display controlling behaviours.

These results suggest that other than IPV and the respective ages of the woman and the husband, CMD is mediated by the husband's educational level, his controlling behaviour and women's poor physical health.

6.9 Summary of the chapter

In this chapter the results of the inferential analysis were presented. As expected from the extensive overlap of different types of IPV prevalence presented in Figure 5.4, Chapter 5, the various types of IPV were significantly associated with each other, in particular psychological and physical IPV. The results of this study suggest that CMD and physical health may be mediated by IPV. The husband's controlling behaviour and husband's frequency of drunkenness increased the odds of different types of IPV. Sexual IPV and CMD were also significantly associated and this is an important finding of this study, the implications and significance of which are discussed in the next chapter.

CHAPTER 7

DISCUSSION

“Let me not beg for the stilling of my pain but for the heart to conquer it.”– Rabindranath Tagore

7.1 Introduction to the chapter

In this chapter the results of the study are discussed, and the findings are interpreted in relation to the literature. The first section will summarise the results of each research question and explain them in the context of this and prior research. Based on the results and findings of the study, implications of the research for further understanding of the IPV problems are explored incorporating qualitative findings about the research problem developed during the study. Next the implications for theory are discussed including the contribution to knowledge and implications for the wider body of knowledge. The strengths, significance and limitations of the study, implications for further research and a list of proposed recommendations complete this chapter.

7.2 Response to the research questions

This study has provided an intimate glimpse into the lives of women who live in the Pratikshanagar slum in Mumbai, India and their experiences with IPV. The results of this study confirm that IPV is prevalent in this sample of Indian women and that the violence is significantly related to CMD. As hypothesised, experiencing any type of violence and specifically sexual violence were significantly associated with CMD. In this study the size of the support network and the use of spirituality as a coping mechanism in times of stress were not found to be associated with improved mental health outcomes. IPV and CMD were also associated with husband’s controlling behaviours. The next sections will discuss each research question separately.

7.2.1 What is the prevalence and incidence of IPV?

The prevalence of any form of IPV in this study (28.7%) was lower than the rates obtained in other studies; however it is well known that a common limitation of

surveys investigating sensitive issues such as IPV is under-reporting (Ellsberg and Heise, 2005). Evidence of under-reporting in this study was demonstrated when several respondents volunteered information on their experiences of IPV in the open ended questions that investigated sources of anxiety, yet responded negatively to all questions in the sections dealing with violence. The survey instrument used in this study was designed to minimize misunderstandings so it is perplexing as to why some women responded negatively to IPV when in an earlier section they admitted to being hit by their husband. Perhaps using the words 'domestic violence' in the title of the survey section, labeled their experiences and prevented them from further disclosing and discussing something that is perceived as taboo.

Rao (1997) also found that some women denied experiencing IPV during focus group discussions even though they were physically hit by their partners during a previous incident that occurred in a public place in front of the author. Other studies that surveyed both men and women (Babu and Kar, 2010, Babu and Kar, 2009) found that prevalence of IPV experiences (except for sexual violence) as reported by women were lower by 3%-9% when compared to prevalence of IPV perpetration as reported by men. Nevertheless, the fact that such contradictions were observed with several respondents indicates that the prevalence of IPV in this sample was likely to have been under-reported.

In this study most of the respondents that experienced partner violence sometime in their lifetime also reported current IPV, that is the prevalence and incidence of IPV in this sample was nearly the same, 28.7% and 28.2%. This result is different from results obtained from other studies where the prevalence rates are usually higher than the incidence rates (Sudha and Morrison, 2011, Pico-Alfonso et al., 2006, Pico-Alfonso, 2005, Khosla et al., 2005).

Psychological IPV prevalence in this study was 22.9%, which was lower than the prevalence found by Babu et al (2009, 2010) at 56% but higher than the prevalence reported by Sudha (2011) at 15% and Dalal et al (2010) at 14.5%. Babu et al (2009,

2010) used 13 different items to determine psychological and emotional violence and included other family members as perpetrators, so it is not surprising that their prevalence rate was so much higher.

Dalal et al (2010) and Sudha et al (2011) analysed data collected for the Indian National Family Health Survey 3 (NFHS-3) which used the same survey instrument as in this study, however their samples included only women of reproductive age i.e. 15-49 years and were limited to certain states and localities. The incidence of psychological violence in Sudha et al's study (2011) was 10.5%, much lower than in the present study (20.8%). It has previously been documented that the risks of all types of IPV increase with lower incomes and lower socio-economic status (Abramsky et al., 2011, Mburia-Mwalili et al., 2010, Krishnan et al., 2010, Babu and Kar, 2010). Since the population in this study has very low incomes, and are from the lowest socio-economic strata, it is possible that the incidence of psychological IPV obtained is a reflection of this increased risk.

In this study the incidence and prevalence of physical violence was 19.8%. As a lifetime prevalence rate, it is lower than in most other studies of IPV in India including Dalal et al (2010) and Sudha et al (2011) whose rates were 31% and 41.4% respectively. Babu et al (2009, 2010) on the other hand used only a 2 item survey to determine physical violence and obtained a lifetime prevalence of 16.1%. As an incidence of IPV experience in the previous 12 months, the rate obtained in this study was the same as the incidence rate in Sudha et al (2011) study.

The sexual IPV prevalence rate in this study was 15.5%. By comparison, Dalal et al (2010), Sudha et al (2011) and Babu et al (2009, 2010) had lifetime prevalence rates of 8%, 9.2% and 25.4% respectively. Sudha et al (2011) and Dalal et al (2010) used the same two questions to investigate sexual violence as in this study, namely "Has your husband ever physically forced you to have sexual intercourse with him even when you did not want to?" and "Has your husband forced you to perform any sexual acts you did not want to?". Babu et al (2009, 2010) used a 3 item survey "Has your husband ever coerced sex"; "Has he ever denied sex" and "Has he ever caused

sexual injury or hurt?” to investigate sexual violence. This result was unexpected because it was almost twice as high as the rates reported by the other two studies using the same instrument (Dalal and Lindqvist, 2010, Sudha and Morrison, 2011). On the other hand, Babu et al (2009, 2010) found that sexual violence rates were higher in women from Backward Castes and Scheduled Tribes and women that had lower levels of education which are characteristics of the population of this study. It is possible that the concentration of Backward and Scheduled castes and tribes, lower average literacy levels and incomes that exist in the Pratikshanagar slum are embodied in the higher rates of sexual violence.

There was a large degree of overlap between all three forms of abuse (see Figure 5.4 in Chapter 5) with 1 in 10 women experiencing all three forms suggesting that Indian women in abusive relationships experience multiple forms of abuse at the hands of their husbands and once abuse begins it continues over their lifetime. Comparison with other studies is not possible because none to date measured all three types of IPV separately or reported rates of co-occurrence.

The factors that increased the risks of the three types of IPV were very different to each other, and a summary of these findings is provided in Table 7.1 below.

Table 7.1. Determinants of IPV

	Psychological IPV	Physical IPV	Sexual IPV
Psych IPV		X	X
PIPV	X		X
SIPV	X	X	
Husband’s education	X	X	
Controlling behaviour	X		X
Living in nuclear family	X		
Respectful behaviour	X		
Frequent drunkenness		X	
Love marriage		X	
Spirituality		X	
CMD			X

Other than husband's education and the presence of other types of IPV, the results suggest that the determinants of are quite different to the determinants of psychological and sexual IPV. Controlling behaviour has emerged as a significant risk factor for psychological and sexual violence. This can be explained through the feminist theory where in patriarchal societies such as India, husbands might have the notion that they should control their wives through the traditional gender hierarchy (Ahmed-Ghosh, 2004, Kaur and Garg, 2010). The findings on the protective effects of living in an extended family against psychological IPV lend support to Menon and Johnson's (2007) findings that women in joint households are less likely to experience IPV. They theorise that extended family members can act either as buffers and monitors and prevent a woman from reacting in a way that may result in IPV, or can act as potential supporters or mediators in a disagreement.

The protective effect of respectful behaviour against psychological IPV is logical, the more polite and courteous a husband is towards his wife the less likely he is to humiliate and emotionally abuse her. The researcher was unable to find any literature on the risks of disrespectful behaviour on IPV, an indicator of the role of such behaviour in IPV is lent by the many batterer programs that promote respectful behaviour as a way to address IPV perpetration (Carville et al., 2007, Stephens et al., 2005).

Frequent drunkenness which is a proxy indicator of the husband's excessive alcohol consumption was a significant risk factor for physical violence only. Perhaps the effects of alcohol on speech (slurring speech, depressed cognitive functioning) and on sexual functioning prevents men from verbally abusing their wives and sexually assaulting them, but enables men to be physically aggressive (Monteiro et al., 2010, DeBoer et al., 2012, Gluckman et al., 2005).

The results on increased risk of physical violence in love marriages were consistent with other studies (Krishnan et al., 2010, Babu and Kar, 2010). This outcome may be mediated through the lack of dowry that a woman brings to her marriage in a love marriage. Some studies have found that an insufficient dowry is a risk factor for IPV

including its extreme form of dowry deaths (Babu and Babu, 2011, Srinivasan and Bedi, 2007, Rudd, 2001), and women that have love marriages usually go against their families' wishes and end up being disowned, thus bring no dowry to the husband or his family. This could then result in physical violence. This speculative explanation is supported by the comments of some of the women in this study which stated that since they went against their families' wishes and married the man of their own choosing, their natal family has disowned them, their parents do not provide any support and blame the woman for the violence saying she deserves it since she brought shame on the family with her actions.

Whilst the results of this study cannot be used to determine causality, these results together with the results of other studies (Mburia-Mwalili et al., 2010, Haqqi and Faizi, 2010, Fadardi and Ziaee, 2009, Dutton, 2009, Houry et al., 2006, Bonomi et al., 2006, Jain et al., 2004, Hegarty et al., 2004) can be used to suggest that CMD and the use of spirituality as coping probably do not cause sexual and physical IPV, but rather they are a result of IPV i.e. women develop CMD and turn to spirituality to cope with the IPV in their life.

Women's level of autonomy on the other hand was significantly correlated to self-reported health status. Consistent with other studies, higher levels of autonomy were related to better health status (Chen et al., 2005, Koenig et al., 2003).

7.2.2 What is the prevalence of CMD and its association with IPV?

The prevalence of CMD as measured by the GHQ-12 in this study was 28.2% which was higher than the prevalence of 10.7% obtained by Shidhaye and Patel (2010) and 8.2% by Nayak et al (2010) using the same instrument (GHQ-12) among Indian women. Chandra et al (2009) found CMD prevalence rates of 31% among Indian women however they used a different instrument and their sample was recruited from a clinical setting. Delving deeper into the results of the studies conducted by Shidhaye and Patel (2010) and Nayak et al (2010), it can be seen that prevalence of CMD was almost three times higher in women who had less than or primary level education, were from the lowest standard of living index group, and were of

scheduled caste or tribe. Their respondents included women from all socio-economic and education strata, however the women in our study belong almost exclusively to those higher risk groups identified above and this may explain why the prevalence of CMD in this study was almost three times as high as in the other studies. The scoring and particularly the cut-off scores of the GHQ-12 were also different between this study and the others and this may have contributed to the difference.

Co-prevalence of CMD with IPV was clearly demonstrated in Table 5.3 in Chapter 5, where twice as many women that reported any IPV also had CMD and women that reported sexual IPV had almost three times as higher rate of CMD as women with no IPV. Inferential analysis showed that women that experienced IPV in this study were significantly more likely to have CMD. Specifically sexual abuse increased the odds of CMD almost three fold, while experiencing any IPV increased the odds 2.4 times. Overall these results are in agreement with findings from numerous other studies (Shidhaye and Patel, 2010, Nayak et al., 2010, Tiwari et al., 2008, DeJonghe et al., 2008, Chowdhary and Patel, 2008, Patel et al., 2006b, Pico-Alfonso, 2005, Kumar et al., 2005, Jeyaseelan et al., 2004, Nurius et al., 2003, Humphreys and Thiara, 2003, WHO, 2002, Coker et al., 2000, Ellsberg et al., 1999a, Resnick et al., 1997).

Shidhaye et al (2010) found that any IPV (measured using the same instrument as in this study) was strongly associated with CMD (measured using GHQ-12) (OR 2.2; 95% CI 1.7–2.9), while Nayak et al (2010) found that IPV increased the odds of CMD (also measured using GHQ-12) fourfold. Kumar et al (2005) using different instruments obtained a similar result with women experiencing any IPV having a two fold increase in the likelihood of having common mental health problems. Most of the earlier studies on IPV and mental health (pre 2000) used physical violence or physical and psychological violence together as indicators of IPV. In that respect this study is important as it is one of the very few that has investigated the effects of the different types of IPV separately on CMD.

In this study, support for associations between IPV and risk of CMD was found in the analysis shown in Chapter 5. Ishida et al (2005) found that sexual IPV increased the odds of CMD by 1.6, while Ali et al (2009) found that marital rape in Pakistani women increased their odds of CMD three fold. Pico-Alfonso et al (2006) and Bonomi et al (2007) investigated the effects of concomitance of sexual violence together with physical and/or psychological IPV and found that the experience of sexual violence was associated with increased depression and increased severity of depressive symptoms and suicidal ideation.

These findings contribute to strengthen the evidence base linking IPV with negative mental health outcomes. Specific to this study is the establishment of the magnitude of the effect of sexual IPV on CMD. The results strongly suggest that sexual IPV should be investigated together with other types of IPV as its effect on mental health in particular is large.

Sexual IPV obviously has a big effect on CMD, and studies that do not account for the effect of sexual violence when investigating effects of IPV are resulting in partial results and only investigate a fraction of the problem. Particularly related to CMD, and considering the large overlap between sexual IPV and the other types of IPV, it is possible and even likely that not accounting for the effect of sexual IPV leads to false conclusions and incorrect attribution of mental health outcomes to physical or emotional IPV, when in fact they may be caused by sexual violence. This oversight can have great implications for the diagnosis and treatment of mental health effects of IPV. Lack of awareness of the large effect of sexual violence on mental health, larger even than physical and emotional IPV may lead to incorrect diagnosis and ineffective treatment of patients.

In this study, high autonomy was significantly correlated to lesser odds of CMD and husband's controlling behaviours even after controlling for IPV. Autonomy is theorized to mediate improvement in women's health by giving them control over resources that can be converted into health, for themselves or their children (Hadley et al., 2010, Acharya et al., 2010, Chen et al., 2005, Jejeebhoy, 2002). Chen

et al (2005) found support for this theory in a population study on American women where high autonomy was associated with lower CMD symptomatology. Patel et al. (2006) found that Indian women's autonomy was associated in a dose-response relationship with CMD, with lower levels of autonomy being associated with greater odds of having CMD or anxiety.

Hadley et al (2010) on the other hand theorise that particularly in developing countries, women's fight against male dominant ideology and gender norms while exercising their autonomy may generate psychosocial stress which in turn causes common mental disorders like depression and anxiety. In their comprehensive population study in Uzbekistan, Hadley et al (2010) showed that that for some health outcomes the impact of autonomy was positive, for some it was negative, and for others no influence either way was observed. In particular, they found that freedom to travel (high travel autonomy) was protective against CMD but decision making autonomy (being in control of household decisions) increased the risk of CMD. In this study, the autonomy scale was composed of items mainly addressing household decision making control (5/6 items), thus the results support Hadley et al (2010)'s theory. One of the dimensions measured in our study was the freedom to travel. It is possible that the inclusion of the travel autonomy in the final autonomy scale in this study has diluted the magnitude of the true effect of decision making autonomy on CMD.

A potential explanation for this discrepancy between particular autonomy measures and mental health outcomes lies in the level of agreement between spouses on the different dimensions of autonomy. When spouses are in conflict over a dimension of autonomy, women will experience negative mental health as their autonomy increases because the increasing autonomy escalates the disagreement between men and women (Brunson et al., 2009, Hadley et al., 2010). This could also be the reason why women with high autonomy experience more IPV than those with low autonomy, see Table 6.4, Chapter 6. As women exercise their autonomy they challenge the husband's perceived superiority which may result in increased risk of

experiencing violence as men resort to IPV to try and maintain control (Vyas and Watts, 2009, Koenig et al., 2003).

The increasing age of the woman decreased the odds of CMD while increasing age of the husband was associated with increased risk of CMD. The results on the effects of the woman's age on CMD conflict with findings from other studies e.g. (Patel et al., 2002), that found that increasing age is associated with increasing risk of CMD and attributed it to multiple stressors related to childrearing and income generating activities. On the other hand some studies found that younger women felt unable to manage the pressures of employment and household work, their days often spanned 16–18 hours, and young mothers were particularly stressed (Krishnan et al., 2010, Gorospe and Oxentenko, 2012). Whereas older age women have their children to help out around the house, and if their sons marry they have the daughter-in-law to carry out most of the housework, thus their stress levels decrease as they age. This explanation could account for the pattern found in this study.

Respectful behaviours and controlling behaviours decreased and increased the risk of CMD respectively in this study. These risk factors can affect mental health directly or through their effect on IPV. As discussed earlier both of these variables are associated with various types of IPV. From a mental health perspective, controlling behaviours such as jealousy, constant surveillance, and limitation of movement can directly affect mental health (Carlson et al., 2002).

Frequent drunkenness and alcoholism was another factor that increased the odds of CMD significantly. A husband's excessive alcohol consumption can affect the wife's mental health directly or via its association with sexual violence. A woman whose husband is frequently drunk may need to seek employment herself to be able to feed her family and provide for the household as the man uses up any income on alcohol. Some women in this study mentioned that their husband does not give them any money as he uses it all on alcohol. To obtain and keep a job, a woman needs to increase her freedom to travel as well as decision making freedom

i.e. her autonomy increases and this can contribute to worsening mental health as discussed in earlier sections. This mediation pathway is supported by the result that a woman's autonomy increases with an increase in the frequency of the husband's occasions of drunkenness. Thus having a husband that is frequently drunk directly impacts on her risk of developing CMD.

These relationships were further investigated by grouping women into those that experience IPV and those that didn't. For women that did not experience any IPV, the risk of CMD was decreased by the woman's increasing age and increased by the husband's increasing age, his controlling behaviour and his frequent drunkenness. Whereas in women with IPV, CMD risk decreased with the woman's age and the husband's increasing education, and increased with the husband's age and controlling behaviour and with worsening of a woman's self-reported health. These results suggest that in woman with no IPV, frequency of drunkenness impacts on CMD via the pathway described above, whereas in women with IPV, frequency of drunkenness effects on CMD are mediated via its association with sexual abuse i.e. frequency of drunkenness increases risk of sexual IPV, but it is the sexual IPV that increases the risk of CMD.

Controlling behaviours can also affect CMD via two pathways, directly by affecting mental health through putting the woman down, acting jealous, limiting her movements etc., and indirectly via its association with IPV. In women with no IPV, controlling behaviours seem to act through the direct pathway, while in women with IPV they seem to act via both pathways. This deduction is supported by the increase in the magnitude of the odds of CMD due to controlling behaviours in women with IPV compared to women with no IPV (3.1 vs. 2.3 respectively).

7.2.3 Social support, IPV and CMD

The social support scale developed in this study was based on a validated instrument which had been previously used successfully with Indian migrant students in the USA. One of the issues observed in the social support section was that most of the respondents listed only 1 person under each item (e.g. how many

people do you have to turn to in case of financial difficulties), and often the same person was listed under all the items, in effect giving a social support network size of 1 or maximum 2 making valid analysis impossible. Thus it was not possible to use this measure as proposed.

One possibility is that the women in this study had very limited social support, and the social support network as established via this survey represents the reality that these women are very isolated and have very few if any people to turn to in times of need. This conclusion is supported by the large proportion of women that reported dissatisfaction (69.1%) or neither satisfaction nor dissatisfaction (16.8%) with the emotional and social support they receive, and the fact that between 10-45% of women (depending on the item) did not have anyone to turn to in times of hardship. It is possible that the limited social support could be in part due to their residence in an urban slum area where the usual extended family support networks were absent.

An interesting question raised by some of the respondents of this study is whether social support in India would be as effective in lessening CMD or IPV as in western countries? Some of the women commented that their natal family were not very supportive when told of their daughter's IPV, asking them to go back to their husband, to compromise and to put up with it for the sake of the family's honour. This kind of social support could better be termed as social control, and may have a negative effect on CMD.

Some studies from the US found that in women that had been sexually assaulted, negative social reactions were strongly associated with increased psychological symptoms, whereas most positive social reactions were unrelated to adjustment (Sullivan et al., 2010, Green and Kane, 2009). Therefore it would be interesting to investigate further the size of the social support network for Indian women, their experiences with negative and positive social interactions and their effects on CMD.

