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Health consequences of violence within marriage: Need for strengthening the health sector response



Marital violence in India is a serious issue and an accepted practice. The most recent estimates show that as many as 35 percent of married women aged 15–49 had experienced physical violence and 10 percent had experienced sexual violence perpetrated by their current or former husband over the course of their married life (IIPS and Macro International, 2007). Policies and programmes have increasingly focused on preventing violence against women and supporting women who experience such violence. For example, the Protection of Women from Domestic Violence Act 2005, passed in 2006, adopts a broad definition of domestic violence, and provides for immediate and long-term relief to women in situations of violence of any kind in the home.

While the prevalence of violence within marriage is well documented in India, evidence of the adverse consequences of marital violence for women's health and well-being remains sparse and scattered. As a result, services that address the needs of women who have experienced marital violence are limited.

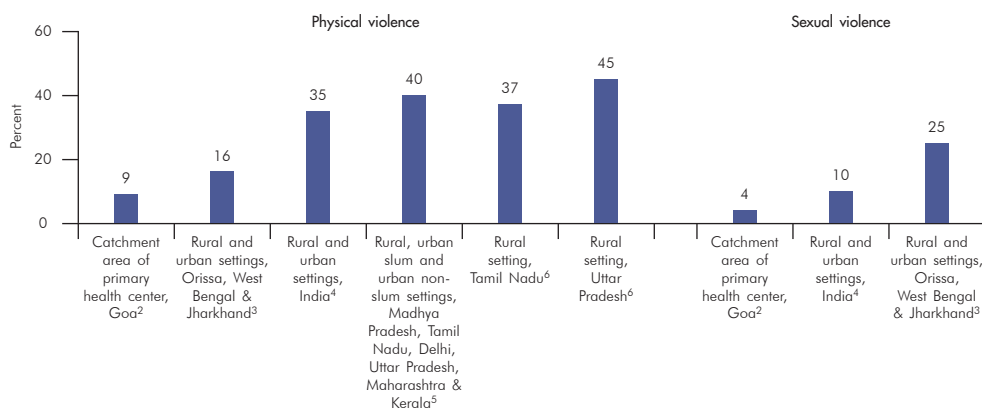
This policy brief provides a synthesis of available evidence of the magnitude of marital violence experienced by women, including married young women, in India, and the ways in which the experience of physical and sexual violence within marriage compromises health, with a focus on sexual, reproductive and child health, as well as mental health. It argues for strengthening the health sector response to address the needs of women who have experienced marital violence.

Evidence comes from an extensive review of over 25 published and unpublished studies on violence within marriage in India. This evidence is supplemented by further analyses of data from 3 major survey exercises on the situation of youth in India that enable us to link the experience of physical and sexual violence in marriage with a range of health outcomes.

Violence within marriage is common, including among the young

Evidence indicates that between one-tenth and half of women surveyed in various

Figure 1: Magnitude of lifetime experience of physical and/or sexual violence within marriage among women aged 15–50



studies had experienced physical violence, and between one in twenty and one in four women had experienced sexual violence perpetrated by their husband.¹

Sizeable proportions had experienced physical and/ or sexual violence even when they were pregnant—between one in 20 and half in the case of physical violence and between one in twenty and one in three in the case of sexual violence.¹

Among young women, studies have shown that 21–56% had experienced physical violence and 11–56% had experienced sexual violence within marriage.¹ Indeed, the experience of marital violence begins early in married life. Findings from one

study show that 10% of young women had experienced physical violence and 27% had experienced forced sex from early on in married life.¹⁴

Health consequences of marital violence

Adverse consequences of marital violence have been reported in a number of studies. They highlight, moreover, that many of these associations are observed early in marriage, suggesting that women are at risk of ill-health for much of their married life. Many studies have shown strong associations between women’s experience of marital violence and adverse health outcomes, even after controlling for a range of socio-demographic background variables.

