

Chapter 5

Health Consequences Of Domestic Violence

5.1: Introduction

The largely hidden health consequences of violence against women take a heavy toll on the well-being of women. The resulting morbidity and sometimes mortality result in both tangible and intangible losses to their families and communities and to the society. Domestic violence poses a direct threat to women's health (Heise *et al.* 1994a) and also has adverse consequences for other indicators of women's and children's health and well-being. Several reviews of the literature (Heise *et al.* 1999; Campbell 2002) emphasize the linkages between the experience of domestic violence and both fatal and nonfatal outcomes for women and their children. Table 5.1 presents a list of health consequences of violence against women, reflecting about the range and depth of several health problems.

Among the mental health problems found to occur more frequently among women experiencing violence are higher rates of depression, posttraumatic stress, and eating disorders. Poor physical health among abused women manifests as chronic conditions including chronic pain, injuries, gastrointestinal disorders, and generally poor health status among others. Abused women's reproductive health is also compromised through much higher rates of gynecological problems like vaginal bleeding, urinary tract infections, pelvic pain and be diagnosed with uterine fibroids, cervical neoplasia, HIV and sexually transmitted infections (STIs), miscarriages, abortions, unwanted pregnancy, and low birth weight. Also noted in the literature are trauma injuries including sprains, fractures, burns, concussions and injuries requiring surgery such as splenic and liver trauma (Campbell *et al.* 2002).

It is evident that the impact of domestic violence on women's health is devastating. While literature suggests that negative health outcomes are far reaching and numerous, our understanding of these women's health issues is limited. Malnutrition is the leading risk factor for mortality in the world, contributing to nearly 12 percent of all deaths and 16 percent of all disability-adjusted life years lost globally (Murray 1997).

Table 5.1: Health consequences of violence against women.

NON FATAL OUTCOMES

Physical health outcomes

- **Injury (from lacerations to fractures and internal organs injury)**
- **Unwanted pregnancy**
- **Gynaecological problems**
- **STDs including HIV/AIDS**
- **Miscarriage**
- **Pelvic inflammatory disease**
- **Chronic pelvic pain**
- **Headaches**
- **Permanent disabilities**
- **Asthma**
- **Irritable bowel syndrome**
- **Self-injurious behaviours**
- **smoking, unprotected sex**

Mental health outcomes:

- **Depression**
- **Fear**
- **Anxiety**
- **Low self-esteem**
- **Sexual dysfunction**
- **Eating problems**
- **Obsessive-compulsive disorder**
- **Post traumatic stress disorder**

FATAL OUTCOMES

- **Suicide**
- **Homicide**
- **Maternal mortality**
- **HIV/AIDS**

Source: "Violence against Women", WHO Consultation, 1996

Nutritional anemia results from inadequate availability of micronutrients required for hemoglobin synthesis, accounting for 841,000 deaths and 35,057,000 disability-adjusted life years lost annually, predominantly in low-income countries (Stoltzfus 2003). The burden of chronic malnutrition falls disproportionately on developing countries, including India. In 1998–1999, anemia afflicted 74 percent of children and 52 percent of women of childbearing age in India, while 47 percent of children and 36 percent of women of childbearing age were underweight (IIPS NFHS-3 2007). Recent estimates suggest that prevalence of underweight remains virtually unchanged (46 percent for children, 33 percent for women of childbearing age), while anemia increased (79 percent for children, 57 percent for women of childbearing age) (IIPS NFHS-3 2007). Although biomedical and socioeconomic risk factors for malnutrition in India are well known (Stoltzfus 1998, Subramanian *et al.* 2007, Kumar 2005),

the role that psychosocial factors play in anemia and underweight is less understood. Exposure to domestic violence is a psychosocial factor that may be associated with anemia and underweight for women as well as their children. Domestic violence increases psychological stress among Indian women (Vizcarra 2004). Psychological stress increases oxidative stress and metabolic levels risk factors for anemia and underweight (Epel 2004). Domestic violence could also increase the risk of poor nutritional outcomes through environmental circumstances such as the withholding of food by abusive family members (Raj 2006).