7.2.4 Spirituality, IPV and CMD

Spirituality was the main coping mechanism used by women in this study to deal with stressful or anxious situations and it is puzzling why no association was found between spirituality and CMD, as suggested by other studies (Kandasamy et al., 2011, Dutton and Greene, 2010, Koenig, 2009, Baetz and J, 2009, Yick, 2008, Thirthalli and Chand, 2009). The only significant relationship was found between physical IPV and spirituality with women experiencing physical IPV more likely to use spirituality as a coping mechanism compared to other strategies. One possibility exists in the way spirituality is practiced by this group of women in India compared to how it is practiced in western countries.

Spirituality in Hindu and Buddhist religions is practiced individually, for example as the women in this study have mentioned, by reading the Gita (holy book) or praying. Even when spirituality is practiced at a place of worship, it occurs individually, with worshipers sitting and meditating or praying alone in a temple. There are no communal or group activities unless it is a special occasion or holy day. By contrast the practice of spirituality in western countries i.e. in Judeo-Christianity occurs in a different manner.

While people can and do pray alone at home or at a church, in Judeo-Christian societies there are regular communal worship activities e.g. mass, which are followed by social interaction with other members of the religious community. It is possible that the association of spirituality with improved mental health that has been observed in western studies is mediated in part through the social support and interaction that religious people have when they practice their spirituality. This conclusion is supported by Giesbrecht and Sevcik (2000) findings that for victims of IPV, the church community functioned as an extended family system.

The women in that study found that their church community could provide “social support, spiritual encouragement and practical assistance” (Gracey and King, 2009). Another study found a positive relationship between religious involvement and level of social support among African American victims of IPV, which then helped to

protect against depression and other psychiatric disorders (Watlington and Murphy, 2006). This explanation would account for the lack of association with spirituality in this study, even though a large proportion of the participants used religion to cope.

The idea that it may be the social support aspect or something else that has a protective effect on CMD in religious people has been pointed out by other researchers and reflects the dilemma in trying to differentiate the subdivisions of religion and spirituality (Yick, 2008).

As reviewed in Chapter 2, studies have also found that the type of religious coping can have an effect on mental health outcomes. “Positive religious coping” strategies, such as benevolent religious appraisals of negative situations and spiritual support are associated with greater well-being while “negative religious coping” strategies or religious struggles are linked to more distress (Babar et al., 2004, Tsey et al., 2007). In this study the type of religious coping the women used was not determined, thus it is possible that the type of coping the women in this group use confounds any significant association between spirituality and better mental health outcomes.

Tarakeshwar (2003) found that when faced with great tragedy some women struggled emotionally to understand their situation, and visits to the temple or reading the Gita did not provide the answers they were looking for and participants ended up questioning whether God or religion could provide solutions. In such situations spirituality would not assist with mental health and in statistical analysis it would not have significant associations.

7.3 Significance and contributions of the study

The study makes important contributions to understanding the risk and protective factors of IPV and CMD in multiple ways and for several groups:

- It contributes to the research field through the examining, analysis and establishment of correlation between different types of IPV and CMD. Using the ecological framework to underpin the research, this study adds to the IPV

literature by expounding on individual, family and community-level risk factors, as proposed by Heise (Heise, 1998).

- The findings of the study have applicability and significance in India, as well as other communities in the developing world. The WHO, World Bank and other international health bodies have long decried the lack of research on mental health from developing countries (WHO, 2011) especially research investigating the effects of violence on the mental health of women from India. Therefore, studies like this one can add to the facilitation of policy development and legislation that address IPV and its impact on the Indian community as well as have great implications for practice, policy and research in general. In particular the results of this study indicate that there is a need to investigate the effects of IPV separately (physical, psychological and sexual) as well as one combined variable.
- The women in the community of Pratikshanagar were able to disclose and discuss their experiences of IPV with the research team and were able to obtain information on the available support services in their locality. For some it may have been the first time they revealed the abuse in an empathic environment and despite the difficulties associated with such disclosure, the women would have felt empowered to some extent (Lo Fo Wong et al., 2008).
- This study is also important to KJ Somaiya Hospital and other service providers that work in the slums of Mumbai as they can use the results to develop, plan and implement services and programs to address the identified issues. This study provides an evidence based picture of the current conditions of the women of Pratikshanagar, particularly with respect to their experiences of IPV and mental health, compared to what previously was merely anecdotal information.
- The collaboration between Curtin University and KJ Somaiya Hospital, initiated through this PhD project, benefits both the Australian and Indian academic communities. Other students from Curtin University have carried out projects with the collaboration of KJ Somaiya Hospital since this study was completed.

- This study was also significant for the researcher as it contributed to her understanding of the complexities associated with IPV in the Indian cultural context. It has also added significantly to the author's research skills, her capacity to conduct research in a non-Australian context, the challenges in carrying out research in another language, and how to overcome these challenges. In addition, it has also increased the researcher's capacity and understanding of how, as a female, to conduct research in a highly patriarchal society by negotiating the perceptions of women in research.

7.4 Limitations of the study

One of the limitations of this study (and cross sectional studies in general) is the fact that it was carried out at one time point and as such it can give no indication of the sequence of events — whether CMD occurred before, after or during the onset of IPV. Longitudinal study designs are warranted to firmly establish such causal links.

A second limitation of this study (and others that investigate IPV) is the sensitive nature of the subject investigated. As Ellsberg and Heise (2005) noted: "To be identified as a victim of abuse in most societies is so shameful that few women report abuse when it has not actually occurred, women are far more likely to deny or minimize experiences of violence" (p 86). Consequently, prevalence studies, including this study, then measure the number of women willing to reveal the abuse, which is not necessarily the same as the true number of women who are abused (Ellsberg and Heise, 2005). This limitation was evidenced by the contradictory responses of some women and the obvious under-reporting of IPV as discussed earlier in this chapter.

Research based on data from Nicaragua, Kenya, and Colombia that use the same instruments as this study suggest that the extent of IPV using the DHS survey is underestimated compared with other surveys such as the WHO's multi-country survey on gender-based violence and other specialised violence surveys (Dalal and Lindqvist, 2010). Thus, it is possible that the prevalence reported in the study participants may represent an underestimation.

Another potential cause for lower prevalence rates of IPV was the fact that this study included married women of all ages, whereas other studies tend to survey women of reproductive age, usually up to 49 years. It is well documented that IPV decreases with increasing age of a woman. However, including older women provides a more accurate prevalence rate among all women and a truer description of reality.

The use of a cross sectional survey to collect the information from a population residing in a small geographical area and that have many common characteristics limits the generalizability of the findings to other population subgroups, such as rural people or urban non-slum populations. The findings of this study can only be generalized to other similar Indian urban slum populations. Another limitation related to the cross sectional design of the study is that the survey identified only the current cases of CMD. Women who had CMD but had recovered were not identified.

7.5 Strengths of the study

Despite these limitations, the study had several methodological strengths:

1. The use of standardised pre-tested instruments - for example the study used instruments that have been developed and modified for use with this specific population e.g. Hindi GHQ 12. The instruments have also been validated in the target cultural group i.e. women from India e.g. DHS Demographics and Domestic Violence survey. Thus it can be assumed that the questions in these surveys convey the meaning of the enquiry exactly as intended and provide the correct manner in obtaining this information from the respondents to generate the most accurate responses possible (Hyman et al., 2006). The benefits of using pre-tested and standardised survey instruments is that the degree of validity of the instruments is likely to be high, resulting in data of higher quality (Hyman et al., 2006).
2. Methodology and instruments that adhere to ethical standards for research in IPV as approved by the Curtin Human Research Ethics Committee thus ensuring

that this research was of sufficient quality to potentially contribute to knowledge base on IPV as well as potentially directly benefit the participants themselves through the provision of information on local support services.

3. Inclusion of all age groups to ensure that the experiences of women of all ages are documented. Most other research studies focus only on women of reproductive age (e.g. (Sudha and Morrison, 2011, Sambisa et al., 2011, Shay-Zapien and Bullock, 2010, Kapadia et al., 2010), but the inclusion of women of all ages provides the opportunity to study IPV across the life span to provide a more complete picture of women's experiences of violence throughout their lifetime.
4. Following best practice guidelines (Ellsberg and Heise, 2002), the study trained existing CHWs familiar with the community and women to carry out the surveys resulting in the up skilling of existing field workers. This project used CHWs already employed on HIV related research and service provision which ensured they had at least basic writing skills, and some experience with data collection processes, characteristics considered vital to ensure quality data collection (Green and Baxen, 2002). By participating in this study, the skills and knowledge of the CHWs increased through training, capacity building and education, to providing them with insights into IPV as well as a broad understanding and experience of the research processes.
5. Existence of rapport between the community health workers with the study community and participants was considered necessary in this study due to the sensitive topic investigated. Using workers that are familiar with the study area ensured that they shared and understood the social and cultural practices of the respondents, were fluent in the languages and dialects spoken, and had a pre-existing working relationship with the study population through their work with HIV. This rapport is likely to perhaps have resulted in less under-reporting of IPV.

7.6 Implications for further research

The major implication of this study for further research is that sexual abuse by an intimate partner has significantly detrimental effects on victims' mental health, more so than physical and psychological IPV and as such it needs to be investigated simultaneously with physical and psychological violence. In this study, half the women that reported psychological IPV or physical IPV also reported sexual IPV, but investigating and attributing detrimental outcomes only to the physiological and physical IPV can be misleading.

Thus it is strongly suggested that in research studies that investigate IPV, the violence should be measured using its separate components of psychological, physical and sexual IPV. The husband's controlling behaviours increased the risk of IPV and the risks of CMD, and inferences were made on the possible pathways of action. Thus it is necessary to explore these relationships further to conclusively establish the causation pathways of controlling behaviours in women with IPV and without IPV.

An additional implication relates to excessive alcohol use by husbands and its correlation with all types of IPV and CMD. Two thirds of incidences of IPV in this study occurred when the husband was under the influence of alcohol. Husbands' frequent and excessive alcohol consumption was a risk factor that increased the odds of IPV and CMD significantly. This clearly highlights the need for studies that investigate in more depth the role of alcohol on IPV in India. It also highlights the need for interventions that address excessive alcohol use as one pathway of reducing IPV.

Despite the lack of association between spirituality and CMD in this study, there is enough evidence from other studies (as discussed earlier) to justify investigating this matter in a more robust and focused manner. Furthermore, social support should be investigated concurrently with spirituality as prior evidence is that they are closely associated. This study investigated IPV and CMD within the lowest

socio-economic strata, and most other studies investigate the issues between the various socio-economic strata. It would be interesting to establish whether similar relationships are found within other socio-economic strata.

7.7 Recommendations from the study

One of the main findings of this study is the high prevalence of IPV and CMD in the population studied, and thus these two issues should be addressed as a priority. The following recommendations all aim to decrease both IPV and CMD rates by addressing some of the variables identified in this study as contributing to the problem. It is vital to realize that IPV is a very complex issue that has multiple causes thus a multipronged approach is recommended. These recommendations are aimed primarily at KJ Somaiya Hospital and Trust as this was the site of the project however they are equally applicable to any other hospital, medical center or non-government organisation that frequently encounters victims of IPV.

Recommendation 1

Develop a community mental health outreach program targeting all women in the community serviced by KJ Somaiya Hospital and Medical Centre.

This study has shown that CMD such as depression is prevalent in the study community, but it does not seem to be detected or treated. Indeed, an important question is whether depression is even recognized or acknowledged in this population as a medical condition that can be treated. None of the respondents to this survey mentioned they have a mental illness or that they are being treated for a mental illness, but many had psychosomatic complaints and unexplained medical conditions which are a frequent presentation of depression and anxiety (Patel et al., 2007). Thus it is recommended that a mental health community outreach program be developed and implemented to identify and treat CMD.

Patel and colleagues (Patel et al., 2007) have reviewed hundreds of international studies on effective interventions for depression and found that interventions such as group interpersonal psychotherapy and individual counselling sessions at home by minimally trained counsellors resulted in statistically significant improvements.

Furthermore these interventions are low cost and can be implemented in the community or in the home and thus are a viable option in low income countries like India (Patel et al., 2007).

The **community outreach model** is recommended in this case for several important reasons.

- Firstly, the WHO recommends that community based mental health services should be the most frequent type of mental health service in an ideal mental health system (WHO, 2011).
- Secondly it is obvious that CMD is not recognized as an illness in this community and thus women do not seek assistance for it. Through outreach, the community can be educated on CMD, its causes and treatments bringing the issue out into the open and thereby reducing stigma associated with it which may be one of the reasons women are not currently seeking help disclosing the issue.
- Thirdly, many of the women targeted by the community outreach will be of lower socio-economic status, often unable to help themselves and often underserved by health services in general.
- Fourthly, implementing an outreach service ensures that women that have difficulties in leaving their homes or accessing health care due to lack of money or other reasons will still be able to receive care.
- Lastly, community outreach for a health purpose can be an acceptable and safe vehicle to identify and provide support for women experiencing IPV, a service that is currently absent from this community.

Recommendation 2

Develop policies and protocols on how medical and allied health staff respond to IPV and educate them about the impact of IPV on mental and physical health and how they should screen and provide support and referral.

Medical and allied health staff can play an important role in identifying women who are experiencing IPV and halting the cycle of violence through screening, offering support, and working to ensure that there are prevention and referral options

available in the community (American College of Obstetricians and Gynecologists, 2012). In Western countries, health care providers are often the first professionals to offer care to women who are abused and thus this is a role that medical and allied health staff at KJ Somaiya could acquire and develop. This is especially salient as the current medical and nursing curriculum in India does not train or teach students to deal with IPV and as such most doctors and nurses do not treat IPV as the complex, chronic health threat it is (Yee, 2013).

Health staff need adequate training and education to provide them with the necessary knowledge, skills and confidence they need to work with patients, colleagues, and health care systems to combat IPV (Ambuel et al., 2011). Staff education should also ensure that women experiencing IPV are not judged, lectured, their experiences minimised or dismissed. This education should be accompanied by the development and distribution of a written protocol document with all the information needed to perform an IPV assessment.

The American Academy on Violence and Abuse (Ambuel et al., 2011) has developed a document on the competencies needed by health professionals and health institutions. They recommend that institutional core competencies around IPV should include:

- An interdisciplinary approach to IPV and a no wrong door policy
- A focus on prevention including healthy relationships
- Partnering up with the community in education, intervention and prevention
- Engaging in multi-disciplinary collaboration and outreach in response to IPV.

Finally, this recommendation is in line with the reforms suggested by former chief justice of India, JS Varma, that the Indian government develop medical guidelines to respond to IPV based on Centre for Enquiry Into Health and Allied Themes (CEHAT) manuals and policy recommendations (Yee, 2013).

Recommendation 3

Screen women attending the outpatient clinic at the KJ Somaiya Hospital and Medical Centre for IPV and CMD and implement a referral procedure to appropriate local services.

Primary health care practices and general practitioners as well as emergency departments in many western countries screen women for IPV and routine screening is recommended by national medical bodies. This is based on numerous studies that document the high prevalence of IPV e.g. (Sudha and Morrison, 2011, Sambisa et al., 2011, Rees et al., 2011, Dalal and Lindqvist, 2010); the multiple medical consequences of physical, sexual and emotional violence e.g. (Graham-Bermann et al., 2011, Devries et al., 2011, Abramsky et al., 2011, Nayak et al., 2010, Haqqi and Faizi, 2010, Brewer et al., 2010) and the resulting increases in abused women's use of health care services e.g. (Kruse et al., 2011, Campbell and Campbell, 2007, Stephenson et al., 2006, Heise et al., 1994).

Studies have found that abused women want to be asked about their experiences of IPV, while non-abused women do not mind being asked and all women agreed that health care providers should ask all female patients about IPV, although only at gynecologic or obstetric appointments or when women present with physical injuries (McNutt et al., 1999). Thus it would be considered best practice to screen all women seeking health care, ideally at all primary health care centers where women seek care including KJ Somaiya Hospital for IPV, especially as this study found that women that were abused tended to report worse health (Chapter 5).

It is also important not to screen women for IPV unless there are processes in place to provide some kind of support or referral to other services upon disclosure. It is harmful for a health professional to ask or be told by a woman about IPV and do nothing or act unconcerned, or even worse to have a health professional justify the violence or blame the victim for it (McNutt et al., 1999). Best practice recommends that upon disclosure, health professionals should validate IPV as a serious problem and provide information about referrals to community services that can assist them. Specifically, abused women found blaming or judgmental attitudes by health staff,

lecturing (e.g. telling the woman it is her duty to stay) and giving empty assurances (e.g. telling the woman that everything will be OK and send her home) as undesirable (McNutt et al., 1999, Nelson, 2004).

Recommendation 4

Initiate and take the lead in a coordinated community response to IPV to change community norms and attitudes to violence in collaboration with women's support groups and women's legal service groups.

To achieve increased IPV victim protection and offender accountability coordination of the responses of those in the community who come into contact with IPV issues needs to occur, as long as the primary goal of the process is increased victim safety. A lack of focus on victim safety can, in fact, be harmful to victims. The well-known Duluth model, is an example of coordinated community response. The underlying theory of the Duluth model is that perpetrators of IPV use violence to control their partners, and that changing the need to control others is the most efficient way to eliminate battering behavior. Implementation of the model in Duluth, Minnesota consisted of coordinating the actions of a variety of agencies dealing with domestic conflict resulting in better outcomes of victims of IPV. It is recommended that any community response to IPV developed by KJ Somaiya should be based on local consultation and take into consideration the specific context and needs of the community.

Components of an **effective community response** programs include:

- The creation of a network of support for IPV victims and their families that is both available and accessible;
- Using the full extent of the community's legal system to protect victims, hold batterers accountable, and enforce the community's intolerance of domestic violence; and
- Engaging the entire community in efforts to change the social norms and attitudes that contribute to domestic violence (American Medical Association, 1996).

The rationale for a coordinated response is fourfold. **First**, the complexity of IPV means that often several organisations are involved in a response, thus the effectiveness of many responses depends on the effectiveness of others (Shepard and Pence, 1999). For example, legislation that protects women against violence is not effective unless the police actually enforce it.

Second, different service providers have contact with victims of IPV in different settings and thus each has different or unique pathways to enable women to access support (Shepard and Pence, 1999). A coordinated response means that regardless of the entry point into the system, a woman is able to access the services she needs i.e. no wrong door policy. For example, many women may not be willing or able to contact a women's shelter but they may still seek medical care; thus the health care setting is an important avenue through which victims of IPV can be identified and linked in to support services.

Third, inviting different members or groups within a community to participate in a coordinated community response to IPV can increase the effectiveness of the response, particularly in collectivist societies such as in India. While there are core groups that need to be involved in the response, for example the police, women's shelters and advocacy groups there are other community institutions such as religious institutions or the media which may have a more powerful impact on modifying social norms than the state systems (legal system, police) (Shepard and Pence, 1999).

In particular religious and other community leaders have been found to play a very important role in the community acceptability of IPV. For example, a study in Moldova found that religious leaders were giving advice to members that condoned IPV and thus undermined women's ability to seek assistance (Minnesota Advocates for Human Rights, 2000). Such leaders can play an important role in a coordinated response particularly after being provided with information and education on IPV. They can contribute to ending IPV by speaking out on the subject and encouraging women to seek assistance, while at the same time sending the message that IPV will

not be tolerated by the community. In another study in India, Rao (Rao, 1997) found that intervention by a local religious leader in a violent relationship had the effect of ending IPV, thus highlighting the power such people can exert on community members and the necessity of involving them in any efforts to address IPV.

Fourthly, a comprehensive community response can also address social problems associated with IPV that contribute to or prevent women from accessing services such as poverty, stigma and discrimination (Shepard and Pence, 1999).

Center for the Enquiry into Health and Allied Themes (CEHAT), a NGO in Mumbai would be the organisation to engage in the pursuit of a coordinated response to IPV. CEHAT in conjunction with the Brihanmumbai Municipal Corporation (BMC), which oversees public hospitals have set up India's only crisis center for violence against women, Dilaasa, based at Kurla Bhabha Hospital in Mumbai's Bandra West neighbourhood (Yee, 2013). Furthermore, CEHAT has trained hundreds of staff at Mumbai's 16 free government hospitals to recognize signs of IPV which have resulted in these hospitals offering better services for victims as well as referrals to Dilaasa (Yee, 2013). These efforts by CEHAT have also resulted in a small number of hospitals updating and adopting new examination protocols for victims of IPV, including the use of rape kits, specific questionnaires and referral procedures.

Recommendation 5

Establish a program to address alcohol misuse by males in the community serviced by KJ Somaiya Hospital and Medical Centre.

There are many alcohol detoxification programs and models but discussion on their effectiveness and appropriateness is beyond the scope of this document. It is sufficient to say that there is ample evidence that supports the effectiveness of alcohol interventions in decreasing alcohol misuse and dependence in a variety of contexts (Pal et al., 2007, Kaner et al., 2007, Raistrick et al., 2006). One of the findings of this study was that a large proportion of the violence occurred when the husband was drunk, and frequent drunkenness and addiction to alcohol were mentioned numerous times as the reason for IPV. Thus it is reasonable to assume

that decreasing the number of husbands that abuse alcohol would result in less IPV, so it is recommended that some kind of alcohol detoxification and intervention program be implemented in the study community.