Figure 2: Magnitude of physical and/or sexual violence during pregnancy

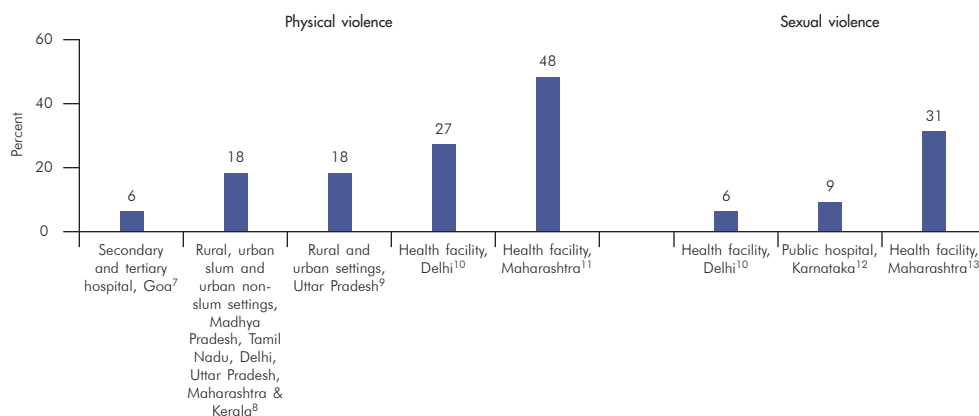


Figure 3: Magnitude of lifetime experience of physical and/or sexual violence within marriage among young women aged 15–24

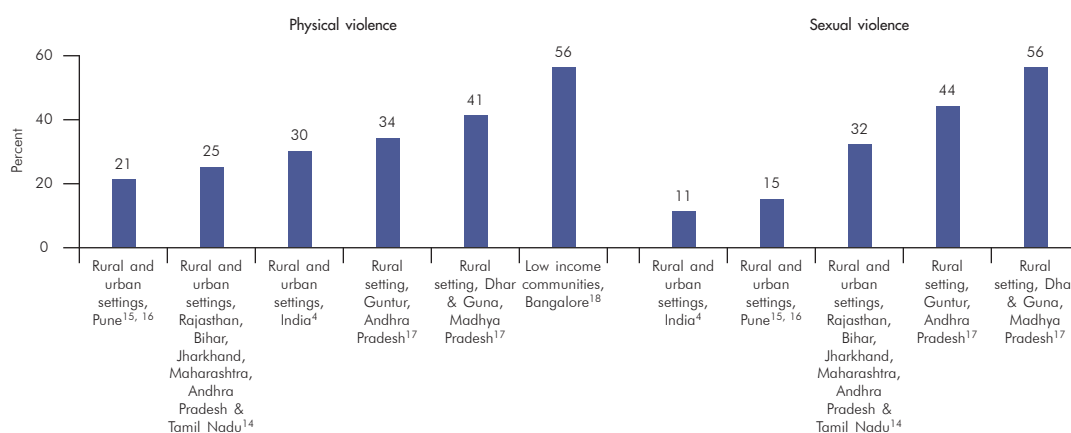
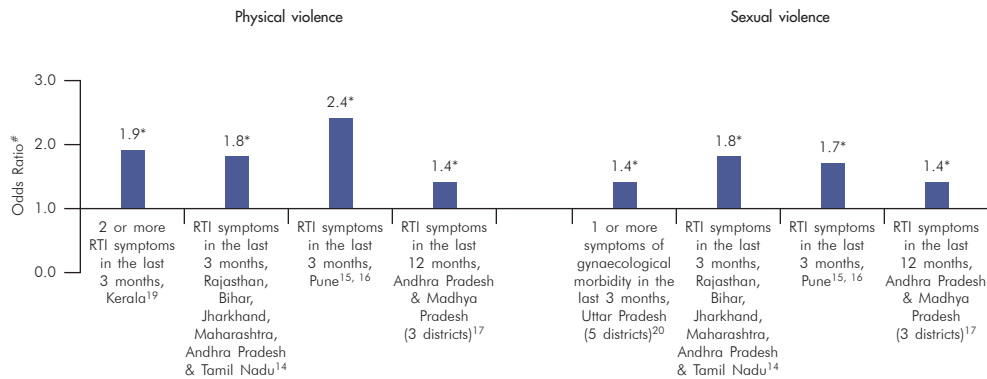


Figure 4: Association between marital violence and experience of symptoms of RTI/STI



*Odds ratios greater than 1 suggest the extent to which women who experience marital violence are more likely than those who have not to also experience a particular outcome after controlling for socio-demographic factors; conversely, odds ratios less than 1 suggest the extent to which they are less likely to experience a particular outcome.^a

^aStatistically significant at .05 level or better, after controlling for the effects of a range of socio-demographic factors.