The effects of violence on a victim's health are far-reaching and devastating. Women who are battered may suffer from a variety of medical problems, from depression to chronic pain; they may also be at an increased risk of sexually transmitted infections (STIs) or unplanned pregnancies. They may need to miss significant amounts of work due to medical problems. Domestic violence may be fatal. Worldwide, 40-70% of all female murder victims are killed by an intimate partner. Victims of domestic violence are more likely to commit suicide. Domestic violence also contributes to other forms of violence against women; women who experience violence at home may be more willing to look for and accept an uncertain and potentially risky job abroad, placing them in danger of being trafficked. Domestic violence also has significant consequences for children, family, friends, co-workers, and the community. Family and friends may themselves be targeted by the abuser in retaliation for helping a woman leave a violent relationship or find assistance. Children in homes where domestic violence occurs may be witnesses to abuse, may themselves be abused, and may suffer harm "incidental" to the domestic abuse.

The effects of violence on a victim's health are severe. In addition to the immediate injuries from the assault, battered women may suffer from chronic pain, gastrointestinal disorders, psychosomatic symptoms, and eating problems. Although psychological abuse is often considered less severe than physical violence, health care providers and advocates around the world are increasingly recognizing that all forms of domestic violence can have devastating physical and emotional health effects. Domestic violence is associated with mental health problems such as anxiety, post-traumatic stress disorder, and depression. Women who are abused suffer an increased risk of unplanned or early pregnancies and sexually transmitted diseases, including HIV/AIDS. As trauma victims, they are also at an increased risk of substance abuse. According to a U.S. study, women who experience intimate partner abuse are three times more likely to have gynecological problems than non-abused women. Women are particularly vulnerable to attacks when pregnant, and thus may

more often experience medical difficulties in their pregnancies. Recent research has called for increased study of pregnancy associated deaths. "Pregnancy associated deaths" are "deaths occurring to women who have been pregnant within the previous year." A study conducted by researchers in Maryland of 247 pregnancy associated deaths found that the leading cause of death was homicide. The researchers have called for "enhanced surveillance" of pregnancy associated deaths and additional research focusing more specifically on the role of domestic violence (Lemon 2001). Other studies have shown that there are significant obstetric risk factors associated with domestic violence. Abused women are more likely to have a history of sexually transmitted disease infections, vaginal and cervical infections, kidney infections and bleeding during pregnancy, all of which are risk factors for pregnant women. Abused women are more likely to delay prenatal care and are less likely to receive antenatal care. In fact, domestic violence during pregnancy may be a more significant risk factor for pregnancy complications than other conditions for which pregnant women are routinely screened, such as hypertension and diabetes.

In many countries, marriage is believed to grant men unconditional sexual access to their wives, and to permit the use of violence if their wives do not comply. Women's lack of sexual autonomy in these situations puts them at risk of unwanted pregnancies and sexually transmitted infections. Recent research in Nicaragua, for example, suggests that domestic abuse increases the likelihood that women will have many children and found that abused women were twice as likely to have four or more children.

Although biomedical and socioeconomic risk factors for malnutrition in India are well known (WHO 2001a, Stoltzfus 1998; Subramanian 2006, 2007), the role that psychosocial factors play in anemia and underweight is less understood. Exposure to domestic violence is a psychosocial factor that may be associated with anemia and underweight for women. Domestic violence increases psychological stress among Indian women (Kumar *et al.* 2005; Vizcarra *et al.* 2004). Psychological stress increases oxidative stress (Epel *et al.* 2004; Hapurachchi *et al.* 2003) and metabolic levels (Seematter *et al.* 2000), risk factors for anemia and underweight. Domestic violence could also increase the risk of poor nutritional outcomes through environmental circumstances such as the withholding of food by abusive family members (Raj *et al.* 2006). Thus data on the nutritional status of women can provide a summary measure of women's general health. Malnutrition is the leading risk factor for mortality in the world, contributing to nearly 12 percent of all deaths and 16 percent of all disability-adjusted life years lost globally (Murray 1997) and one third of all disability-adjusted life years lost in low-income countries (Mason 2003). Compromised nutritional