It is important however to investigate the issue in depth to ensure that any program implemented will have a high chance of success, particularly as a recent review found that issues of availability, affordability, manpower and governmental policies in developing countries such as India can impact on success and effectiveness rates (Thirthalli and Chand, 2009).

Recommendation 6

Develop a men's support group where issues such as anger management, IPV, and role modeling can be discussed.

Due to the entrenched traditional attitudes and beliefs existing in the study population it is recommended that any programs directed at men should be generic in nature rather than perpetrator specific programs as defined in the IPV literature. Moreover, most perpetrator programs that have been evaluated to date found them only marginally or moderately successful at preventing further abuse (Gondolf, 2004).

Thus it is recommended that any intervention programs for men should include the goals of promoting gender equity and encourage men to respect their partners' rights to self-determination (Rothman et al., 2003). For example, the Australian Family Violence Project runs community led groups for Aboriginal men focused on their roles and health related issues and use the opportunity to also discuss family violence (Aboriginal & Torres Strait Islander Social Justice Commissioner, 2007).

Other topics include personal values, recognising and responding to anger, resolving conflict and the key message of the program is that family violence in any form is unacceptable. Another participatory, group intervention to promote gender equity was conducted with young men in Mumbai (Verma et al., 2006). Compared to the baseline, intervention participants decreased their support for inequitable gender

norms and reported less sexual harassment, and there were trends toward less risky behaviors. Therefore it is recommended that men's programs be implemented that aim to promote gender equity and respect for women's rights in a positive and interactive environment.

These recommendations are collated and detailed in a framework presented in Figure 7.1. The structure incorporates elements of best practice related to effective interventions for IPV, as well as findings of this study. While this figure was specifically developed for KJ Somaiya Hospital and Trust, other organisations such as NGOs or grass roots organisations are able to use this framework by modifying components to suit their particular situation. For example an NGO that does not provide any clinical services may use on the community outreach components and develop a collaborative relationship with a local health service that may be able to take on the clinical aspects of the framework.

The most important component of this framework is the recommendation to routinely screen women for IPV and CMD. The American Medical Association states that "domestic violence and its medical and psychiatric sequelae are sufficiently prevalent to justify routine screening of all women patients in emergency, surgical, primary care, pediatric, prenatal, and mental health settings" (American Medical Association, 1992). Other advocacy groups and professional health bodies in developed countries such as USA, Australia and United Kingdom hold similar views and many health services now routinely screen women for IPV. The main argument in favor of screening for IPV is that improves identification and responsiveness to IPV.

On the other hand, the US Preventive Services Task Force (USPSTF) found insufficient evidence to recommend for or against routine screening of women for IPV (US Preventive Services Task Force, 2004) a response reflective of the limited empirical evidence about effective interventions that decrease IPV. Whilst the ultimate aim of any intervention around this issue is to eradicate IPV, in this

instance a more urgent aim is to provide some support and services to women in need, and thus routine screening is an appropriate first step.

The aim of the routine screening for IPV and CMD as proposed in this study is multi-fold. The obvious aims are to identify and provide services and support to women experiencing IPV or its sequelae. Additionally by screening routinely all women, the process will bring IPV out from behind closed doors and into the public arena. It will create awareness about IPV being a systemic problem that needs to be addressed as opposed to something women have to endure. It may also put perpetrators on notice that their behaviour is unacceptable and may have negative consequences such as the involvement of the police. The routine screening may also assist community outreach and mobilization efforts as it demonstrates the seriousness of the matter through the involvement of service providers and professionals at all levels of the community.

Based on the results of this study, it is recommended that women be screened not only for IPV but also for CMD. It is important to carry out both at the same time as screening for only one or the other may result in women receiving the wrong or incomplete care or support. For example screening only for IPV may result in a woman being referred to the police or an IPV support group, however she may also suffer from a CMD which may prevent her from fully benefiting from the services offered. By contrast, screening only for CMD may result in a woman being offered treatment for her mental condition but the potential underlying cause of the CMD, the violence is not being addressed thus the treatment may not be sufficient. Screening for both IPV and CMD simultaneously allows the identification of women that have neither problem, experience only violence, or have only a CMD but also identifies women that suffer from both IPV and CMD and allows for appropriate referrals and service provision to occur. In this framework it is recommended that screening be carried out not only in a clinical setting but also by community health workers (CHWs) as part of their routine service delivery.

Before routine screening can be commenced, it is necessary that appropriate policies and procedures are developed and implemented within the KJ Somaiya Hospital (and similar primary health care centers) to inform, support and enable staff to routinely screen women for IPV and CMD. These have been illustrated under the clinical systems of the framework in Figure 7.1. Part of the enabling process, as well as being best practice, is the development of internal and external referral pathways to services for women that experience IPV only, have a CMD or experience both IPV and have a CMD.

Although the framework is separated into the community related systems and the clinical systems, both of these should be developed with extensive and ongoing consultations and input from the affected community. Community consultation and input is vital for promoting ownership and acceptance of the process and its outcomes and can occur at various levels and through various avenues as highlighted by the red, double arrows. For example community reference groups could be set up (male only, female only and/or mixed sex as appropriate) which discuss and highlight needs in relation to IPV and IPV related CMD in the community. The community reference groups could be made up of members representing various other health related interest groups in the community, for example a women's group on action against IPV or a mental health support group.

These reference groups feed directly into the committees that manage the outreach and mobilization systems. Ideally this would occur through mutual representation by both groups on each other's committees. For example the chair of the community reference group would be a member on the community outreach and mobilization committee, while the community outreach and mobilization committee would send a member to attend the community reference group meetings. This also ensures that knowledge and information is filtered back from KJ Somaiya Hospital and Trust to the community members.

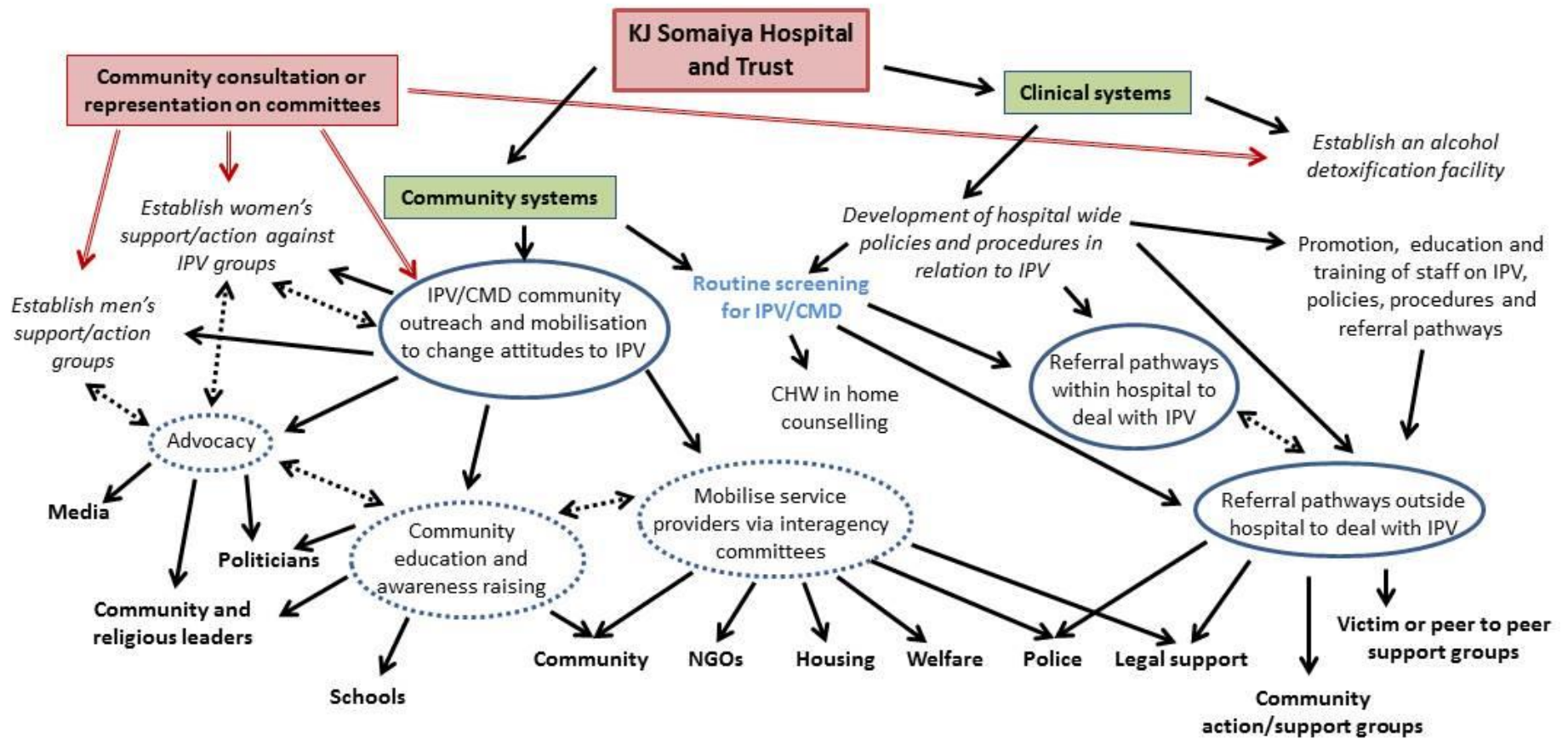


Figure 7.1 Suggested framework to identify and address IPV and IPV related CMD by KJ Somaiya Hospital and Trust

The community systems in the proposed framework will have three main roles: advocacy, community education and awareness raising and mobilisation of service providers to address IPV in the community. There is a reciprocal relationship between these activities as indicated by the dashed, double headed arrows, and many of the strategies that will be used will target the same groups. For example, advocacy and community education and awareness raising will target community and religious leaders as well as local politicians, while the community at large will be targeted through community education and awareness raising and mobilisation activities.

The objectives of the three different parts of the community systems are different. Advocacy aims to make the issue of IPV and IPV related CMD of primary importance in the media, for politicians and for community and religious leaders to create a desire and urgency to address the issue. Community education and awareness aims to inform the community on the effects of IPV, on the various support services available and attempt to change attitudes towards wife beating. Each part of the community outreach pathway is important but mobilising other service providers to develop and improve services to victims of IPV is one of the lynchpins of the framework. For a truly holistic approach to addressing IPV, other service providers such as the police, housing services, legal services need to have a similar commitment to the effort as KJ Somaiya. This commitment should translate into actions such as internal policies and procedures on how to deal with IPV victims and perpetrators, implementation of these policies into everyday work, and education of staff on how to appropriately deal with victims of IPV. Furthermore, referral pathways should be developed between service providers to enable a streamlined service delivery whereby a client does not have to repeat her story many times and is supported through the process.

This concept of 'no wrong door' approach has been used to integrate services for people with co-occurring disorders such as mental health, substance abuse and IPV, and has been shown to be effective in increasing client capture, streamlining service provision and improving outcomes (Macy and Goodbourn, 2012, Purdon and

Tettero, 2008). The researcher was also involved in implementing a similar 'no wrong door' policy for victims of IPV in the Western Australian town of Kalgoorlie as an outcome of a needs assessment for decreasing service duplication and clients falling through the gaps. The outcome in this case consisted of:

- Commitment to participation on an ongoing basis on a regular committee to continue to improve services to victims of IPV and to work towards decreasing IPV in the community;
- Memoranda of Understanding (MOUs) signed by all participants (police, women's refuge, counselling service, correctional services, health services, Aboriginal health services);
- Development and implementation of shared referral forms;
- Promotion of the use of shared referral forms among staff members;
- Commitment to participate in joint case conferencing on complex individual cases, and
- Participation in service evaluation activities.

An example of a potential 'no wrong door' referral pathway within the KJ Somaiya Hospital is provided in Figure 7.2. It shows that regardless of how a woman accesses a service delivered by KJ Somaiya, routine screening for IPV and CMD allows for the identification and referral of the client to the appropriate services. The figure also illustrates some of the potential referral pathways between the other service providers within and outside the hospital structure.

This 'no wrong door' referral pathway can be extended to include local service providers through MOUs that detail the shared understanding and commitment to the issue and through the use of shared referral forms. Thus outside service providers would be able to refer clients to KJ Somaiya Hospital ensuring that a wraparound service is provided, and that regardless of where a woman enters the system, she will be offered the appropriate services.

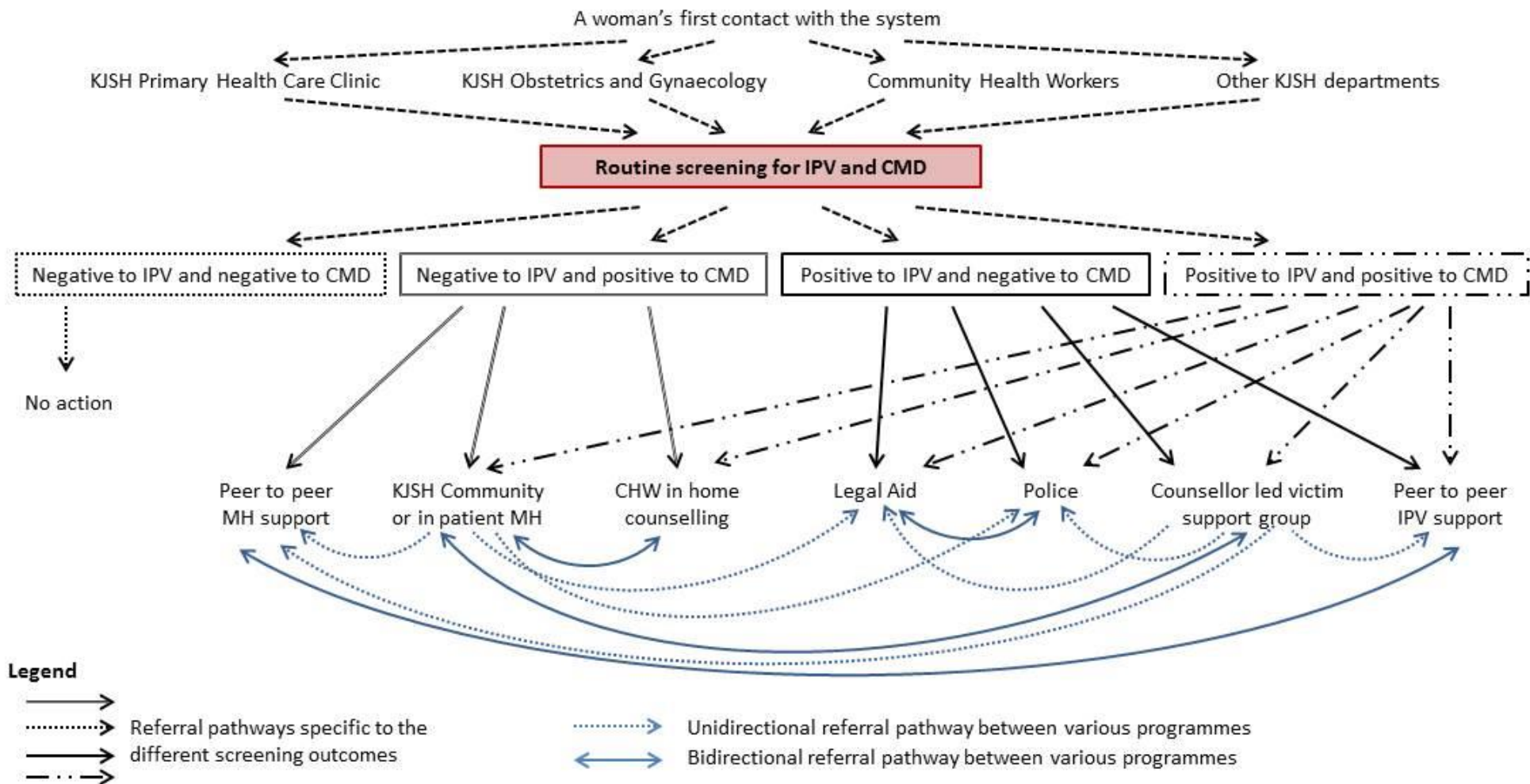


Figure 7.2 Potential 'no wrong door' referral pathways for women that access health services at KJ Somaiya Hospital

7.8 Concluding comments

This study provides a glimpse of the stark reality of the lives of women in the Pratikshanagar slum in Mumbai. Most of the women live in abject poverty, are isolated and restricted by cultural and societal norms. Their husbands' alcoholism results in psychological, physical and/or sexual violence. Not surprisingly, many women displayed common mental health disorders, and although some seek answers in their faith, they often feel helpless. Despite these difficulties the women of Pratikshanagar continue to strive to provide the best upbringing for their children, take care of their homes and they continue to hope that one day in the near future, their lives will improve. They display a unique resilience to cope and survive against great odds and the harsh existence of their daily lives

This study was a steep learning curve, academically, professionally and personally for the researcher. Bearing witness to the plight of some of these women as they voiced fears for their lives and struggled to reconcile to the violence in their lives was confronting for the researcher, and being unable to help in any tangible way was and still is difficult to accept.

Most researchers choose their careers because they want their research to make a difference, they want to highlight and study an issue and improve the lives and health of those in need. Like many PhD students, the researcher started out idealistically wanting to save the world and make a difference; however it is her sincere hope that the personal information shared by these courageous and resilient women and the recommendations proposed can be used to improve the lives of the women of Pratikshanagar and possibly women in India.

The study revealed the intricacies and complexities of the lives of women in an urban slum in Mumbai, India. It also highlighted their agency and struggle against entrenched cultural and institutional practices. There is the pressing need to evaluate the impact of the challenges faced by the women on their self-esteem, resilience, and coping – aspects that build agency. Policymakers, health practitioners and the government need to identify and respond to key factors in

Indian women's experiences of violence. An alternative approach to addressing this endemic and widespread issue affecting women's lives in India would be to value women's own accounts of the violence they experience, their coping mechanisms and suggestions for change. Many of the social factors affecting women's health also affect the entire community, health programming as proposed in the recommendations needs to investigate methods that involve families and communities and include educational, economic and culturally appropriate components.

There comes a time in the cycles of societies where radical breakthrough is likely to occur. The brutal rape and subsequent death of a young Indian woman in New Delhi in December 2012 highlighted that it is no longer acceptable to ignore the reality of violence against women in India. The national outcry and response to the rape revealed the immediate need for a change in policy and practice. Indian policy makers will need to understand that in order to accept changes in practice a process of unlearning customs, traditions, and cultural practices that promote gender violence and inequality will be needed along with education and engagement of men in the process. Hopefully, this study will add to the growing body of research in understanding the complex issue of Intimate Partner Violence and the interventions and community framework elucidated will be translated into policy action.

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Every reasonable effort has been made to acknowledge the owners of copyright material. I would be pleased to hear from any copyright owner who has been omitted or incorrectly acknowledged.

Appendix 1 - Copy of the Human Research Ethics Committee approval

MINUTE

To	Ms Andrea Pillai, 3 Markham Place, Bentley, WA, 6102
From	Max Page, Executive Officer, Human Research Ethics Committee
Subject	Protocol Approval HR 18/2004
Date	8 June 2004
Copy	Associate Professor Paola Ferroni, Centre for International Health Graduate Studies Officer, Division of Health Sciences

Office of Research and Development

Human Research Ethics Committee

TELEPHONE 9266 2784

FACSIMILE 9266 3793

EMAIL s.darley@curtin.edu.au

Thank you for providing additional information for the project "EFFECTS OF INTIMATE PARTNER VIOLENCE ON THE MENTAL HEALTH AND HEALTH CARE SEEKING BEHAVIOUR OF INDIAN WOMEN".

The information you have provided has satisfactorily addressed the points raised by the Committee, and final approval is confirmed.

Please find below a comment from the reviewer for your consideration:

Excellent response to comments - thank you. One observation regarding consent forms is the use of the four-digit code (presumable for anonymity) despite a signature being required at the end of the form. Seems unusual. Possibly name and signature would be OK if consent forms were stored separately from survey and interview data.

Approval of this project remains for the period of twelve months **16/04/2004 to 15/04/2005**. The approval number for your project is **HR 18/2004**. *Please quote this number in any future correspondence.*

SDarley
PP

Maxwell Page
Executive Officer
Human Research Ethics Committee

J:\OR\HREC\REG99\HR 18/2004

Appendix 2 – Trilingual project information sheet

PROJECT INFORMATION SHEET – ENGLISH (2005)

Working title: Effects of marital relationship on the health of Indian women and their experiences of social support

Aims: The aims of this study are to investigate the effects of certain facets of marital relationships, such as reproductive health, autonomy, health care, work, violence and social support on the physical, mental and emotional health and well being of Indian women living in Mumbai.

Procedures: 1000 currently married women living in Mumbai will be interviewed using a specifically prepared questionnaire. The information requested includes disclosure of personal information such as age, income, contraceptive use, health history, violent behaviour and social interaction. All information you provide will be collected anonymously and data will be kept confidential at all times. At the completion of the study all such identifying information will be destroyed.