Marital violence is positively associated with reproductive tract infections (RTI)/sexually transmitted infections (STI) and other gynaecological morbidity

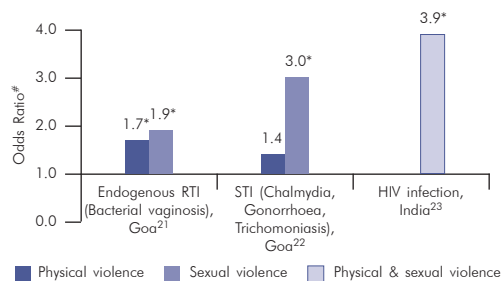
A number of studies show that women who had experienced physical violence in marriage were up to two and a half times more likely, and those who had experienced sexual violence up to 80% more likely than those who had not experienced violence to report symptoms of infection (See Figure 4).

Studies that explored the links between marital violence—physical and sexual—and clinically or laboratory detected RTI/STI and HIV have also shown a clear association (see Figure 5). For example, women who had experienced physical and sexual violence were 70% and 90% more likely, respectively, than those who had not experienced such violence, to be diagnosed with endogenous infections such as bacterial vaginosis.²¹ Another study showed that the experience of sexual violence within marriage resulted in a threefold increase in women’s risk of acquiring STIs.²² And a third study showed that women who experienced both physical and sexual violence were almost 4 times more likely than those who did not experience any violence to be HIV infected.²³

Marital violence increases the risk of pregnancy-related complications and compromises care seeking

The experience of marital violence also has consequences for women’s pregnancy related experiences. Studies have shown that women who experienced physical violence were less likely than those who did not to seek antenatal care or were more likely to delay seeking antenatal care. Evidence from young women in one study suggests that those who experienced physical or sexual violence were, respectively, 40% and 70% more likely

Figure 5: Association between marital violence and experience of clinically/laboratory detected RTI/STI



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^aStatistically significant at .05 level or better, after controlling for the effects of a range of socio-demographic factors.



than those who did not experience violence to report pregnancy-related complications.¹⁷

Physical violence within marriage elevates chances of experiencing foetal, infant and early childhood mortality

Women who experienced physical violence in marriage were up to one-and-a-half times more likely than women who did not to have experienced foetal mortality, two to two-and-a-half times more likely to have experienced perinatal mortality, and one-and-a-half to two times more likely to have experienced neonatal mortality (See Figure 6). At the same time, while there are just a few studies, their findings show that both infant and early childhood mortality are significantly higher—10–20% higher—among women who have experienced physical violence within marriage than among those who have not so experienced (See Figure 7). No such association was,

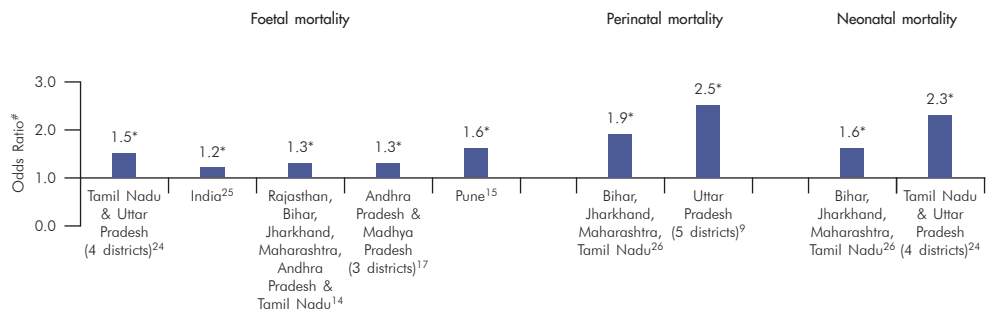
however, observed with the experience of sexual violence.