Participant risks: To minimize risks, participants are interviewed in privacy and are advised not to divulge any questions and details discussed during the interview to anyone not directly involved in the study. They are further advised to describe the research as a study investigating women's health and experiences of social support.

Limitations of benefits: This study will have benefits mainly in the long term as it will provide vital information for health and social workers on the effects of certain aspects of marital life on women's health and on the role of social support. Of direct benefit to participants may be the opportunity to discuss and bring into open, in a non-judgmental environment, issues that affects their health and well-being. They will also be provided with referral to counseling/medical care should they require or request it. All participants will be offered a sheet with contact information for local, government and non-government organizations that work in various aspects of women's health and welfare.

Confidentiality and anonymity: Confidentiality and anonymity will be ensured throughout the study by the use of cross-linked coding and restriction access to data only to researchers involved in the study. Any material published will be written in a way that guarantees anonymity. All data will be stored securely at Curtin University, Australia and will be destroyed after 5 years.

This study has been approved by the Curtin University Human Research Ethics Committee and the Somaiya Medical Research Center Human Ethics Committee. If needed, verification of approval can be obtained either by writing to the Curtin University Human Research Ethics Committee, (c/- Office of Research and Development, Curtin University of Technology, GPO Box U1987, Perth, WA 6845, or by telephoning 61 8 9266 2784) or the Somaiya Medical Research Center Human Ethics Committee (address, phone)

प्रकल्प की जानकारी / बडे पैमानेपर सर्वेक्षण

काम का नाम - भारतीय स्त्री के स्वास्थ्यपर वैवाहिक सम्बन्ध का प्रभाव और उनके सामाजिक आधार का अनुभव.

उद्देश्य - इस अध्ययन का मुख्य उद्देश्य वैवाहिक सम्बन्धों के विशिष्ट पहलुओं के प्रभाव का शोध करना है। जैसे की, पुनरुत्पादन शक्ति, स्वायत्तता, शारिरीक देखभाल, काम, हिंसा और मुंबई में रहनेवाली भारतीय महिलाओं के शारिरीक, मानसिक एवं भावनात्मक स्वास्थ्य और अच्छाई के लिए सामाजिक आधार।

स्वरूप - अध्ययन का प्रथम भाग के लिए मुंबई स्थित व वर्तमान स्थिती में शादी शुदा १४०० महिलाओं से साक्षात्कार या मुलाकात एक मुख्यरूप से तैयार की गई प्रश्नावली द्वारा कि जाएगी। इस प्रश्नावली में नीजी जानकारी को विनंतीपूर्वक शामिल किया गया है। जैसे की - उम्र, आय- कमाई, गर्भनिरोधी साधन का इस्तेमाल, आरोग्य इतिहास, हिंसात्मक व्यवहार और सामाजिक मेल मिलाप। प्रश्नावली पूर्ण रूप से अनामिक है और कोई भी पहचान प्रश्नावली में शामिल नहीं है और सम्बन्धीत जानकारी प्रकाशित नहीं होगी। प्रश्नावली पर ४ अंको का कोड नंबर होगा जो की किसी भी नीजी जानकारी से सम्बन्धीत नहीं है और सिर्फ कार्यालय के उपयोग में लाया जाएगा।

सहभागी व्यक्ती की जोखीम - जोखीम कम करने के लीए सहभागी को गुप्तता और एकान्त में मुलाकात देनी है। सलाह दि जा रही है कि, इस अध्ययन से प्रत्यक्षरूप से सम्बन्धीत न होने वाले किसी भी व्यक्ती से प्रश्नावली में पुछे सवालोंनेर विस्तारपूर्वक चर्चा न करें। इस अभ्यास के आधारपर महिलाओं के स्वास्थ्यसम्बन्धी और उनको मिलनेवाले सामाजिक आधार के अनुभवों का निरीक्षण किया जाएगा।

लाभ की मियाद- यह अभ्यास मुख्य रूप से भविष्य में लाभ देगा, वैवाहिक रिश्तों का महिलाओं के स्वास्थ्यपर प्रभाव और उनको समाजसे मिलनेवाला आधार इन अनुभवों के पहलुओंपर जानकारी मिलेगी। जिस का उपयोग मुख्यरूप से आरोग्य व समाजसेवी व्यक्तीओं को मिलेगा। इसका सीधा लाभ सहभागी महिलाओं को मिलेगा जैसे - उनकी स्वास्थ्य एवं हित पर प्रभाव करने वाली बातें खुलकर बोलने का एक अनिर्णयात्मक मौका मिलेगा। जरूरत महसूस होने पर या महिला के अनुरोध पर उसे स्वास्थ्य एवं समुपदेशन की सहाय्यता का निर्देश दिया जाएगा।

प्रकल्पाचे माहिती पत्रक / मोठ्या प्रमाणावर सर्वेक्षण

कामाचे नांव - वैवाहिक नातेसंबंधांचे भारतीय स्त्रीच्या आरोग्यावर होणारे परिणाम आणि त्यांचे सामाजिक आधाराचे अनुभव.

उद्देश - वैवाहिक नातेसंबंधांच्या विशिष्ट पैलूंवर प्रकाश टाकणे व नातेसंबंधांच्या परिणामांचा शोध घेणे हा या अभ्यासाचा उद्देश आहे. जसे की, पुनरुत्पादन शक्ती, स्वायत्तता, आरोग्याची काळजी, कामकाज, हिंसा आणि मुंबई शहरात चांगल्याप्रकारे रहाता यावे यासाठी समाजाकडून मिळणारा शारिरीक, मानसिक व भावनिक आधार.

स्वरूप - अभ्यासाचा एक भाग म्हणून, मुंबईत रहाणाऱ्या व सध्या विवाहित असलेल्या १४०० महिलांची मुलाखत एका विशिष्ट उद्देशाने तयार केलेल्या प्रश्नावलीच्या आधारे घेण्यात येणार आहे. असे विनंतीपूर्वक कळविण्यात येत आहे की, त्या माहितीमध्ये काही खाजगीबाबींचा समावेश असणार आहे. जसे वय, उत्पन्न, गर्भनिरोधी साधनांचा वापर, आरोग्याबाबतचा इतिहास, हिंसा व उत्पात करण्याची वृत्ती आणि सामाजिक ताळमेळ. ही प्रश्नावली पूर्णपणे अनामिक/निनावी असून आणि कुठल्याही प्रकारची ओळख त्यात येणार नाही. फक्त एक ४ आकडी क्रमांक कार्यालयीन कामासाठी प्रश्नावलीवर देण्यात येईल, ज्याचा कोणत्याही प्रकारच्या खाजगी माहितीशी संबंध नाही.

सहभागी व्यक्तीची जोखिम - जोखिम कमी करण्यासाठी सहभागी व्यक्तीची मुलाखत गुप्ततेत घेण्यात येईल आणि पुढे असा सल्ला देण्यात येत आहे की, यासाठी होणारी चर्चा व विचारलेल्या प्रश्नांबाबत या अभ्यासात संबंधीत नसलेल्या व्यक्तींपासून गुप्त ठेवाव्यात व उघड करू नयेत. तसेच या अभ्यासाच्या आधारे महिलांच्या आरोग्याबाबत आणि त्यांचे सामाजिक आधाराचे अनुभव या बाबींचे निरीक्षण करण्यात येणार आहे.

मिळणाऱ्या लाभांच्या सीमा - ह्या अभ्यासाचे फायदे मुख्यतः भविष्यात दूरवर दिसतील आणि याद्वारे उपलब्ध होणारी, वैवाहिक नातेसंबंधांचे भारतीय स्त्रीच्या आरोग्यावर होणारे परिणाम आणि त्यांचे सामाजिक आधाराचे अनुभव याची माहिती आरोग्य व समाज सेवकांना उपयोगी ठरणार आहे. सहभागी महिलांना मिळणारा सरळ लाभ म्हणजे त्यांना मिळणारी एक संधी ज्याद्वारे त्यांच्या आरोग्य व हितकारक जीवनावर परिणाम करणाऱ्या घडलेल्या अव्यक्त घटनांना अनिर्णयात्मक वातावरणात व्यक्त करता येईल. तसेच समुपदेशन आणि वैद्यकिय मदत आवश्यक वाटल्यास किंवा त्या स्त्रीने विनंती केल्यास निर्देश देण्यात येईल.

Appendix 3 - Trilingual survey

Interviewer name (please print): मुलाकात लेनेवाली महिला का नाम / मुलाखत घेणाऱ्या महिलेचे नांव :

Interview date: मुलाखत की तारीख _____ (DD/MM/YYYY) (दिन /माह /साल)

001	<p>Read out following introduction. Hello. I am from Somaiya Hospital and Research Center and I am conducting a survey on women's health. The interview will take approximately one hour. Your participation in this survey would be greatly appreciated. नमस्कार, मैं सोमैय्या अस्पताल से हूँ और मैं औरतोंके स्वास्थ्यके बारे में जानना चाहती हूँ (सर्वे कर रही हूँ)। इस मुलाकात का समय करीबन एक घंटा है। कृपया आप अपना समय दे तो अच्छा होगा।</p> <p>नमस्कार, मी सोमैय्या हॉस्पिटल कडून आले आहे आणि मी स्त्रियांच्या आरोग्याविषयी माहिती जाणून घेऊ इच्छिते. ही माहिती देण्याकरिता साधारणपणे एक तास लागेल. कृपया आपण थोडा वेळ देऊ शकाल का</p> <p>Respondent agrees हा / हो Respondent refuses नही / नाही</p> <p>If the respondent say NO, Thank her for the attention and move on to the next household on the list. उनको धन्यवाद देकर आपकी सुची में दी गये अगले घर में जाए।</p>	<input type="checkbox"/> 1 <input type="checkbox"/> 2	<p>→ 002 →NEXT household on list सुचीमें दी गया अगला घर यादीतील पुढच्या घरी जा</p>
002	<p>It is necessary for this interview to be conducted in privacy because some of the questions focus on reproductive health matters. Is it possible to obtain this privacy in your household at the current time? अगर आपके पास समय हो, तो क्या आप से हम कुछ सवाल पुछ सकते हैं? अगर नहीं तो क्या हम फिर कभी आ सकते हैं? कुछ ऐसे सवाल है जो औरतोंके समस्या संबंधी है, इसलिये मैं अकेलेमें बात करना चाहूंगी।</p> <p>काही स्त्रीयांच्या आरोग्याविषयीचे गोपनीय प्रश्न आहेत. जर आता तुमच्याजवळ वेळ / गोपनीयता शक्य असेल तर प्रश्न विचारणार किंवा वेळ नसेल तर परत येऊ.</p> <p>Yes हा / हो No नही /नाही</p>	<input type="checkbox"/> 1 <input type="checkbox"/> 2	<p>→ NEXT PAGE अगला पन्ना/ पुढील पान →003</p>
003	<p>Is there a more suitable time when I can return when privacy for the interview can be guaranteed? आपके घर में अगर इस समय गोपनीयता नहीं है तो क्या हम फिर कभी आ सकते हैं? क्या हम अभी बात कर सकते हैं? आप अगर चाहों तो आपके घरमें बैठ सकते है। क्या हम आपसे अकेलेमें बात कर सकते है या नहीं ?</p> <p>जर आता तुमच्याजवळ वेळ किंवा गोपनीयता नसेल तर तुम्ही सांगा आम्ही कधी येऊ ? आपण तुमच्या घरात बसून बोलूया का? तीथे आपण दोघीच बसून बोलू शकतो का ?</p> <p>Respondent provides alternate time for visit जबाबीने दुसरा समय दिया। तीने दुसरा वेळ किंवा दिवस सांगितला.</p> <p>Respondent is not able to provide alternate time जबाबीने दुसरा समय नहीं दिया। तीने दुसरा वेळ वगैरे सांगितला नाही.</p>	<input type="checkbox"/> 1 <input type="checkbox"/> 2	<p>NEW DATE नयी तारीख NEW TIME नया समय। ADDRESS पता।</p> <p>→नयी तारीख तथा समय लिखें।↑ →004</p>
004	<p>Read following: Since privacy can not be assured in your home, I am not able to conduct the interview. क्यो की आपके घरमें संभाषणमें गोपनीयता नहीं है, मैं और सवाल नही पुछुंगी। असो, तुमच्या घरात गुप्ततेची खात्री नसल्याने मी तुमची मुलाखत घेऊ शकत नाही. Thank her for the attention and move on to the next household on the list. उनको धन्यवाद देकर आपकी सुचीमें दी गये अगले घरमें जाए। त्यांचे आभार माना व पुढील घरी जा.</p>		

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Section 6: GHQ12 / साधारण स्वास्थ्यसंबंधी सवाल / सामान्य आरोग्याबाबत प्रश्न

Section 7: Domestic violence / घरेलु झगडें / घरातील भांडणे

SECTION 1. RESPONDENT'S BACKGROUND / जबाबी महिलाकी परीस्थिती / उत्तर देणाऱ्या महिलेची परिस्थिती

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
101	First I would like to ask some questions about you and your household. For most of the time before your marriage, did you live in a city or in the countryside? पहेले, मैं कुछ सवाल आपके और आपके घर के बारे में पुछुंगी। आपके शादी के पहले आपने ज्यादा समय शहरमे बीताया या गांव में थे? प्रथम मी तुम्हाला, तुमच्या व तुमच्या घरासंबंधी काही प्रश्न विचारनी. विवाहापुर्वी तुम्ही जास्त कालावधी शहरात घालवलात किंवा गावात ?	SHEHER शहरमे शहरात <input type="checkbox"/> ₁ GAON गांवमें गावात <input type="checkbox"/> ₂	
102	How long have you been living in your current residence? IF LESS THAN ONE YEAR, RECORD '00' YEARS आप इस घरमे या इस पते पर कब से रह रहें है ? अगर एक सालसे कम है तो लिखें "००" साल. तुम्ही या घरात पत्त्यावर कधीपासून आहात ? जर एक वर्षापेक्षा कमी असेल तर '००' असे लिहा.	YEARS / साल / वर्ष	
103	How old are you? आपकी उमर कितनी है? तुमचे वय किती ?	उमर / वयसाल / वर्ष	
104	What is the highest level of school you have completed? primary (year 1-4), high school (year 5-10), junior college (year 11-12) or degree college? आपने ज्यादा से ज्यादा कितनी कक्षा तक पढाई की है? प्राथमिक (१ - ४ कक्षा तक) माध्यमिक (५ - १० कक्षा तक) ज्यु कॉलेज (११ व १२ कक्षा तक) पदवी (महाविद्यालय) तुमचे जास्तीत जास्त शिक्षण कितवी पर्यंत झाले आहे ? प्राथमिक (१-४) माध्यमिक (५ -१०) ज्यु कॉलेज (११ व १२) पदवी	NONE - DID NOT ATTEND SCHOOL <input type="checkbox"/> ₁ अशिक्षित / निरक्षर PRIMARY SCHOOL/ प्राथमिक/प्राथमिक <input type="checkbox"/> ₂ HIGH SCHOOL/माध्यमिक/माध्यमिक <input type="checkbox"/> ₃ JUNIOR COLLEGE / ज्यु कॉलेज/ ज्यु कॉलेज <input type="checkbox"/> ₄ DEGREE COLLEGE/पदवी/पदवी (महाविद्यालय) <input type="checkbox"/> ₅	
105	What is your religion? आपका धर्म क्या है? तुमचा धर्म कोणता ?	HINDU हिंदु <input type="checkbox"/> ₁ MUSLIM मुसलमान मुस्लीम <input type="checkbox"/> ₂ CHRISTIAN ईसाई ख्रिश्चन <input type="checkbox"/> ₃ SIKH सीख / शीख <input type="checkbox"/> ₄ BUDDHIST बुध्द / बौध्द <input type="checkbox"/> ₅ OTHER - SPECIFY अन्य बतलायें / किंवा इतर कोणता ते लिहा <input type="checkbox"/> ₅	→106 →107
106	What caste/tribe are you? आप किस जात के है? तुमची जात कोणती ?	SCHEDULED TRIBE अनुसुचित जन जाती <input type="checkbox"/> ₁ SCHEDULED CASTE अनुसुचित जाती <input type="checkbox"/> ₂ SHUDHRA शुद्र <input type="checkbox"/> ₃ VAISHYA वैश्य <input type="checkbox"/> ₄ KSHATRIYA क्षत्रिय <input type="checkbox"/> ₅ BRAHMIN ब्राह्मण <input type="checkbox"/> ₆ OTHER / अन्य <input type="checkbox"/> ₇	
107	Now I would like to ask you a few questions about your marriage. What was your age at marriage? अब मैं आपके वैवाहिक जीवनके बारेमें कुछ सवाल पुछना चाहुंगी। शादिके समय आपकी उमर क्या थी? आता मी तुम्हांला तुमच्या विवाहासंबंधी काही प्रश्न विचारणार आहे. विवाहाच्या वेळी तुमचे वय काय होते?	YEARS साल वर्षे	
108	What kind of marriage did you have: arranged or love? आपकी शादी कैसे तय हुई थी? आपका प्रेम विवाह था या तय किया हुआ था? तुमचा विवाह कसा ठरला ? तुमचा प्रेम विवाह कि ठरवुन केलेला ?	ARRANGED तय किया हुआ ठरवुन केलेला <input type="checkbox"/> ₁ LOVE प्रेम प्रेम विवाह <input type="checkbox"/> ₂	
109	Do you usually live with your husband? क्या आप अपने पतिके साथ रहती हो? तुम्ही पती बरोबर रहाता का?	YES हा हो <input type="checkbox"/> ₁ NO नहीं नाही <input type="checkbox"/> ₂	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
110	Who else, other than your husband, lives in your house? आपके पतिके अलावा और कौन आपके घरमें रह रहें हैं? तुमच्या नव-व्याव्यतिरिक्त तुमच्या घरात आणखीन कोण रहाते?	MOTHER/FATHER माता / पिता आई / वडील <input type="checkbox"/> ₁ SISTER/BROTHER बहने / भाइ बहिण / भाऊ <input type="checkbox"/> ₂ CHILD/CHILDREN बच्चे / बच्चियाँ मुलगा / मुलगी <input type="checkbox"/> ₃ M-IN-LAW/F-IN-LAW साँस / ससुर सासू / सासरे <input type="checkbox"/> ₄ OTHER – SPECIFY अन्य बतलाये इतर, सांगा <input type="checkbox"/> ₅	→next section →111
111	Where does your natal family live? आपका मायका कहाँ है? तुमचे माहेर कुठे आहे?	MUMBAI मुंबई <input type="checkbox"/> ₁ OUTSIDE MUMBAI मुंबई के बाहर /मुंबईच्या बाहेर <input type="checkbox"/> ₂	
112	How many times a year do you see your natal family? सालमें कितने बार आप अपने मायकेवालोंसे मिलते है? वर्षातून तुम्ही माहेरच्यांना किती वेळा भेटता?	_____ times in a Year सालमेंबार वर्षातून वेळा	

SECTION 2: REPRODUCTION AND CONTRACEPTIVES / प्रजोत्पादन और गर्भनिरोधी साधन/ पुर्नउत्पादन आणि गर्भनिरोधक साधनांबाबत

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
201	Now I would like to ask about all the births you have had during your life. Have you ever given birth? अब मैं, आपके प्रजननसंबंधी कुछ सवाल पुछना चाहती हूं। क्या आपने जनम दिया है? आता मी तुम्हाला तुमच्या प्रजननाच्या संबंधी काही प्रश्न विचारणार आहे. तुम्ही जन्मदात्री आहात का ?	YES हा हो <input type="checkbox"/> ₁ NO नहीं नाही <input type="checkbox"/> ₂	
202	How many living children do you have? आपके कितने जीवित बच्चे हैं? तुमची किती अपत्ये जिवंत आहेत?CHILDREN बच्चे अपत्ये	
203	How many sons do you have? IF NONE, RECORD '00'. कितने बेटे हैं आपके ? अगर नहीं तो, लिखें "००". तुम्हाला किती मुलगे आहेत? नसल्यास ०० लिहाSONS बेटे	
204	Is your firstborn, living child a son or a daughter? क्या आपका पहला बच्चा बेटा या बेटी हैं? तुमचे पहिले अपत्य मुलगा आहे की मुलगी?	SON बेटा / मुलगा <input type="checkbox"/> ₁ DAUGHTERS बेटी / मुलगी <input type="checkbox"/> ₂	
205	Have you ever had a pregnancy that miscarried, or ended in a stillbirth? Please don't include abortions. क्या आपका नैसर्गिक हुआ था? (या मरा हुआ बच्चा पैदा हुआ था?) (करवाया गर्भपात की दखल ना ले) तुमचा नैसर्गिक गर्भपात झाला होता किंवा अपत्य जन्मतःच मृत होते ? (केल्या गेलेल्या गर्भपातांचा संबंध येथे नाही.)	YES हा हो <input type="checkbox"/> ₁ NO नहीं नाही <input type="checkbox"/> ₂	
206	Are you pregnant now? क्या आप गर्भवती हैं ? तुम्ही गरोदर आहात का ?	YES हा हो <input type="checkbox"/> ₁ NO नहीं नाही <input type="checkbox"/> ₂ DON'T KNOW नहीं मालूम / माहित नाही <input type="checkbox"/> ₃	→210 →210
207	Whose decision was it for you to become pregnant? किसका फैसला था की आप गर्भवती बनें? तुम्ही गरोदर रहावे हा निर्णय कोणाचा होता ?	RESPONDENT औरत का /स्त्रीचा <input type="checkbox"/> ₁ JOINT DEC W HUSBAND दोनोंका /दोघांचा <input type="checkbox"/> ₂ HUSBAND पति का / पतीचा <input type="checkbox"/> ₃ HUSBAND JOINTLY WITH IN LAWS पति का और साँस-ससुर / पती व सासू -सासरे <input type="checkbox"/> ₄	

208	<p>Are you and your husband currently doing something or using any method to delay or avoid getting pregnant?</p> <p>मैं परिवार नियोजन के बारेमें बात करना चाहती हूँ : क्या आप या आपके पती परिवार नियोजन के साधन (गर्भनिरोधक साधन)इस्तमाल कर रहे हो?</p> <p>आता मी कुटुंब नियोजनाबाबत विचारणार आहे. - तुम्ही किंवा तुमचे पती कुटुंबनियोजनाची साधने (गर्भनिरोधक साधन)वापरत आहात का?</p>	<p>YES हा हो <input type="checkbox"/>₁</p> <p>NO नहीं नाही <input type="checkbox"/>₂</p>	<p>→211</p> <p>→214</p>
209	<p>Which method are you using?</p> <p>आप गर्भनिरोध के लिये कौनसा तरीका इस्तमाल कर रहे हो?</p> <p>कोणती गर्भनिरोधक साधने वापरत आहात?</p>	<p>CONDOM कंडोम (निरोध) <input type="checkbox"/>₁</p> <p>PILL गोलीयाँ / गोळ्या <input type="checkbox"/>₂</p> <p>COPPER T/LOOP/IUD कॉपर टी / तांबी लुप <input type="checkbox"/>₃</p> <p>ABSTINENCE/WITHDRAWAL/RHYTHM <input type="checkbox"/>₄</p> <p>परहेज/ निकास/ तालमेल</p> <p>ABORTION गर्भपात <input type="checkbox"/>₅</p> <p>OTHER – SPECIFY <input type="checkbox"/>₆</p> <p>अन्य बतलायें/ इतर साधने सांगा</p>	<p>→212</p>
210	<p>What is your reason for using contraceptive?</p> <p>गर्भनिरोधक साधन के उपयोग का क्या कारण है ?</p> <p>गर्भनिरोधक साधनांचा उपयोग करण्यामागे काय कारण आहे?</p>	<p>बतलायें / सांगा</p>	<p>→213</p>
211	<p>You have told me that you are currently using contraception. Generally speaking, is contraception use your decision, your husband's decision or did you both decide together?</p> <p>PROCEED TO SECTION 3: HEALTH CARE</p> <p>आपने बताया कि नियोजनके साधन इस्तमाल कर रहे हो, यह किसका निर्णय था? आपका, आपके पतिका या दोनोंका?</p> <p>अगले विभाग की ओर चले</p> <p>तुम्ही म्हणालात की परिवार नियोजनाची साधने वापरत आहात हा निर्णय कोणाचा होता? पुढच्या विभागाकडे जाऊ</p>	<p>RESPONDENT औरतका /स्त्रीचा <input type="checkbox"/>₁</p> <p>HUSBAND पति का /पतीचा <input type="checkbox"/>₂</p> <p>JOINT DECISION दोनोंका / दोघांचा <input type="checkbox"/>₃</p>	<p>→ proceed to section 3 विभाग ३</p>
212	<p>You have told me that you are currently NOT using contraception. Generally speaking, is not using contraception your decision, your husband's decision or did you both decide together?</p> <p>आपने बताया कि गर्भनिरोध/नियोजन के साधन नहीं इस्तमाल कर रहे हो, आम तौरपे किसका निर्णय था? आपका, आपके पतिका, दोनोंका?</p> <p>तुम्ही म्हणालात की परिवार नियोजनाची / गर्भनिरोधक साधने वापरत नाही - हा निर्णय कोणाचा होता? तुमचा, तुमच्या पतीचा, की दोघांचा ?</p>	<p>RESPONDENT औरतका / स्त्रीचा <input type="checkbox"/>₁</p> <p>HUSBAND पतिका /तुमच्या पतीचा <input type="checkbox"/>₂</p> <p>JOINT DECISION दोनोंका / दोघांचा <input type="checkbox"/>₃</p>	<p>→215</p>
213	<p>What are the reasons for not using contraceptives?</p> <p>किस कारण परिवार नियोजनके साधन नहीं इस्तमाल कर रहे हो? कोणत्या कारणाने कुटुंब नियोजनाची साधने वापरत नाही?</p> <p>Fertility related eg. infrequent sex/no sex, menopausal/hysterectomy, subfecund/infecund, wants as many children as possible Opposition to use eg. respondent opposed, husband opposed, religious prohibition Method related eg. health concerns, fear of side effects, costs too much, inconvenient to use, interferes with body's normal processes Lack of knowledge, knows no method, knows no source</p> <p>१-प्रजोत्पादन के बार में - शारिरीक संबंधोंका अभाव, जादा बच्चे चाहिए, माहावारी आना बंद इत्यादी</p> <p>२-उपयोग में लाने से विरोध - महिला (स्वयं), पती का या धर्म का विरोध</p> <p>३-उपयोग के पद्धती से संबंधीत - दाम जादा होने के कारण, इस्तमाल करना मुश्किल, दुसरे परीणामोंका डर लगता है, शारीरीक बदलाव होते हैं।</p> <p>४-जानकारी न होने के कारण - उपयोग कैसे करें और उपलब्धी कहाँ संबंधी जानकारी नहीं होने से।</p> <p>१-प्रजोत्पादन बाबत - शारिरीक संबंध न ठेवल्याने अजुनही मुले हवी आहेत म्हणून, किंवा मासिक पाळी येणे बंद झाल्याने</p> <p>२-उपयोग करण्यास बंदी - स्त्री स्वतःचा, पतीचा किंवा धर्माचा विरोध</p> <p>३-उपयोगाच्या पद्धती बाबत - किंमत जास्त, वापरण्यास कठिण, दुष्परीणामांची भीती वाटते, शरीराला अनुरूप नाही</p> <p>४-योग्य माहिती नसल्यामुळे - उपयोग कसा करावा व उपलब्ध कुठे माहिती नसल्याने वापरत नाही.</p>	<p>FERTILITY RELATED – प्रजोत्पादन के बार में /प्रजोत्पादन बाबत <input type="checkbox"/>₁</p> <p>OPPOSITION TO USE – उपयोग में लाने से विरोध / उपयोग करण्यास बंदी <input type="checkbox"/>₂</p> <p>METHOD RELATED - उपयोग के पद्धती से संबंधीत / उपयोगाच्या पद्धती बाबत <input type="checkbox"/>₃</p> <p>LACK OF KNOWLEDGE – जानकारी न होने के कारण / योग्य माहिती नसल्यामुळे <input type="checkbox"/>₄</p>	

SECTION 3: HEALTH CARE AND AUTONOMY / स्वास्थ्य संबंधी और स्वायत्तता / आरोग्य बाबत आणि स्वातंत्र

301	Now I would like to ask you some questions about your health and health care activities. In general, would you say your overall health is good, fair or poor? अभी मैं आप के (स्वयं) स्वास्थ्य और आपके स्वास्थ्यकी देखभाल के बारेमें पुछना चाहती हूँ । आम तौरपे आपकी स्वास्थ्य कैसी है ? आता मी तुमचे आरोग्य व तुम्ही तुमच्या आरोग्याची देखभाल कशी करता हे विचारु इच्छिते - सर्वसाधारणपणे तुमचे आरोग्य कसे आहे?	GOOD बहुत अच्छी /छान <input type="checkbox"/> 1 FAIR ठीक है /ठीक <input type="checkbox"/> 2 POOR खराब है /खराब <input type="checkbox"/> 3	→306 →302 →302
302	Could you please explain why you rated your overall health as fair or poor? आपने बताया कि आपके स्वास्थ्य ठीक है / खराब है - क्यों ? तुम्ही म्हणालात तुमची तब्येत ठीक आहे / खराब आहे - असे का?	SPECIFY विस्तार से बतलायें व्यवस्थित सांगा	
303	Do any of these health problems impair your daily activities? क्या ऐसी स्वास्थ्य समस्या आपके दैनिक कार्यक्रमको बाधा करती है? तुमच्या खराब प्रकृतीमुळे दैनंदिन कामामध्ये अडथळे येतात का?	YES - SPECIFY हां - बतलायें हो - सांगा <input type="checkbox"/> 1 NO नहीं नाही <input type="checkbox"/> 2	
304	Has (have) these health problem(s) been treated? क्या ऐसी स्वास्थ्य समस्या का उपचार किया था ? तुम्ही या समस्येवर उपचार घेतले का?	YES हा हो <input type="checkbox"/> 1 NO नहीं नाही <input type="checkbox"/> 2	→306 →305
305	What are the reasons for not treating this illness/injury? आपने उपचार क्यों नहीं किया ? का उपचार घेतले नाहीत? Opposition to treatment eg. respondent opposed, husband opposed, religious prohibition / Method related eg. costs too much, fear of side effects, inconvenient to treat, no treatment available उपचार में विरोध - महिला का खुद (स्वयं), पती का या धर्म का विरोध उपचार के पद्धती से संबंधित - ज्यादा खर्च होने के कारण, इस्तमाल करना मुश्किल, दुसरे परीणामोंका डर लगता है, शारीरीक बदलाव होते हैं। उपचार करण्यास बंदी - स्त्री स्वतःचा, पतीचा किंवा धर्माचा विरोध उपचाराच्या पद्धती बाबत - किंमत जास्त, वापरण्यास कठिण, दुष्परीणामांची भीती वाटते, शरीराला अनुरूप नाही	OPPOSITION TO TREATMENT - SPECIFY विरोध का कारण बताना / विरोधाचे कारण सांगणे <input type="checkbox"/> 1 METHOD RELATED - बतलायें / सांगा <input type="checkbox"/> 2 OTHER - SPECIFY अन्य बतलायें / इतर कारण सांगणे <input type="checkbox"/> 3	
306	Generally speaking, who in your family has the final say on decisions concerning your own health care? आम तौरपे आपके स्वास्थ्य संबंधी मामलोंपर कौन फैसला करता है ? सर्वसाधारणपणे, तुमच्या घरी तुमच्या आरोग्य संबंधी बाबींवर निर्णय कोण घेते ?	RESPONDENT औरतका / स्त्री <input type="checkbox"/> 1 JOINTLY WITH HUSBAND दोनोंका / दोघे <input type="checkbox"/> 2 HUSBAND पतिका / पती <input type="checkbox"/> 3 HUSBAND JOINTLY WITH IN LAWS पतिका और साँस / ससुर पती व सासू सासरे / पती सासू सासरे यांच्या शिवाय <input type="checkbox"/> 4	
307	When you get sick where do you go to for health treatment/advice? बीमारीके वक्त आप कहाँ जाती है ? आजारी पडल्यावर तुम्ही कोठे जाता?	AYURVEDIC DOCTOR आर्युवेदीक डॉक्टर <input type="checkbox"/> 1 HOMEOPATHIC DOCTOR होमीओपॅथिक डॉक्टर <input type="checkbox"/> 2 NATUROPATH नैच्युरोपॅथ <input type="checkbox"/> 3 UNANI युनानि <input type="checkbox"/> 4 RELIGIOUS/TRADITIONAL HEALER वैदु <input type="checkbox"/> 5 GOVT/PRIVATE/WESTERN DOCTOR सरकारी / प्रायव्हेट / वेस्टर्न डॉक्टर <input type="checkbox"/> 6 OTHER - SPECIFY अन्य बतलायें <input type="checkbox"/> 7	
308	Many different factors can prevent women from getting medical advice or treatment for themselves. Which in your view are the THREE MOST frequent obstacles that prevent you from accessing health services? औरतोंको अपनी बीमारी के वक्त उपचार ना करनेके कई कारण हो सकते हैं । आपके विचारमें तीन मुख्य कारण कौनसे है? स्त्रियांच्या स्वतःच्या आजारपणाच्यावेळी उपचार न घेण्याची काय कारणे असू शकतात ? तुमच्या मते अशी तीन कारणे कोणती	1. 2. 3.	

309	Generally speaking, when your child is ill, who decides whether or not the child should be taken for medical treatment? आम तौरपे, आपके बच्चे की बमारी के वक्त उपचार संबंधी मामलोंपर कौन फैसला करता है सर्वसाधारणपणे, तुमच्या घरी तुमच्या मुलांच्या आरोग्य संबंधी बाबींवर निर्णय कोण घेते ?	RESPONDENT औरत का / स्त्री <input type="checkbox"/> 1 JOINTLY WITH HUSBAND दोनोंका / दोघे <input type="checkbox"/> 2 HUSBAND पति का / पती <input type="checkbox"/> 3 IN LAWS/OTHER FAMILY MEMBERS साँस / ससुर / कुटुंबके अन्य सदस्य सासू / सासरे / सासरचे इतर कोणी <input type="checkbox"/> 4	
310	Do you drink alcohol? क्या आप शराब पीती है? तुम्ही दारु पीता का?	YES हा हो <input type="checkbox"/> 1 NO नहीं नाही <input type="checkbox"/> 2	→311 →313
311	In general how many glasses of alcohol do you drink in a week? SHOW card with picture of glass. सामान्यतः आप कितने ग्लास शराब एक सप्ताह में पीती है? साधारणपणे एका आठवड्याला किती ग्लास दारु पीता? Glasses in a week / ग्लास एका आठवड्याला / एक सप्ताह में	
312	In general, what type of alcohol do you drink? किस प्रकार की शराब ? कोणत्या प्रकारची दारु ?	COUNTRY देशी <input type="checkbox"/> 1 ENGLISH इंग्लिश <input type="checkbox"/> 2 OTHER – SPECIFY अन्य बतलायें <input type="checkbox"/> 3	
313	Do you use any drugs on a regular basis? क्या आप हररोज नशीले पदार्थों का सेवन करती हैं? आमली पदार्थोंकी नशा नेहमी करता का?	YES हा हो <input type="checkbox"/> 1 NO नहीं नाही <input type="checkbox"/> 2	→314 →315
314	In general, what drug do you use? सामान्यतः कौन से नशीले पदार्थ का सेवन करती हैं? साधारणपणे कोणत्या आमली पदार्थोंकी नशा करता ?	CANABIS चरस <input type="checkbox"/> 1 HEROIN हशिश <input type="checkbox"/> 2 COCAINE कोकेन <input type="checkbox"/> 3 OTHER – SPECIFY अन्य बतलायें <input type="checkbox"/> 4	
315	Have you ever been in a de-addiction program or clinic? क्या आप कभी नशा छुड़ाने वाले अस्पताल या संस्था में दाखील हुए है? आपण कधी नशा दूर करणाऱ्या संस्था किंवा दवाखान्यात उपचार घेतला आहे का?	YES हा हो <input type="checkbox"/> 1 HOW MANY TIMES? कितने बार / किती वेळा ? NO नहीं नाही <input type="checkbox"/> 2	

SECTION 4. HUSBAND'S BACKGROUND AND WOMAN'S WORK / पती के बारे में और औरतोंके काम के संबंधी / पतीबाबत आणि स्त्रीच्या कामाच्या संबंधी

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
401	Now I need some information on your husband. How old was your husband on his last birthday? अभी मैं आपके पति के बारेमें कुछ सवाल पुछना चाहुंगी । आपके पति की उम्र क्या है? / आता मी तुमच्या पतीसंबंधी काही प्रश्न विचारु इच्छिते. तुमच्या पतीचे वय काय आहे ?	YEARS साल / वर्ष	
402	What is the highest level of school your husband has completed? आपके पति कितनी कक्षा तक पढ़े हैं? तुमच्या पतीचे शिक्षण किती आहे?	NONE – DID NOT ATTEND SCHOOL <input type="checkbox"/> 1 अशिक्षित / निरक्षर PRIMARY SCHOOL/ प्राथमिक/प्राथमिक <input type="checkbox"/> 2 HIGH SCHOOL/माध्यमिक/माध्यमिक <input type="checkbox"/> 3 JUNIOR COLLEGE / ज्यु कॉलेज/ ज्यु कॉलेज <input type="checkbox"/> 4 DEGREE COLLEGE/पदवी/पदवी <input type="checkbox"/> 5 DON'T KNOW माहित नाही / पता नहीं <input type="checkbox"/> 6	
403	Does your husband provide you with money for living expenses on a regular basis? क्या आपके पति, नियमित रूपसे दैनिक खर्चकेलिए आपको पैसे देते है? तुमचे पती तुमच्या दैनंदिन खर्चासाठी तुम्हाला नियमित पैसे देतात?	YES हा हो <input type="checkbox"/> 1 NO नहीं नाही <input type="checkbox"/> 2	
404	Does your husband work on a regular basis? क्या आपके पति, नियमित रूपसे काम करते हैं? तुमचे पती नियमित कामावर जातात का?	YES - SPECIFY हा - बतलायें हो - सांगा <input type="checkbox"/> 1 NO नहीं नाही <input type="checkbox"/> 2	→405 →406
405	What is your husband's average monthly income? आपके पति की, नियमित मासिक कमाई कितनी हैं? तुमच्या पतीचे मासिक वेतन किती आहे?	RUPEES/MONTH <input type="checkbox"/> 1 रु. / मासिक रु / प्रति महिना DON'T KNOW नहीं मालूम माहित नाही <input type="checkbox"/> 2	→407

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
406	What are the MAIN factors that prevent your husband from doing paid work? आपके पति के पास काम न होने का क्या कारण है ? तुमच्या पतीकडे काम नसण्याचे काय कारण आहे?		
407	Aside from your own housework, are you currently doing any other paid work? घर के काम के अलावा क्या आप कुछ दुसरा काम करके पैसे कमाते हैं? घर कामाव्यतिरिक्त तुम्ही इतर काही काम करुन पैसे मिळवता का?	YES - SPECIFY हा - बतलायें हो - सांगा <input type="checkbox"/> ₁ NO नहीं नाही <input type="checkbox"/> ₂	→409 →408
408	What are the MAIN factors that prevent you from doing any paid work? आपके के पास काम न होने का क्या कारण है ? तुमच्याकडे काम नसण्याचे काय कारण आहे?		
409	Do you usually do this work at home or away from home? क्या आप ये काम घरसे करते हैं या बाहर जाते हैं ? तुम्ही हे काम घरी करता की बाहेर जाता?	HOME घर / घरी <input type="checkbox"/> ₁ AWAY बाहर / बाहेर <input type="checkbox"/> ₂	→410 →411
410	What are the MAIN reasons for working from home? घरसे काम करने का मुख्य कारण क्या है? तुम्ही हे काम घरीच करण्याचे मुख्य कारण काय आहे?		
411	How are you paid for this work? (RATE) आप को इस काम का वेतन किस प्रकारसे दिया जाता है? तुम्हाला या कामाचा मोबदला कसा दिला जातो - कोणत्या दराने?	CASH ONLY पैसे / पैशाच्या स्वरूपात <input type="checkbox"/> ₁ CASH AND KIND पैसे (नगद) और राशन / पैसे व धान्य स्वरूपात <input type="checkbox"/> ₂ IN KIND ONLY सिर्फ राशन / फक्त धान्य स्वरूपात <input type="checkbox"/> ₃	→412 →412 →415
412	How much is your average monthly income? आपकी मासिक तनखाह क्या है ? तुमचे मासिक वेतन काय आहे?	RUPEES/MONTH रु. / मासिक रु / प्रति महिना	→413
413	Do you disclose to your husband all the money you earn? क्या आप अपने पति को अपनी पूरी कमाई (पैसे) के बारे में बतलाती हैं? तुम्ही तुमच्या पतीला सांगितले आहे का तुम्हाला कामाचे सगळे मिळून किती पैसे मिळतात?	YES हा हो <input type="checkbox"/> ₁ NO नहीं नाही <input type="checkbox"/> ₂ WHY NOT? क्यों नहीं / का नाही	→414
414	Generally speaking, who in your family has the final say on how your income is spent? आम तौरपे, आपके परिवार में आपकी तनखाह से खर्च का फैसला कौन लेता है ? सर्वसाधारणपणे, तुमच्या घरी तुमचे वेतन कसे खर्च करायचे याचा निर्णय कोण घेते ?	RESPONDENT औरत का / स्त्री <input type="checkbox"/> ₁ JOINTLY WITH HUSBAND दोनोंका / दोघे <input type="checkbox"/> ₂ HUSBAND पति का / पती <input type="checkbox"/> ₃ IN LAWS WITH/OUT HUSBAND पति और / या साँस / ससुर <input type="checkbox"/> ₄	
415	Generally speaking, who in your family has the final say on decisions concerning large household purchases? आम तौरपे आपके परिवारमें बड़े घरेलु सामान की खरीदारीमें कौन फैसला लेता है ? सर्वसाधारणपणे, तुमच्या घरी मोठ्या घरगुती खरेदीसंबंधी निर्णय कोण घेते ?	RESPONDENT औरतका / स्त्री <input type="checkbox"/> ₁ JOINTLY WITH HUSBAND दोनोंका / दोघे <input type="checkbox"/> ₂ HUSBAND पति का / पती <input type="checkbox"/> ₃ IN LAWS WITH/OUT HUSBAND पति और / या साँस / ससुर <input type="checkbox"/> ₄	
416	Generally speaking, who in your family has the final say on decisions concerning household purchases for daily needs? आम तौरपे आपके परिवारमें दैनिक जरूरतों के घरेलु सामान की खरीदारी में फैसला कौन लेता है ? सर्वसाधारणपणे, तुमच्या घरी दैनंदिन घरगुती खरेदीसंबंधी निर्णय कोण घेते ?	RESPONDENT औरतका / स्त्री <input type="checkbox"/> ₁ JOINTLY WITH HUSBAND दोनोंका / दोघे <input type="checkbox"/> ₂ HUSBAND पति का / पती <input type="checkbox"/> ₃ IN LAWS WITH/OUT HUSBAND पति और / या साँस / ससुर <input type="checkbox"/> ₄	
417	Generally speaking, who in your family has the final say on decisions concerning what food should be cooked each day? आम तौरपे आपके परिवार में हररोज भोजन पकाने संबंधी विषयोंपर कौन फैसला लेता है ? सर्वसाधारणपणे, तुमच्या घरी रोजच्या जेवणाच्याबाबत (भोजन काय करावे) निर्णय कोण घेते ?	RESPONDENT औरतका / स्त्री <input type="checkbox"/> ₁ JOINTLY WITH HUSBAND दोनोंका / दोघे <input type="checkbox"/> ₂ HUSBAND पति का / पती <input type="checkbox"/> ₃ IN LAWS WITH/OUT HUSBAND पति और / या साँस / ससुर <input type="checkbox"/> ₄	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
418	Generally speaking, who in your family has the final say on decisions concerning visits to YOUR family or relatives? आम तौरपे आपके परिवारमें आपके मायकेवालोंसे मिलने के मामलेपर कौन फैसला लेता है ? सर्वसाधारणपणे, तुमच्या घरी तुमच्या माहेरच्याना भेटण्यासंबंधी निर्णय कोण घेते ?	RESPONDENT औरतका / स्त्री <input type="checkbox"/> 1 JOINTLY WITH HUSBAND दोनोंका / दोघे <input type="checkbox"/> 2 HUSBAND पति का / पत्नी <input type="checkbox"/> 3 IN LAWS WITH/OUT HUSBAND पति और / या साँस / ससुर <input type="checkbox"/> 4	