Unwanted pregnancy and induced abortion are more likely to be reported by women who experience marital violence

Unwanted pregnancy is also more likely among women—including the young—who experience marital violence than other women. While the strength of effects varied across studies, by and large, studies suggest that women who experienced physical and/or sexual violence in marriage were 20–70% more likely than those who did not to report an unwanted pregnancy, although some studies have found that they were 2–3 times more likely to have so experienced (See Figure 8).

Information on the relationship between the experience of marital violence and induced abortion comes from studies of young

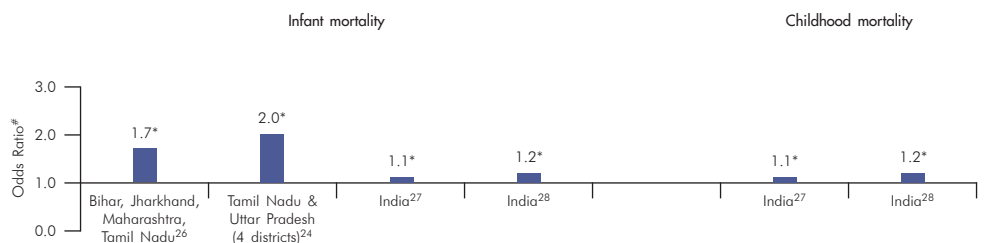
Figure 6: Association between physical violence within marriage and foetal, perinatal and neonatal mortality



[#]Odds ratios greater than 1 suggest the extent to which women who experience marital violence are more likely than those who have not to also experience a particular outcome after controlling for socio-demographic factors; conversely, odds ratios less than 1 suggest the extent to which they are less likely to experience a particular outcome.^a

^{*}Statistically significant at .05 level or better, after controlling for the effects of a range of socio-demographic factors.

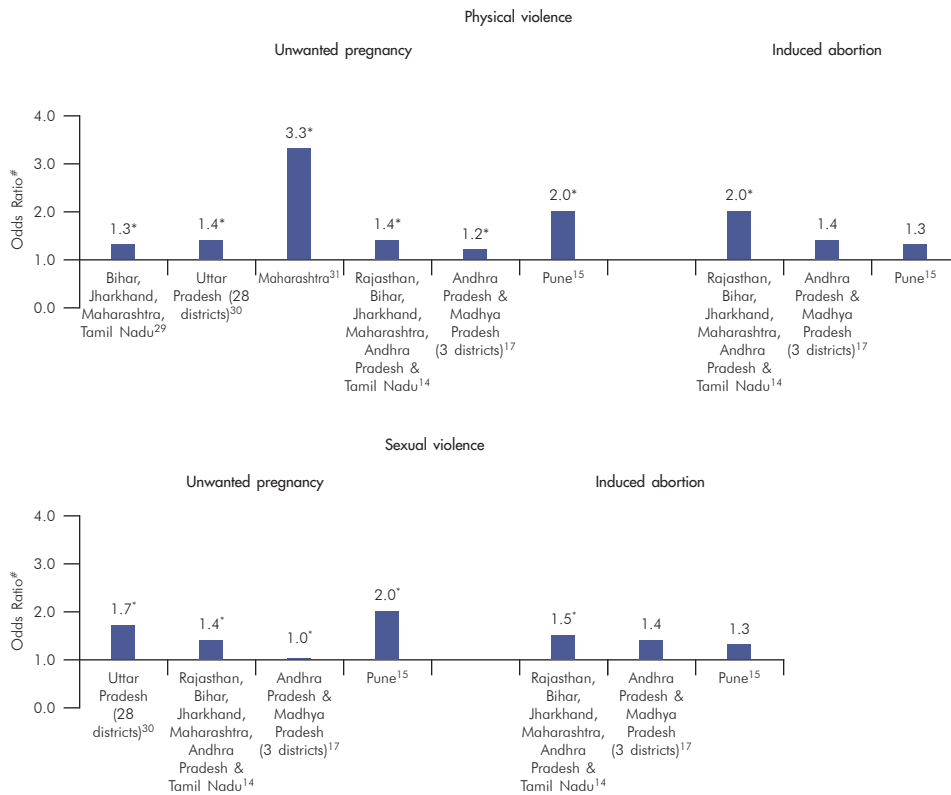
Figure 7: Association between physical violence within marriage and infant and early childhood mortality