SECTION 5: SOCIAL SUPPORT / सामाजिक समर्थन / समाजाकडून होणारे समर्थन व मदत

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
<p>READ TO ALL RESPONDENTS: I would like to get an idea of your social circle and the people you interact with on a regular basis. What is your understanding of emotional support? WAIT FOR WOMAN'S ANSWER. So what you are saying is that emotional support is having someone to talk to when you are upset or sad or having someone do things for you to make you feel better. WAIT FOR WOMAN TO AGREE TO STATEMENT. Now that we have a shared view of what emotional support is, let's continue with the questionnaire. अब मैं आपके सामाजिक परिसर एवं संबंधीत परीचीत लोगों के बारे में जानना चाहूंगी। आप भावनीक /मानसिक आधार का मतलब क्या बताएंगी? (स्त्री के उत्तर की प्रतिक्षा करें) तो आपके कहने के मुताबीक भावनीक/मानसिक आधार का मतलब - जब आप दुखी या परेशान हो तब कोई आपसे बातें करें या आपको खुशी देने वाली आपको अच्छा लगनेवाली क्रीया करें । - क्या सही कहना चाहती है आप? अगर हां, तो आपकी सोच बराबर है, अब हम अगले प्रश्न की तरफ ध्यान दें।</p> <p>आता मला तुमच्या आसपासच्या सामाजाबद्दल आणि संबंधीत परीचयाच्या लोकांबद्दल जाणून घ्यायला आवडेल. तुमच्या मते भावनीक / मानसीक आधार म्हणजे काय? (स्त्रीच्या उत्तराची वाट बघा.) तर तुमच्या मते - जेव्हा तुम्ही दुःखी किंवा त्रासलेल्या असता तेव्हा तुमच्या भावना समजून घेऊन कोणी तुमच्याबरोबर बोलेल किंवा तुमच्या आवडत्या गोष्टी करून तुम्हाला आनंद देईल. - असाच अर्थ आहे का? स्त्री ने हो म्हटल्यास पुढच्या प्रश्नाकडे वळा.</p>			
501	Generally speaking, on a scale of 1 to 10, with 1 being not satisfied at all and 10 being completely satisfied, where would you rate your satisfaction with the emotional support you receive? आम तौर पे - मान लो अगर, '१' का मतलब असंतुष्टपजनक है (जरा भी सामाजिक सहयोग नहीं मिलता) और '१०' का मतलब पूरी तरह से संतुष्ट है (अच्छा सामाजिक सहयोग मिलता है), तो आप को कितना सामाजिक सहयोग मिलता है? साधारणपणे, तुम्हाला मिळणाऱ्या सामाजिक समर्थन व मदतीबद्दल मोजून सांगा. समजा '१' म्हणजे अगदीच निराशाजनक (थोडीदेखील मदत किंवा समर्थन मिळत नाही) आणि '१०' म्हणजे चांगल्याप्रकारे (उत्तम मदत किंवा समर्थन मिळते). 1 2 3 4 5 6 7 8 9 10		
502	Are you a member of a woman's support group such as the Mahila Mandal? क्या आप किसी महिला संगठन या महिला मंडल की सदस्य है ? तुम्ही एखाद्या महिला मंडळ किंवा संघटनेच्या सदस्य आहात का?	YES हा हो <input type="checkbox"/> 1 NO नहीं नाही <input type="checkbox"/> 2 WHY NOT?	→503 →504
503	Generally speaking, does this group provide you with support when you need it? TYPE OF SUPPORT CAN BE: financial, emotional आम तौर पर क्या आपको इन संस्थाओंसे मदत मिलती है? मदत जैसे की - पैसे या जज्बाती सहयोग साधारणता तुम्हाला अशा मंडळांकडून मदत मिळते का? मदत कोणत्या स्वरुपात जशी आर्थिक किंवा मानसिक मदत	YES - SPECIFY TYPE OF SUPPORT हा - बतलायें हो - सांगा <input type="checkbox"/> 1 NO नहीं नाही <input type="checkbox"/> 2	
504	Generally speaking, who are the people who provide you with significant emotional support? PROMPT BY ASKING 'Do you talk to someone if you are upset? IF SHE SAYS NO ONE, PUT IN ZERO '0' आम तौरपर, आपको जज्बाती सहयोग कौन देता है? ठीक से पुछे, 'जब आप नाराज होती है, तो किससे बात करती है?' अगर उसने कहीं, 'किसीसेभी बात नहीं करती.' तो ० लिखें। सर्वसाधारणपणे तुम्हाला भावनात्मकदृष्ट्या कोणाकडून आधार मिळतो? व्यवस्थित विचारा, 'जेव्हा तुम्ही निराश असता तेव्हा कोणाबरोबर बोलता?' जर ती 'कोणाशीही बोलत नाही' म्हणाली तर ० लिहा.	NAME/RELATIONSHIP SEX नाम व नाता स्त्री/पुरुष नांव व नाते स्त्री/पुरुष	If 0 अगर ० है जर ०असेल →506

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP	
505	<p>Can you specify what type of support do these people generally provide? For example they listen to your worries, or maybe they give advice or loan you something you need.</p> <p>आम तौरपे आपको किस प्रकारका सहयोग लोगों से मिलता है ? क्या वह आपकी परेशानीयाँ सुनते हैं और सलाह देते हैं या पैसे की मदद करते हैं या जरूरी चीजे उधार देते हैं?</p> <p>साधारणपणे तुम्हाला लोकांकडून कोणत्या प्रकारची मदत मिळते ? लोक तुमच्याशी तुमच्या चिंतांबद्दल बोलतात का सल्ला देतात का पैसे देतात किंवा गरजेच्या वस्तु उधार देतात.</p> <p>SPECIFY बतलाईए / सांगा</p>			
506	<p>When you are unwell or sick who steps in to help out or do the work that is generally expected of you?</p> <p>अगर आप बीमार हैं तो आपके घर का काम कौन करता है?</p> <p>तुम्ही आजारी असताना तुमच्या घरची कामे कोण करते ?</p>	<p>NAME/RELATIONSHIP</p> <p>नाम व नाता नांव व नाते</p>	<p>SEX</p> <p>स्त्री/पुरुष स्त्री/पुरुष</p>	
507	<p>When/If you have urgent financial problems, who do you turn to?</p> <p>अगर आपको पैसोंकी कमी (जरूरत) है तो आप किसके पास जातीं है?</p> <p>पैशांची अत्यंत आवश्यकता किंवा गरज असल्यास तुम्ही कोणाकडे जाता?</p>	<p>NAME/RELATIONSHIP</p> <p>नाम व नाता नांव व नाते</p>	<p>SEX</p> <p>स्त्री/पुरुष स्त्री/पुरुष</p>	<p>If 0 अगर ० है जर ०असेल →509</p>
508	<p>Generally speaking, do these people help you, as you would expect?</p> <p>आपको इन लोगोंसे अपेक्षानुसार मदद मिलती है या नहीं?</p> <p>या लोकांकडून तुम्हाला अपेक्षेप्रमाणे मदत मिळते का ?</p>	<p>YES - SPECIFY</p> <p>हां - बतलायें हो - सांगा <input type="checkbox"/>₁</p> <p>NO नहीं नाही <input type="checkbox"/>₂</p>		
509	<p>In your experience, who is the person or persons who cause you the greatest anxiety or upset you the most?</p> <p>आम तौरपर, किसकी वजह से आपको ज्यादा परेशानी या दुख होता है?</p> <p>सर्वसाधारणपणे कोणामुळे तुम्हाला जास्त त्रास होतो किंवा दुःख होते?</p>	<p>NAME/RELATIONSHIP</p> <p>नाम व नाता नांव व नाते</p>	<p>SEX</p> <p>स्त्री/पुरुष स्त्री/पुरुष</p>	<p>If 0 अगर ० है जर ०असेल →511</p>
510	<p>What are some of the things these people say or do to make you upset - SPECIFY</p> <p>वो क्या करते हैं या क्या बोलते हैं? जीससे आपको ज्यादा तकलीफ या दुख होता है। बतलायें -</p> <p>ते काय बोलतात किंवा काय करतात ज्यामुळे तुम्हाला जास्त त्रास होतो किंवा दुःख होते? सांगा</p>			
511	<p>Generally speaking what kind of things do you do to relax or re-energize yourself? - SPECIFY</p> <p>आम तौरपर आराम पाने के लिए या परेशानी से मुक्त होने के लिए आप क्या करती हैं? बतलायें -</p> <p>सर्वसाधारणपणे आराम मिळवण्यासाठी किंवा तरतरीत (तणावमुक्त) होण्यासाठी तुम्ही काय करता ? सांगा -</p>			
512	<p>Generally speaking, how do you cope/deal with stressful situations or when you are upset? - SPECIFY</p> <p>आम तौरपे आप परेशानीयाँ का मुकाबला किस तरह से करती है या आप दुखी होने पर क्या करती है ? बतलायें -</p> <p>सर्वसाधारणपणे तुम्ही त्रासदायक प्रसंगांत काय करता किंवा दुःखद घटनांना कशाप्रकारे सामोरे जाता ? सांगा -</p>			

READ TO ALL RESPONDENTS:

I would like to get an idea of how you have been feeling emotionally and mentally in the past month. Please answer the questions as accurately as possible; there are no wrong answers.

हम यह जानना चाहेंगे कि क्या आपको कोई चिकित्सा संबंधी शिकायतें हैं। सामान्य रूप से पिछले सप्ताह में आपको स्वास्थ्य कैसा रहा? कृपया आप निम्न पृष्ठों पर दिये गये सभी प्रश्नों के उत्तर केवल रेखंकन अथवा चिन्ह लगा कर दें, जिनको आप, सर्वाधिक स्वयं पर लागू होते हुए महसूस करते हैं। स्मरण रखें कि हम वर्तमान और नवीन शिकायतों के बारे में ही जानना चाहते हैं, न कि उनके बारे में जो अतित में थी। यह आवश्यक है कि आप सभी प्रश्नों के उत्तर देने का प्रयत्न करें। आम्ही हे जाणून घेऊ इच्छितो की, तुम्हांला कोणती चिकित्सेबाबत तक्रार आहे का? साधारणपणे गेल्या आठवड्यात तुमचे आरोग्य कसे होते? कृपया तुम्ही पुढे विचारलेल्या प्रश्नांच्या उत्तरांसाठी त्यापुढे दिलेल्या पर्यायांपैकी तुम्हांला लागू असलेल्या पर्यायासमोर रेषा किंवा खूण करा. लक्षात घ्या की आम्हाला सध्याच्या आणि वर्तमान काळाच्या तक्रारीबाबत जाणून घ्यायचे आहे, गतकाळातील परीस्थितीबाबत नाही. तुम्ही सर्व प्रश्नांची उत्तरे देण्याचा प्रयत्न करणे आवश्यक आहे.

601	During the past month, have you been able to concentrate on what you're doing? क्या आप इन दिनों जो भी काम कर रहे हैं उसमें ध्यान केंद्रित कर पाते हैं ? गेल्या काही दिवसात तुम्ही जी कामे केली त्यामध्ये तुम्ही किती लक्ष केंद्रित करू शकलात?	BETTER THAN USUAL सामान्य से अच्छा नेहमी पेक्षा चांगले <input type="checkbox"/> ₁	SAME AS USUAL सामान्य की तरह ही नेहमी सारखेच <input type="checkbox"/> ₂	LESS THAN USUAL सामान्य से कम नेहमीपेक्षा कमी <input type="checkbox"/> ₃	MUCH LESS THAN USUAL सामान्य से बहुत कम नेहमीपेक्षा खूपच कमी <input type="checkbox"/> ₄
602	During the past month, have you lost much sleep over worry? क्या आपको इन दिनों यह महसूस होता है कि चिन्ता के कारण आपको नींद नहीं आती? गेल्या काही दिवसात तुम्हाला असे जाणवले आहे की काळजीमुळे तुम्हाला झोप येत नाही?	NOT AT ALL बिल्कुल नहीं बिल्कुल नाही <input type="checkbox"/> ₁	NO MORE THAN USUAL सामान्य से अधिक नहीं नेहमी पेक्षा जास्त नाही <input type="checkbox"/> ₂	RATHER MORE THAN USUAL सामान्य से अधिक नेहमी पेक्षा जास्त <input type="checkbox"/> ₃	MUCH MORE THAN USUAL सामान्य से कहीं अधिक नेहमी पेक्षा खूप जास्त <input type="checkbox"/> ₄
603	During the past month, have you felt you were playing a useful part in things? क्या आप इन दिनों महसूस करते हैं कि कार्यों के बारे में आपकी भूमिका उपयोगी रही है? गेल्या काही दिवसातील घटनांमध्ये तुमचा उपयोगी सहभाग होता असे तुम्हाला वाटते कां ?	MORE SO THAN USUAL सामान्य से कुछ अधिक नेहमी पेक्षा जरा जास्त <input type="checkbox"/> ₁	SAME AS USUAL सामान्य की तरह ही नेहमी सारखाच <input type="checkbox"/> ₂	LESS USEFUL THAN USUAL सामान्य से कम उपयोगी नेहमी पेक्षा कमी उपयोगी <input type="checkbox"/> ₃	MUCH LESS THAN USUAL सामान्य से काफी कम नेहमी पेक्षा बरेच कमी <input type="checkbox"/> ₄
604	During the past month, have you felt capable of making decisions about things? क्या आपने इन दिनों अपने आपको विभिन्न निर्णय लेने में समर्थ महसूस किया है? गेल्या काही दिवसांत तुम्हाला असे जाणवले की आपण वेगवेगळे निर्णय घेण्यास समर्थ आहोत?	MORE SO THAN USUAL सामान्य से कुछ अधिक नेहमी पेक्षा जरा जास्त <input type="checkbox"/> ₁	SAME AS USUAL सामान्य की तरह ही नेहमी सारखाच <input type="checkbox"/> ₂	LESS SO THAN USUAL सामान्य से कुछ कम नेहमी पेक्षा जरा कमी <input type="checkbox"/> ₃	MUCH LESS THAN USUAL सामान्य से काफी कम नेहमी पेक्षा बरेच कमी <input type="checkbox"/> ₄
605	During the past month, have you felt constantly under strain? क्या आप इन दिनों अपने में लगातार तनाव महसूस करते रहे हैं? गेल्या काही दिवस तुम्हाला सतत तणाव जाणवला काय?	NOT AT ALL बिल्कुल नहीं बिल्कुल नाही <input type="checkbox"/> ₁	NO MORE THAN USUAL सामान्य से अधिक नहीं नेहमी पेक्षा जास्त नाही <input type="checkbox"/> ₂	RATHER MORE THAN USUAL सामान्य से कुछ अधिक नेहमी पेक्षा जरा जास्त <input type="checkbox"/> ₃	MUCH MORE THAN USUAL सामान्य से काफी अधिक नेहमी पेक्षा बरेच जास्त <input type="checkbox"/> ₄
606	During the past month, have you felt you couldn't overcome your difficulties? क्या आप इन दिनों यह महसूस करते हैं कि आप अपनी कठिनाईयां दूर करने में असमर्थ हैं? गेल्या काही दिवस तुम्हाला असे जाणवले की, तुम्ही तुमच्या अडचणी दूर करण्यास असमर्थ आहात?	NOT AT ALL बिल्कुल नहीं बिल्कुल नाही <input type="checkbox"/> ₁	NO MORE THAN USUAL सामान्य से अधिक नहीं नेहमी पेक्षा जास्त नाही <input type="checkbox"/> ₂	RATHER MORE THAN USUAL सामान्य से कुछ अधिक नेहमी पेक्षा जरा जास्त <input type="checkbox"/> ₃	MUCH MORE THAN USUAL सामान्य से काफी अधिक नेहमी पेक्षा बरेच जास्त <input type="checkbox"/> ₄