[#]Odds ratios greater than 1 suggest the extent to which women who experience marital violence are more likely than those who have not to also experience a particular outcome after controlling for socio-demographic factors; conversely, odds ratios less than 1 suggest the extent to which they are less likely to experience a particular outcome.^a

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Figure 8: Association between marital violence and experience of unwanted pregnancy and abortion



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*Statistically significant at .05 level or better, after controlling for the effects of a range of socio-demographic factors.

women. In one study of young women, those who experienced physical and sexual violence, respectively, were twice as likely as and 50% more likely than other women to have had an induced abortion.¹⁴

While evidence concerning the association with contraceptive practice was not as consistent, studies among married women of all ages do reiterate that marital violence compromised women's access to contraception.

Marital violence affects the nutritional status of women and children

A study using NFHS-3 data showed that compared to women who did not experience violence, those who experienced physical violence were 27% more likely to be severely anaemic. Moreover, their

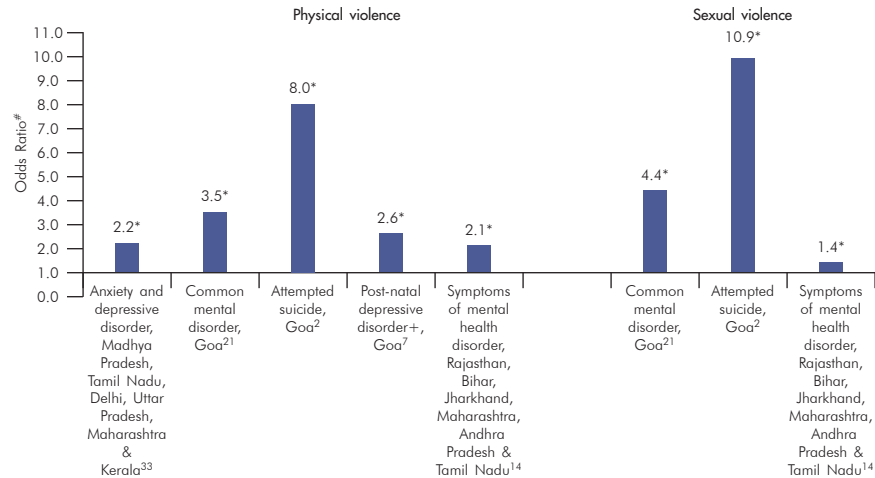
children were 18% more likely to experience wasting, 14% more likely to be stunted and 34% more likely to be severely underweight.³²

Women who experience marital violence tend to report poor mental health status

Findings also suggest that the experience of physical and sexual violence is positively correlated with the experience of symptoms or behaviours suggestive of mental health disorders. For example, studies find that, compared to women who did not experience physical violence in marriage, those who have done so are twice as likely to display symptoms of anxiety, and almost three times as likely to display post-natal depression. Symptoms of common mental disorders were 3.5 and 4.4 times more likely to be reported by those who



Figure 9: Association between marital violence and mental health outcomes



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^{*}Statistically significant at .05 level or better, after controlling for the effects of a range of socio-demographic factors.

[†]Physical or sexual violence.

experienced physical and sexual violence, respectively, than those who had not done so. Even among young women, those who experienced physical violence were twice as likely as, and those who experienced sexual violence 40% more likely than those who had not to report 3 or more symptoms suggestive of mental health disorders (See Figure 9).

Attempted suicide was, in addition, considerably more likely to be reported by those who had experienced marital violence than other women: Indeed, one study found that women who experienced physical violence were 8 times more likely and those who had experienced sexual violence 11 times more likely, to have attempted suicide than other women.²

Why are we seeing these relationships?