607	<p>During the past month, have you been able to enjoy your normal day-to-day activities? क्या आप इन दिनों अपने जीवन की साधारण दिनचर्या का आनन्द ले पा रहे हैं?</p> <p>गेल्या काही दिवसात तुम्ही जीवनाच्या साधारण दिनक्रमाचा आनंद घेऊ शकत आहात काय?</p>	<p>MORE SO THAN USUAL सामान्य से कुछ अधिक</p> <p>नेहमी पेक्षा जरा जास्त <input type="checkbox"/>₁</p>	<p>SAME AS USUAL सामान्य से अधिक नहीं</p> <p>नेहमी सारखाच <input type="checkbox"/>₂</p>	<p>LESS SO THAN USUAL सामान्य से कुछ कम</p> <p>नेहमी पेक्षा जरा कमी <input type="checkbox"/>₃</p>	<p>MUCH LESS THAN USUAL सामान्य से काफी कम</p> <p>नेहमीपेक्षा बरेच कमी <input type="checkbox"/>₄</p>
608	<p>During the past month, have you been able to face up to your problems? क्या आप इन दिनों अपनी समस्याओं का सामना करने में सक्षम रहे हैं?</p> <p>गेल्या काही दिवसात तुम्ही संकटांचा सामना करण्यास सक्षम होतात काय?</p>	<p>MORE SO THAN USUAL सामान्य से कुछ अधिक</p> <p>नेहमी पेक्षा जरा जास्त <input type="checkbox"/>₁</p>	<p>SAME AS USUAL सामान्य की तरह ही</p> <p>नेहमी सारखाच <input type="checkbox"/>₂</p>	<p>LESS SO THAN USUAL सामान्य से कम सक्षम</p> <p>नेहमी पेक्षा कमी सक्षम <input type="checkbox"/>₃</p>	<p>MUCH LESS THAN USUAL सामान्य से काफी कम</p> <p>नेहमीपेक्षा बरेच कमी <input type="checkbox"/>₄</p>
609	<p>During the past month, have you been feeling unhappy and depressed? क्या आप इन दिनों अप्रसन्न एवं दुखी महसूस करते रहे हैं?</p> <p>गेल्या काही दिवसात तुम्हाला दुःखी आणि उदास वाटत होते काय?</p>	<p>NOT AT ALL बिल्कुल नहीं</p> <p>बिल्कुल नाही <input type="checkbox"/>₁</p>	<p>NO MORE THAN USUAL सामान्य से अधिक नहीं</p> <p>नेहमी पेक्षा जास्त नाही <input type="checkbox"/>₂</p>	<p>RATHER MORE THAN USUAL सामान्य से कुछ अधिक</p> <p>नेहमी पेक्षा जरा जास्त <input type="checkbox"/>₃</p>	<p>MUCH MORE THAN USUAL सामान्य से कहीं अधिक</p> <p>नेहमी पेक्षा खूप जास्त <input type="checkbox"/>₄</p>
610	<p>During the past month, have you been losing confidence in yourself? क्या आप इन दिनों अपना आत्मविश्वास खोते जा रहे हैं?</p> <p>गेल्या काही दिवसापासून तुम्ही आत्मविश्वास गमावत आहात काय?</p>	<p>NOT AT ALL बिल्कुल नहीं</p> <p>बिल्कुल नाही <input type="checkbox"/>₁</p>	<p>NO MORE THAN USUAL सामान्य से अधिक नहीं</p> <p>नेहमी पेक्षा जास्त नाही <input type="checkbox"/>₂</p>	<p>RATHER MORE THAN USUAL सामान्य से कुछ अधिक</p> <p>नेहमी पेक्षा जरा जास्त <input type="checkbox"/>₃</p>	<p>MUCH MORE THAN USUAL सामान्य से काफी अधिक</p> <p>नेहमी पेक्षा बरेच जास्त <input type="checkbox"/>₄</p>
611	<p>During the past month, have you been thinking of yourself as a worthless person? क्या आप इन दिनों अपने आपको एक बेकार व्यक्ति समझते रहे हैं?</p> <p>गेल्या काही दिवसात तुम्ही स्वतःला एक बेकार व्यक्ती समजत आहात काय?</p>	<p>NOT AT ALL बिल्कुल नहीं</p> <p>बिल्कुल नाही <input type="checkbox"/>₁</p>	<p>NO MORE THAN USUAL सामान्य से अधिक नहीं</p> <p>नेहमी पेक्षा जास्त नाही <input type="checkbox"/>₂</p>	<p>RATHER MORE THAN USUAL सामान्य से कुछ अधिक</p> <p>नेहमी पेक्षा जरा जास्त <input type="checkbox"/>₃</p>	<p>MUCH MORE THAN USUAL सामान्य से काफी अधिक</p> <p>नेहमी पेक्षा बरेच जास्त <input type="checkbox"/>₄</p>
612	<p>During the past month, have you been feeling reasonably happy, all things considered? क्या आप इन दिनों सब बातों को साचते हुए अपने आपको प्रसन्न अनुभव करते रहे हैं?</p> <p>गेल्या काही दिवसात, सगळ्या गोष्टींचा विचार केल्यास, तुम्हाला प्रसन्न (आनंदी) वाटत आहे काय?</p>	<p>MORE SO THAN USUAL सामान्य से अधिक</p> <p>नेहमी पेक्षा जास्त <input type="checkbox"/>₁</p>	<p>SAME AS USUAL सामान्य की तरह ही</p> <p>नेहमी सारखाच <input type="checkbox"/>₂</p>	<p>LESS SO THAN USUAL सामान्य से कुछ कम</p> <p>नेहमी पेक्षा जरा कमी <input type="checkbox"/>₃</p>	<p>MUCH LESS THAN USUAL सामान्य से काफी कम</p> <p>नेहमीपेक्षा बरेच कमी <input type="checkbox"/>₄</p>

SECTION 7: DOMESTIC VIOLENCE / घरेलु झगडें / घरातील भांडणे

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP																																							
	<p>CHECK FOR PRESENCE OF OTHERS AGAIN: DO NOT CONTINUE UNTIL EFFECTIVE PRIVACY IS ENSURED.</p> <p>मुलाकात देनेवाली औरत के सीवा दुसरा कोई वहाँ नहीं इसकी जाँच कर ले जब तक गोपनीयता नहीं तब तक आगे के प्रश्न ना पुछे।</p> <p>मुलाखत देणारी महिला एकटीच असल्याची खात्री करुन घ्या. जापर्यंत गोपनीयतेची खात्री होत नाही तोपर्यंत पुढील प्रश्न विचारु नका.</p> <p>PRIVACY OBTAINED / गोपनीयता - है / आहे <input type="checkbox"/>₁ →701 PRIVACY NOT POSSIBLE / गोपनीयता - नहीं है / नाही <input type="checkbox"/>₂ → ?</p>																																									
	<p>READ TO ALL RESPONDENTS: Now I would like to ask you questions about some other important aspects of a woman's life. I know that some of these questions are very personal. However, your answers are crucial for helping to understand the condition of women in India. Let me assure you that your answers are confidential and will be treated anonymously.</p> <p>पढकर सुनाईयेँ - अब मैं आप से महिलाओं के जीवनसंबंधी कुछ सवाल पुछना चाहुंगी। मैं जानती हूँ, उनसे से कुछ सवाल नीजी है। लेकिन, आप से मिलनेवाले जवाबों के आधारपर मैं, 'भारत में महिलाओंकी स्थीती' इस विषयपर छानबीन कर सकुंगी। मैं आपको विश्वास दिलाती हूँ, आपका नाम और जवाब गुप्त रखे जायेंगे और आपको इस वजह से कोई परेशानी नहीं होगी।</p> <p>वाचुन दाखवा - आता मी तुम्हाला स्त्रीयांच्या आयुष्यासंबंधी काही प्रश्न विचारु इच्छिते. मला माहित आहे कि, त्यातील काही प्रश्न खाजगी आहेत. पण तुमच्या उत्तरांच्या आधारे मी, 'भारतात स्त्रीयांची स्थीती' या विषयावर अभ्यास करू शकेन. मी तुम्हाला खात्री देते, तुमचे नांव व उत्तरे गुप्त ठेवली जातील आणि तुम्हाला त्यामुळे काही त्रास होणार नाही.</p>																																									
701	<p>Have you ever separated from your husband?</p> <p>क्या अपने पतिसे अलग हुए हैं?</p> <p>तुम्ही तुमच्या पतीपासून वेगळ्या झाला होतात का ?</p>	<p>YES हा हो <input type="checkbox"/>₁</p> <p>HOW MANY TIMES? / कित्ती वेळा</p> <p>NO नहीं नाही <input type="checkbox"/>₂</p>																																								
702	<p>When two people marry and live together, they share both good and bad moments. In your relationship with your husband do the following happen frequently, sometimes, rarely or never? DEFINE EACH TERM AGAIN.</p> <p>जब दो व्यक्ति शादी करते है और जीवन एक साथ बिताते है, वे दोनो सुख-दुख के पल बाँटते है। आपके पति के साथ आपके रीश्तोंमें क्या आपके साथ नीचे पुछी गयी बातें - बारबार, कभी कभी, कदाचित या कभी नहीं होती? हर एक प्रश्न फिरसे पढकर बताईये।</p> <p>जेव्हा दोन व्यक्ती विवाह करतात आणि एकत्र आयुष्य व्यतीत करतात, दोघे सुख-दुःखाचे क्षण वाटून घेतात. तुमच्या पतीबरोबर असलेल्या नाते-संबंधामध्ये तुमच्याबाबतीत खाली विचारण्यात आलेल्या गोष्टी - वारंवार, कधी कधी, कदाचित किंवा कधीच नाही घडल्या असे झाले आहे का ? पुढील प्रत्येक प्रश्न वाचून दाखवावा.</p>	<table border="1"> <thead> <tr> <th>FREQ</th> <th>S/TIMES</th> <th>RARELY</th> <th>NEVER</th> <th>DK</th> </tr> <tr> <td>बारबार</td> <td>कभी कभी</td> <td>कदाचित</td> <td>कभी नहीं</td> <td>मालूम नहीं</td> </tr> <tr> <td>वारंवार</td> <td>कधी कधी</td> <td>कदाचित्</td> <td>कधीच नाही</td> <td>माहित नाही</td> </tr> </thead> <tbody> <tr> <td>A He usually spends his free time with you? आपके पति उनको मिलनेवाला खाली समय कितने बार आपके साथ बीताते है? तुमचे पती त्यांना मिळणारा रीकामा वेळ कित्ती वेळा तुमच्यासोबत व्यतीत करतात?</td> <td><input type="checkbox"/>₁</td> <td><input type="checkbox"/>₂</td> <td><input type="checkbox"/>₃</td> <td><input type="checkbox"/>₄</td> <td><input type="checkbox"/>₅</td> </tr> <tr> <td>B He consults you on different household matters? वे आपसे घर मामलों पर कीतनी बार बातचीत करते / राय लेते है ? ते तुमच्याशी घरगुती विषयांवर कित्तीवेळा चर्चा करतात/सल्ला घेतात?</td> <td><input type="checkbox"/>₁</td> <td><input type="checkbox"/>₂</td> <td><input type="checkbox"/>₃</td> <td><input type="checkbox"/>₄</td> <td><input type="checkbox"/>₅</td> </tr> <tr> <td>C He is affectionate with you? वे आपसे कितनी बार प्यार से पेश आते है? तुमच्या बरोबर कित्ती वेळा प्रेमाने वागतात?</td> <td><input type="checkbox"/>₁</td> <td><input type="checkbox"/>₂</td> <td><input type="checkbox"/>₃</td> <td><input type="checkbox"/>₄</td> <td><input type="checkbox"/>₅</td> </tr> <tr> <td>D He respects you and your wishes? क्या वे आप का और आप की भावनाओं का आदर करते है? तुमचा आणि तुमच्या भावनांचा ते आदर करतात का?</td> <td><input type="checkbox"/>₁</td> <td><input type="checkbox"/>₂</td> <td><input type="checkbox"/>₃</td> <td><input type="checkbox"/>₄</td> <td><input type="checkbox"/>₅</td> </tr> </tbody> </table>	FREQ	S/TIMES	RARELY	NEVER	DK	बारबार	कभी कभी	कदाचित	कभी नहीं	मालूम नहीं	वारंवार	कधी कधी	कदाचित्	कधीच नाही	माहित नाही	A He usually spends his free time with you? आपके पति उनको मिलनेवाला खाली समय कितने बार आपके साथ बीताते है? तुमचे पती त्यांना मिळणारा रीकामा वेळ कित्ती वेळा तुमच्यासोबत व्यतीत करतात?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	B He consults you on different household matters? वे आपसे घर मामलों पर कीतनी बार बातचीत करते / राय लेते है ? ते तुमच्याशी घरगुती विषयांवर कित्तीवेळा चर्चा करतात/सल्ला घेतात?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	C He is affectionate with you? वे आपसे कितनी बार प्यार से पेश आते है? तुमच्या बरोबर कित्ती वेळा प्रेमाने वागतात?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	D He respects you and your wishes? क्या वे आप का और आप की भावनाओं का आदर करते है? तुमचा आणि तुमच्या भावनांचा ते आदर करतात का?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	
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703	<p>Now I am going to ask you about some situations which happen to some women. Please tell me if these apply to your relationship with your husband?</p> <p>अब मैं आप से जानना चाहुंगी, समाज में महिलाओं के साथ होनेवाली घटनाओं के बारे में। कृपया मुझे बताईये, पति से आप के रीश्तों में क्या आपके साथ भी यह घटनाएँ होती है?</p> <p>आता मला तुमच्याकडून माहिती हवी आहे, ती समाजात स्त्रीयांबरोबर घडणाऱ्या घटनांबाबत. कृपया मला सांगा की पतीबरोबरच्या नातेसंबंधामध्ये तुमच्या बाबतीतही या घटना घडतात का?</p>																																									

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES					SKIP
	<p>A He is jealous or angry if you talk to other men? अगर आप किसी पर-पुरुष से बात करें तो क्या आप के पती को जलन होती है या क्रोध होता है? जेव्हा तुम्ही पर-पुरुषा बरोबर बोलता तेव्हा तुमच्या पतीला राग येतो किंवा हेवा वाटतो का?</p> <p>B He frequently accuses you of being unfaithful? क्या वह बारबार आप को व्यभिचारी होने का दोष लगाता है? तो तुम्हाला वारंवार व्यभिचारी असल्याचा दोष देतो का?</p> <p>C He does not permit you to meet your girl friends? क्या वह आपकी सहेलीयों से मीलने से आपको मना करता है। तो तुम्हांला तुमच्या मैत्रिणींना भेटण्याची परवानगी देत नाही काय?</p> <p>D He tries to limit your contact with your family? क्या वह आपके परीवार से मीलने पर रोकने की कोशिश करता है? तो तुमची आणि तुमच्या कुटुंबियांची भेट होऊ नये असा प्रयत्न करतो का?</p> <p>E He insists on knowing where you are at all times? क्या वह, 'पूरा वख्त आप कहाँ होती हैं' यह जानना जरूरी समझता है? 'पूर्ण वेळ तुम्ही कुठे असता' हे जाणून घेणं तो जरूरी समजतो का?</p> <p>F He does not trust you with any money? क्या वह, आपके पास पैसा रखने में भरोसा नहीं रखता? तुमच्या जवळ पैसे ठेवणं त्याला खात्रीचं वाटतं नाही कां?</p>	FREQ बारबार वारंवार <input type="checkbox"/> ₁	S/TIMES कभी कभी कधी कधी <input type="checkbox"/> ₂	RARELY कदाचित कदाचित् <input type="checkbox"/> ₃	NEVER कभी नहीं कधीच नाही <input type="checkbox"/> ₄	DK मालूम नहीं माहित नाही <input type="checkbox"/> ₅	
704	<p>Some men drink alcohol, and this can affect the relationship between a husband and wife. Can you tell me: How often have you seen your husband DRUNK in the last 12 months? कई पुरुष शराब पीते हैं और उसका प्रभाव पति-पत्नी के रिश्तों पर होता है, क्या आप बता सकती हैं - बीते १२ महिनों में आप ने आप के पति को कितने बार शराब के नशों में देखा है?</p> <p>बरेच पुरुष दारू/मद्य पीतात आणि ज्याचा परीणाम पती-पत्नीच्या नातेसंबंधांवर होतो, तुम्ही सांगू शकाल का की, गेल्या १२ महिन्यांत तुमच्या पतीला तुम्ही किती वेळा मद्यधुंद अवस्थेत पाहिले आहे?</p>	FREQ बारबार वारंवार <input type="checkbox"/> ₁	S/TIMES कभी कभी कधी कधी <input type="checkbox"/> ₂	RARELY कदाचित कदाचित् <input type="checkbox"/> ₃	NEVER कभी नहीं कधीच नाही <input type="checkbox"/> ₄	DK मालूम नहीं माहित नाही <input type="checkbox"/> ₅	
705	<p>Some men also use drugs. Do you know if your husband uses any drugs on a regular basis? कई पुरुष नशिले पदार्थों का सेवन करते हैं। आप को पता है, क्या आप के पति भी किसी प्रकार के नशिले पदार्थ नियमित रूपसे सेवन करते हैं ? बरेच पुरुष आमलीपदार्थांचे सेवन करतात. तुमच्या पतीला देखील अशाप्रकारे आमलीपदार्थांचे व्यसन आहे का या बदल तुम्हाला माहिती आहे का?</p>	YES हा हो NO नहीं नाही DON'T KNOW नहीं मालूम माहित नाही	<input type="checkbox"/> ₁ <input type="checkbox"/> ₂ <input type="checkbox"/> ₃				→706 →707
706	<p>Which type of drugs does your husband use? आप का पति कौन से नशिले पदार्थ की नशा करता है? तुमचा पती कोणत्या आमलीपदार्थांची नशा करतो?</p>	CANABIS HEROIN COCAINE OTHER – SPECIFY	चरस हशिष कोकेन अन्य बतलायें	<input type="checkbox"/> ₁ <input type="checkbox"/> ₂ <input type="checkbox"/> ₃ <input type="checkbox"/> ₄			

REMEMBER THE FOLLOWING PLEASE!!!!

The following questions are divided into two parts, PART 1 and PART 2. PART 1 refers to a particular behaviour that a husband may do. PART 2 refers to whether this behaviour occurs when the husband is sober, drunk or under the influence of drugs.
 IF a woman says her husband is never drunk/doesn't drink alcohol and does not use drugs at all then you **DO NOT** ask PART 2 of the questions.
 IF the woman says her husband only gets drunk but does not use drugs, then ask only the appropriate questions from PART 2 ie. 'Does he do this when he is sober?' and 'Does he do this when he is drunk?' but **DO NOT** ask 'Does he do this when he is under the influence of drugs?'

नीचे दि गयी बातों को ध्यान में रखें।

नीचे दिये गये प्रश्न के दो विभाग किये गये हैं, भाग १ और भाग २। भाग १ में पति के वर्तनसंबंधी प्रश्न पुछे गये हैं। भाग २ में वह ऐसा वर्तन सामान्य तौर पर/ शराब पीने के बाद या कोई नशिला पदार्थ सेवन करने पर करता है, इस पर निर्देश देता है।

अगर महिला कहें, उसका पति कभी शराब नहीं पीता या शराबी नहीं है और कभी भी किसी प्रकार की नशा नहीं करता, तो भाग २ में दिये गये प्रश्न ना पुछे।

अगर महिला कहें, उसका पति सिर्फ शराब पीता है और किसी प्रकार के नशिले पदार्थ की नशा नहीं करता, तो उसे भाग २ में केवल उसके संबंधी प्रश्न पुछे। जैसे की - 'क्या वह ऐसा सामान्यतः करता है?' और 'क्या वह ऐसा शराब पीने के बाद करता है?' पर 'क्या वह नशिल पदार्थ लेने पर ऐसा करता है?' यह सवाल ना पुछें।

खाली दिलेल्या गोष्टी लक्षात घ्या.

खाली दिलेल्या प्रश्नांचे दोन भाग करण्यात आले आहेत, भाग १ आणि भाग २.

भाग १ मध्ये पतीच्या वर्तनाबद्दल प्रश्न आहेत. भाग २ मध्ये तो हे वर्तन सामान्य असताना / दारूच्या नशेत किंवा आमली पदार्थांच्या नशेत करतो या संबंधी निर्देश आहेत. जर त्या स्त्रीने सांगितले, तीचा पती कधीही दारूचे किंवा कोणतेही आमली पदार्थांचे सेवन करीत नाही, तर तीला भाग २ मधिल प्रश्न विचारू नये.

जर त्या स्त्रीने सांगितले कि तीचा पति फक्त दारू पीतो पण आमलिपदार्थांचे सेवन करत नाही. तर भाग २ मधिल फक्त संबंधित प्रश्न विचारा. उदा० 'तो अमूक गोष्ट सामान्यपणे करतो का?' आणि 'तो अमूक गोष्ट दारूच्या नशेत करतो का?' पण 'तो अमूक गोष्ट आमलीपदार्थांच्या नशेत करतो का?' असे विचारू नये.

		PART 1 / भाग १					PART 2 / भाग २	
		DOES YOUR HUSBAND EVER: क्या आपका पति कभी - तुमचे पती कधी -	HOW OFTEN DID THIS HAPPEN IN THE LAST 12 MONTHS? पिछले १ सालमें कितनी बार ऐसा हुआ है गेल्या वर्षभरात असे किती वेळा झाले.					
707	a) Say or do something to humiliate you in front of others? औरोंके सामने आपको नीचा दिखाते हैं इतरांसमोर तुमचा अपमान करतात?	YES <input type="checkbox"/> ₁ → NO <input type="checkbox"/> ₂ ↓	FREQ बारबार वारंवार <input type="checkbox"/> ₁	S/TIMES कभी कभी कधी कधी <input type="checkbox"/> ₂	RARELY कदाचित कदाचित् <input type="checkbox"/> ₃	NEVER कभी नहीं कधीच नाही <input type="checkbox"/> ₄	DK मालूम नहीं माहित नाही <input type="checkbox"/> ₅	SOBER <input type="checkbox"/> ₁ सामान्यतः / सामान्यपणे DRUNK <input type="checkbox"/> ₂ दारूच्या नशेत / शराब के नशे में DRUGS <input type="checkbox"/> ₃ आमली पदार्थांच्या नशेत / नशिले पदार्थ सेवन करके
	b) Threaten you with harm? आपको मारने की धमकी देते हैं तुम्हाला मारण्याची धमकी देतात?	YES <input type="checkbox"/> ₁ → NO <input type="checkbox"/> ₂ ↓	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	SOBER <input type="checkbox"/> ₁ सामान्यतः / सामान्यपणे DRUNK <input type="checkbox"/> ₂ दारूच्या नशेत / शराब के नशे में DRUGS <input type="checkbox"/> ₃ आमली पदार्थांच्या नशेत / नशिले पदार्थ सेवन करके
	c) Threaten someone close to you with harm? कोई प्रिय व्यक्ती को मारने की धमकी देते हैं तुमच्या प्रिय व्यक्तीला मारण्याची धमकी देतात?	YES <input type="checkbox"/> ₁ → NO <input type="checkbox"/> ₂ ↓	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	SOBER <input type="checkbox"/> ₁ सामान्यतः / सामान्यपणे DRUNK <input type="checkbox"/> ₂ दारूच्या नशेत / शराब के नशे में DRUGS <input type="checkbox"/> ₃ आमली पदार्थांच्या नशेत / नशिले पदार्थ सेवन करके
	d) Threaten to leave/divorce you? तलाक की धमकी देते हैं सोडून देण्याची / घटस्फोटाची धमकी देतात?	YES <input type="checkbox"/> ₁ → NO <input type="checkbox"/> ₂ ↓	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	SOBER <input type="checkbox"/> ₁ DRUNK <input type="checkbox"/> ₂ DRUGS <input type="checkbox"/> ₃

		FREQ बारबार	S/TIMES कभी कभी	RARELY कदाचित्	NEVER कभी नहीं	DK मालूम नहीं		
708	a) Push you, shake you, or throw something at you? धक्का देते हैं आपको झिझोड़ देते हैं या आपके ऊपर कुछ फेंकते हैं ? तुम्हारा धक्का देता किवा काही फेंकून मारता?	YES <input type="checkbox"/> ₁ → NO <input type="checkbox"/> ₂ ↓	वारंवार <input type="checkbox"/> ₁	कधी कधी <input type="checkbox"/> ₂	कदाचित् <input type="checkbox"/> ₃	कधीच नाही <input type="checkbox"/> ₄	माहित नाही <input type="checkbox"/> ₅	SOBER <input type="checkbox"/> ₁ DRUNK <input type="checkbox"/> ₂ DRUGS <input type="checkbox"/> ₃
	b) Slap you or twist your arm? थप्पड़ मारते हैं या हाथ मरोड़ देते हैं थप्पड़ मारता किवा हात पिळता ?	YES <input type="checkbox"/> ₁ → NO <input type="checkbox"/> ₂ ↓	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	SOBER <input type="checkbox"/> ₁ DRUNK <input type="checkbox"/> ₂ DRUGS <input type="checkbox"/> ₃
	c) Punch you with his fist or with something that could hurt you? मुक्का मारते हैं ? / ठोसा मारता?	YES <input type="checkbox"/> ₁ → NO <input type="checkbox"/> ₂ ↓	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	SOBER <input type="checkbox"/> ₁ DRUNK <input type="checkbox"/> ₂ DRUGS <input type="checkbox"/> ₃
	d) Kick you or drag you? लात मारते हैं या घसीटते हैं? लाथ मारता किवा फरफटवता?	YES <input type="checkbox"/> ₁ → NO <input type="checkbox"/> ₂ ↓	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	SOBER <input type="checkbox"/> ₁ DRUNK <input type="checkbox"/> ₂ DRUGS <input type="checkbox"/> ₃
	e) Try to strangle you or burn you? आपका गला दबाते हैं या जलाते हैं? तुमचा गळा दाबता किवा चटके देता?	YES <input type="checkbox"/> ₁ → NO <input type="checkbox"/> ₂ ↓	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	SOBER <input type="checkbox"/> ₁ DRUNK <input type="checkbox"/> ₂ DRUGS <input type="checkbox"/> ₃
	f) Threaten you with a knife, gun, or other type of weapon? आपको चाकू बंदूक या किसी हथियार से डराते हैं? तुम्हारा चाकू बंदूक किवा इतर हत्याराने घाबरवता ?	YES <input type="checkbox"/> ₁ → NO <input type="checkbox"/> ₂ ↓	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	SOBER <input type="checkbox"/> ₁ DRUNK <input type="checkbox"/> ₂ DRUGS <input type="checkbox"/> ₃
	g) Attack you with a knife, gun, or other type of weapon? चाकू बंदूक या किसी हथियार से वार करते हैं? चाकू बंदूक किवा इतर हत्याराने वार करता?	YES <input type="checkbox"/> ₁ → NO <input type="checkbox"/> ₂ ↓	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	SOBER <input type="checkbox"/> ₁ DRUNK <input type="checkbox"/> ₂ DRUGS <input type="checkbox"/> ₃
	h) Physically force you to have sexual intercourse with him even when you did not want to? आपकी इच्छा न हो फिर भी यौन संबंध के लिए मजबूर करते हैं? तुमची इच्छा नसतानाही शारीरिक संबंध ठेवण्यासाठी जबरदस्ती करता का?	YES <input type="checkbox"/> ₁ → NO <input type="checkbox"/> ₂ ↓	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	SOBER <input type="checkbox"/> ₁ DRUNK <input type="checkbox"/> ₂ DRUGS <input type="checkbox"/> ₃
	i) Force you to perform other sexual acts you did not want to? दुसरी तरह के यौन संबंधी कार्य करने को मजबूर करते जो आपको पसंद नहीं। इतरप्रकारच्या शारिरीक संबंधांच्या कृती करण्यास भाग पाडतात, तुम्हारा आवडत नसतानाही.	YES <input type="checkbox"/> ₁ → NO <input type="checkbox"/> ₂ ↓	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	SOBER <input type="checkbox"/> ₁ DRUNK <input type="checkbox"/> ₂ DRUGS <input type="checkbox"/> ₃
709	What other reasons, other than alcohol or drugs cause your husband to hit you? Eg. Mother in law/ girlfriend शराब और नशिले पदार्थ के अलावा, दूसरे कीन कारणोंसे आपका पति आपको मारता है? जैसे सास/ दोस्त लडकी की वजह से। दारु व आमलीपदार्थांशिवाय इतर कोणत्या कारणानी तुमचा पती तुम्हारा मारतो? जैसे- सासू /त्याची मैत्रिण यांच्यामुळे.							
710	CHECK 705 to 709: सवाल ७०५ से ७०९ देखें / प्रश्न ७०५ ते ७०९ पहा - AT LEAST ONE 'YES' / किसी एक भी सवाल का जवाब 'हाँ' है तो। / निदान एका प्रश्नाचे उत्तर "हो" असेल तरी NOT A SINGLE 'YES' / एकभी सवाल का जवाब 'हाँ' नहीं दिया। / एकाही प्रश्नाचे उत्तर "हो" नसल्यास					<input type="checkbox"/> ₁ <input type="checkbox"/> ₂	→711 →713	

711	How long after you first got married did (this/any of these things) first happen? शादीके कितने दिन बाद ये घटना हुई? लग्नानंतर कितनी दिवसांनी ही घटना घडली? IF LESS THAN ONE YEAR, RECORD '00'. अगर एक साल से कम है तो "००" लिखें। जर एक वर्षापेक्षा कमी असेल तर "००" लिहा.	NUMBER OF YEARS कितने साल / किती वर्ष..... DON'T KNOW पता नहीं / माहित नाही <input type="checkbox"/> 1 BEFORE MARRIAGE शादी के पहले / लग्नाच्यापूर्वी <input type="checkbox"/> 2 AFTER SEPARATION/DIVORCE <input type="checkbox"/> 3 तलाक या अगल होनेके बाद / घटस्फोट किंवा वेगळे झाल्यानंतर	
712	712A. Did the following ever happen because of something your husband did to you: ये जो मैं आपसे पूछने जा रही हूँ क्या ऐसा आपके आपके पतिकी वजहसे हुआ था? असे कधी तुमच्या पतीमुळे घडले आहे का?	712B. How many times did this happen during the last 12 months? पिछले इक सालमें कितनी बार ऐसा हुआ ह? गेल्या एका वर्षात असे किती वेळा झाले आहे?	
	a) You had bruises and aches? चोंट आई थी? खरचटले होते?	YES <input type="checkbox"/> 1→ NO <input type="checkbox"/> 2 ↓	FREQ वारंवार <input type="checkbox"/> 1 S/TIMES कधी कधी <input type="checkbox"/> 2 RARELY कदाचित् <input type="checkbox"/> 3 NEVER कधीच नाही <input type="checkbox"/> 4 DK माहित नाही <input type="checkbox"/> 5
	b) You had an injury or a broken bone? आप घायल थी या हड्डी टूटी थी? जखम झाली होती किंवा हाड मोडले होते?	YES <input type="checkbox"/> 1→ NO <input type="checkbox"/> 2 ↓	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5
	c) You went to the doctor or health center as a result of something your husband did to you? आप डॉक्टरके पास अस्पताल गयी थी? तुम्ही डॉक्टरांकडे इस्पितळात गेला होतात?	YES <input type="checkbox"/> 1→ NO <input type="checkbox"/> 2 ↓	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5
	d) You stayed in hospital at least one night as a result of something your husband did to you? आपने अस्पताल में कमसे कम इक रात या ज्यादा बितायी थी? तुम्ही इस्पितळात कमीत कमी एक रात्र राहिला होतात?	YES <input type="checkbox"/> 1→ NO <input type="checkbox"/> 2 ↓	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5
713	Have you ever hit, slapped, kicked or done anything else to physically hurt your husband at times when he was NOT already beating or physically hurting you? आपने अपने पतिको कभी मारा हैं ? तुम्ही तुमच्या पतिला कधी मारले आहे?	YES हा हो <input type="checkbox"/> 1 NO नहीं नाही <input type="checkbox"/> 2	→714 →715
714	In the last 12 months, how many times have you hit, slapped, kicked or done something to physically hurt your husband at a time when he was NOT already beating or physically hurting you? इक सालमें कितनी बार आपने अपने पतिको धक्का मारा हैं ? एका वर्षात किती वेळा तुम्ही तुमच्या पतिला मारले आहे?	IF ZERO ASK WHY NOT? कितनी बार / किती वेळा एक बार भी नहीं मारा, तो क्यों नहीं यह पुछें. जर एकदाही मारले नाही, तर का नाही ते विचारा.	
715	Has anyone other than your husband ever hit, slapped, kicked, or done anything else to hurt you physically, even during your childhood? पतिके अलावा और किसीने आपको मारा पीटा क्या आपके बचपन में भी? / पतिशिवाय आणखी कुणी तुम्हाला शारिरीक इजा केली आहे का, अगदी लहानपणी देखील ?	YES हा हो <input type="checkbox"/> 1 NO नहीं नाही <input type="checkbox"/> 2	→718
716	Who has physically hurt you in this way? किसीने आपको चोंट पहुँचाई हैं? मारा / पीटा कुणी तुम्हाला शारिरीक इजा केली आहे का ? Anyone else? और कोई? आणखी कोणी? RECORD ALL MENTIONED. बताया लिखे। सांगितलेले लिहा.	MOTHER/FATHER आई / बाबा <input type="checkbox"/> 1 SISTER/BROTHER बहन / भाई बहीण / भाऊ <input type="checkbox"/> 2 DAUGHTER/SON बेटा / बेटी मुलगा / मुलगी <input type="checkbox"/> 3 MOTHER-IN-LAW/ FATHER-IN-LAW सास / ससुर सासू / सासरे <input type="checkbox"/> 4 OTR FEMALE RELATIVE/IN-LAW ससुरालवाली कोई महिला <input type="checkbox"/> 5 OTR MALE RELATIVE/ IN-LAW ससुरालवाला कोई पुरुष <input type="checkbox"/> 6 STRANGER / अनजान / अनोळखी <input type="checkbox"/> 7 OTHER – SPECIFY / अन्य बतलायें <input type="checkbox"/> 8	

717	In the last 12 months, how many times has this person hit, slapped, kicked, or done anything else to physically hurt you? इक सालमें कितनी बार आपको इस इन्सान ने मारा पीटा या चोट पहुँचाई है? एका वर्षात किती वेळा या व्यक्तीने तुम्हाला शारिरीक इजा केली आहे?	NUMBER OF TIMES / कितने बार / किती वेळा	
718	Has any one ever hit, slapped, kicked, or done anything else to hurt you physically while you were PREGNANT? जब आप गर्भवती थी, क्या किसीने मुक्का, थप्पड, लाथ मारा या अन्य तरह से शारिरीक यातनाए पहुँचाई ? तुम्ही गरोदर असताना, कुणी तुम्हाला ठोंसा, थप्पड, लाथ मारली किंवा अन्य प्रकारची शारिरीक यातना दिली काय?	YES हा हो <input type="checkbox"/> 1 NO नहीं नाही <input type="checkbox"/> 2 NO ANSWER <input type="checkbox"/> 8	→720 →720
719	Who has done any of these things to physically hurt you while you were pregnant? जब आप गर्भवती थी, इनमें से किसीने आपको चोट पहुँचाई है ? तुम्ही गरोदर असताना, यांच्यापैकी कोणी तुम्हाला शारिरीक इजा केली आहे? Anyone else? और कोई? आणखी कोणी? RECORD ALL MENTIONED. बताया लिखें / सांगितलेले लिहा.	HUSBAND पति <input type="checkbox"/> 1 MOTHER/FATHER आई -बाबा / माता-पीता <input type="checkbox"/> 3 SISTER/ BROTHER बहन / भाई बहीण / भाऊ <input type="checkbox"/> 3 DAUGHTER/SON बेटा / बेटी मुलगा / मुलगी <input type="checkbox"/> 4 MOTHER-IN-LAW/ FATHER-IN-LAW सास -ससुर / सासू -सासरे <input type="checkbox"/> 5 OTR FEMALE RELATIVE/IN-LAW <input type="checkbox"/> 6 ससुरालवाली कोई महिला OTR MALE RELATIVE/ IN-LAW <input type="checkbox"/> 7 ससुरालवाला कोई पुरुष STRANGER अनजान / अनोळखी <input type="checkbox"/> 8 OTHER - SPECIFY / अन्य बतलायें <input type="checkbox"/> 9	
720	CHECK 710, 715, AND 718: प्रश्न ७१०, ७१५ आणि ७१८ पहा किसी एक भी सवाल का जवाब 'हाँ' है तो। निदान एका प्रश्नाचे उत्तर "हो" असेल तरी AT LEAST ONE 'YES' <input type="checkbox"/> 1 ↓	एकभी सवाल का जवाब 'हाँ' नहीं दिया। एकाही प्रश्नाचे उत्तर "हो" नसल्यास NOT A SINGLE 'YES' <input type="checkbox"/> 2	→ 724
721	Have you ever told anyone or tried to get help to prevent or stop (this person/these persons) from physically hurting you? किसीसे आपने य बात कहीं, मदद के लीये? क्या इसको रोकने के लिए आपने किसीसे मदद माँगी थी? कोणाजवळ हे सांगितले का, मदत मिळवण्यासाठी ? हे थांबवण्यासाठी तुम्ही कोणाची मदत मागितली होती का?	YES हा हो <input type="checkbox"/> 1 NO नहीं नाही <input type="checkbox"/> 2	→ 722 → 723
722	Who did you tell or from whom have you sought help? किससे मदद माँगी थी? कोणाची मदत मागितली होती ? Anyone else? और कोई? आणखी कोणी? RECORD ALL MENTIONED OTHER CAN BE teacher, employer, religious leader बताया गया लिखें, जैसे की - शिक्षक, मालिक, धर्मगुरु इ. सांगितलेले लिहा, जैसे - शिक्षक, मालिक, धर्मगुरु वगैरे.	MOTHER/FATHER आई -बाबा / माता-पीता <input type="checkbox"/> 1 MOTHER-IN-LAW/ FATHER-IN-LAW सास -ससुर / सासू -सासरे <input type="checkbox"/> 2 OTR FEMALE RELATIVE/IN-LAW <input type="checkbox"/> 3 ससुरालवाली कोई महिला OTR MALE RELATIVE/ IN-LAW <input type="checkbox"/> 4 ससुरालवाला कोई पुरुष FRIEND/NEIGHBOUR <input type="checkbox"/> 5 सहेली या पडोसी / मैत्रिण किंवा शेजारी DOCTOR/MEDICAL PERSONNEL <input type="checkbox"/> 6 डॉक्टर / आरोग्य सेवक WOMEN'A SUPPORT GROUP <input type="checkbox"/> 7 महिला संघटना POLICE / पुलिस/ पोलिस <input type="checkbox"/> 8 OTHER - SPECIFY <input type="checkbox"/> 9 अन्य बतलाएँ / सांगा	AT LEAST ONE 'YES' GO TO 724

723	<p>What is the main reason you have NEVER sought help?</p> <p>क्यों आपने किसीसे मदद नहीं माँगी थी? कोणाचीही मदत न घेण्याचे कारण काय?</p>	<p>DON'T KNOW WHO TO GO TO <input type="checkbox"/>1 कहाँ जाएँ पता नहीं</p> <p>NO USE / उपयोग नहीं <input type="checkbox"/>2</p> <p>PART OF LIFE (DESTINY) जीवन में ऐसा होताही है <input type="checkbox"/>3</p> <p>AFRAID OF DIVORCE/DESERTION <input type="checkbox"/>4 डर है छोड़ देगा या तलाक देगा</p> <p>AFRAID OF FURTHER BEATINGS <input type="checkbox"/>5 डर है और मारेगा</p> <p>AFRAID OF GETTING PERSON BEATING HER INTO TROUBLE <input type="checkbox"/>6 डर है जो मदद करेंगे उन्हे परेशानी होगी</p> <p>EMBARRASSED / घबराहट / घाबरते <input type="checkbox"/>7</p> <p>DON'T WANT TO DISGRACE FAMILY..... <input type="checkbox"/>8 परिवार को अपमानित नहीं करना</p> <p>OTHER – SPECIFY / अन्य बतलाएँ / सांगा <input type="checkbox"/>9</p>	
724	<p>As far as you know, did your father ever beat your mother?</p> <p>जहाँ तक आपको मालूम हैं क्या आपके पिताने आपकी माँको कभी पीटा था? तुमच्या माहितीप्रमाणे तुमच्या बाबांनी तुमच्या आईला कधी मारले होते?</p>	<p>YES हा हो <input type="checkbox"/>1</p> <p>NO नहीं नाही <input type="checkbox"/>2</p> <p>DON'T KNOW नहीं मालूम माहित नाही <input type="checkbox"/>3</p>	

I am really grateful for the time you have given us. This research is expected to improve life for victims of domestic violence. I have asked you many questions and have taken up your valuable time but I might have failed to ask you something that is very important to you and this research. If that is the case I would be happy if you could share that with me. (MAKE NOTES OF ANYTHING SHE SAYS BELOW).

मैं सही में आपकी आभारी हूँ, जो आपने मुझे इतना समय दिया। इस संशोधन से आशा है कि अत्याचार से पिडीतों के जीवन में सुधार आए। मैंने आपसे कई सवाल पूछे और आपका मुल्यवान समय लीया, पर कुछ ऐसी बात है जो मैंने पूछी नहीं पर इस संशोधन या प्रबंध और आपके लिए वह महत्वपूर्ण है, ऐसा हो तो कृपया आप बतायें। मुझे खुशी होगी। (अगर वह कुछ बतायें तो लीख लें।)

खरोखरच मी तुमची आभारी आहे. तुम्ही मला इतका वेळ दिलात. या संशोधनातून अपेक्षा आहे की अन्यायग्रस्तांच्या जीवनात सुधारणा होईल. मी तुम्हांला बरेच प्रश्न विचारले आणि तुमचा अमूल्य वेळ घेतला. पण अजूनही काही गोष्टी अशा असतील ज्या मी विचारण्याच्या राहिल्या, त्या तुमच्या दृष्टीने आणि या संशोधनाच्या / प्रबंधाच्या दृष्टीने महत्वाच्या असतील तर तुम्ही त्या मला जरूर सांगा. मला आनंदच वाटेला. (काही सांगितल्यास लिहून घ्या.)

IF WOMAN HAS ADMITTED TO DV YOU MAY NEED TO TAKE HER NAME AND ADDRESS:

In view of what you have shared with me there might be information that needs to be followed up. If that were the case would you agree to call you and meet with me at a time and place that is mutually convenient and safe for us?

अगर कीसी स्त्री ने पारिवारीक अत्याचार और झगडोंका सामना किया है, तो स्त्री का नाम और पता लीखें।

आपने मुझे जानकारी दी अगर आप उसके बारे में कुछ आगे बताना चाहें तो हम दोबारा ऐसी जगह मिल सकते हैं जहाँ सुरक्षित और आसान हो।

जर कोणत्या महिलेवर कौटुंबिक अन्याय व अत्याचार होत असेल तर तिचे नांव व पत्ता लिहून घ्या. तुम्ही मला जी माहिती दिली त्याबद्दल अजून काही पुढे सांगायचे असेल तर आपण सुरक्षित आणि सोईच्या ठिकाणी पुन्हा एकदा भेटू.

TAKE DOWN NAME AND ADDRESS / नाम और पता लीखें / नांव व पत्ता लिहा

FINISH BY SAYING: धन्यवाद दे कर समारोप करें।

Thank you again for answering my questions. Please know that whatever you share with me will be treated anonymously.

हमारे सारे सवालों के जवाब देने के लिए धन्यवाद। आपकी जानकारी और पहचान गुप्त रखी जाएगी।

माझ्या सर्व प्रश्नांची उत्तरे दिल्याबद्दल आभारी आहे. तुम्ही दिलेली माहिती व तुमचे नांव गुप्त ठेवण्यात येईल.