A number of explanations, biological and socio-cultural, may be offered for the consistent link observed between marital violence and indicators of ill-health:

- Trauma caused physical and sexual violence may result in gynaecologic morbidity.
- Sexual violence may cause vaginal or urethral trauma that may exacerbate

women's risk of acquiring an infection.

- Marital violence in pregnancy may lead to foetal injury, pre-term delivery or stillbirth and provoke serious uterine bleeding.
- The experience of violence fosters a loss of self-esteem and feelings of helplessness and isolation that may result in poor mental health outcomes.
- Abused women are less likely than others to be able to communicate or negotiate with the husband on contraception and condom use and therefore more likely to face unmet need for contraception.
- They may lack the decision-making power, control over resources or the social support necessary to adopt protective actions for themselves and their children, resulting in, for example, limited contraception, difficulty in accessing timely pregnancy-related services or ensuring prompt newborn and child health services, and inability to ensure adequate nutrition for themselves and their children.
- Poor mental health outcomes may also affect women's ability to care for themselves and their children.
- Compromised ability to care for themselves and their children may result in low birth weight and pre-term

delivery, which are well-known risk factors for perinatal and infant mortality.

- Men who perpetrate violence on their wife may also have other characteristics—risky extra-marital sex, non-use of condoms, experience of symptoms of infection—that place their wife at risk of infection.

Programme recommendations

Findings underscore the urgent need to strengthen efforts to prevent the incidence of marital violence. At the same time, given the widespread prevalence of marital violence, there is an urgent need, in the shorter term, to strengthen the health sector's response to marital violence.

Screen and refer women who experience marital violence

Women who experience marital violence may not always disclose the experience when they seek health care services. A top priority is therefore to screen and identify women who experience marital violence. Service protocols must be prepared that include violence screening while recording the regular history of women seeking health care services. Women who have experienced marital violence and attend a particular service may have health and other needs as well that the first point of contact is not equipped to address. It is important, therefore, that screening activities are linked with appropriate referral chains, including to services outside the health arena, for example, legal support, shelter and so on. Given that many abused women may not follow-up on referrals recommended by their primary provider, sensitive outreach activities must be included that support women to access these services.

Screening activities must be provided in a wide range of services

Women in need of care for adverse health consequences of marital violence may seek a number of services and it would be appropriate to establish screening mechanisms in all such services. For example, the immediate physical consequences of marital violence—abdominal/thoracic injuries, lacerations,

fractures and burns—call for screening activities in emergency (casualty) services in general, as well as burns and orthopaedic-related centres.

As most women visit a health centre at some point in their life for reproductive and child health services, these centres could serve as an important focal point to identify women who experience marital violence. Indeed, our findings call for the integration of violence screening in all sexual, reproductive and child health services, including safe motherhood and child survival programmes, VCTC and other HIV-related services. Moreover, findings highlighting the links between marital violence and adverse mental health outcomes emphasize that the National Mental Health Programme must incorporate a special focus on identifying and treating women who experience marital violence.

Address provider level barriers

Key provider level barriers include providers' lack of training on eliciting information and counselling women on gender-based violence, lack of time to provide related services, and providers' discomfort about communicating on the sensitive issue of marital violence with women. Training is needed to strengthen providers' skills in probing women's experiences sensitively, referring them appropriately and maintaining their confidentiality; at the same time, efforts must be made to change provider perceptions that marital violence is "normal" and a family affair, and that providers should not intervene in domestic matters. ASHAs and Integrated Child Development Services (ICDS) workers should be made aware of the links between marital violence and health and survival outcomes for women and children, and trained to support women experiencing marital violence. Finally, health care providers must be made aware of the laws surrounding violence against women and the sources of support available to women from sectors other than health (access to the police, the legal system, shelter, and NGOs, for example).



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^a For example, an odds ratio of 1.8 would suggest that women who have experienced violence are 80% more likely than other women to report a particular outcome; an odds ratio of 0.6 would suggest that they are, conversely, 40% less likely to experience a particular outcome.

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