status, especially in the form of being extremely underweight or obese, is not only a risk factor for diseases such as hypertension and diabetes, but is also hypothesized as one of the many adverse health outcomes of having experienced violence (Heise *et al.* 1999). Anemia is a risk factor for a number of health outcomes, including poor cognitive development, weakened resistance to infection, maternal mortality, pre- and perinatal loss, stunting, and endocrine disruption (WHO 2001). Nutritional anemia results from inadequate availability of micronutrients required for hemoglobin synthesis, accounting for 841,000 deaths and 35,057,000 disability-adjusted life years lost annually, predominantly in low-income countries. Underweight due to energy deficiency, another form of chronic malnutrition, is associated with poor birth outcomes, inability to breastfeed, suppressed immune function, and elevated risk of death in women (Shetty 1994). Underweight among children annually accounts for 3,748,000 deaths and 9.5 percent of all disability-adjusted life years lost worldwide (Rodgers 2004).

Thus, in this chapter we examine how several different demographic and health outcomes for women vary by women's experience of domestic violence. With the objective measures of anemia and underweight, we investigated the extent to which domestic violence predicts the likelihood of being malnourished among women in India. BMI and anemia are affected by many variables including age of the women, number of children, parity, and access to health care or antenatal care, poverty, education rural residence and HIV/AIDS or any other chronic disease. These confounders would have impact and hence the simple bivariate association without these confounders of domestic violence and BMI and anemia needs to be examined cautiously as the associations are masked by the effect of these confounders. We examine women's physical health through two measures of nutritional status: body mass index (BMI) and anemia status. Women's reproductive health is also discussed in this chapter. Indicators of women's reproductive health include measures of women's fertility and their ability to have only the children they want and when they want them, prevalence of HIV and self-reported prevalence of STIs. NFHS-3 survey did not collect information on any measures of mental health for women.

5.2 Measures of Women's Nutritional Status

The Body Mass Index (BMI) is an important measure of women's nutritional status and is based on a woman's weight in relation to her height (Shetty and James 1994). The BMI is defined as weight in kilograms divided by the height in meters squared (kg/m^2). Three categories of malnourishment as per WHO are defined: a BMI of less than 18.5 indicates

underweight; a BMI between 25.0 and 29.9 indicates overweight; and a BMI of 30.0 or higher indicates obesity. While chronic energy deficiency is associated with higher mortality and morbidity, overweight and obesity are known risk factors for many health conditions, including diabetes, heart disease, hypertension, gall bladder disease, and some forms of cancer. Research suggests that the risk of severe obesity is higher among abused women, particularly women who have experienced sexual or nonsexual abuse in childhood (Felitti 1993; Williamson *et al.* 2002). Table 5.2 shows the percentages of women who fall into the different malnourishment categories, according to whether they have experienced violence ever or never.

Table 5.2: Percentage of ever-married women 15-49 who are underweight (BMI<18.5), overweight (BMI 25.0- 29.9), and obese (BMI>30.0) by whether women have experienced violence by their husband ever or never

Forms of violence	Underweight BMI<18.5	Overweight BMI 25.0-29.9	Obese BMI>30.0	Normal weight
Domestic Violence				
Ever experienced	31.4	9.8	2.8	52.8
Never experienced	22.8	14.5	4.5	53.5
Physical violence				
Ever experienced	31.8	9.5	2.8	52.5
Never experienced	23.2	14.3	4.4	53.6
Emotional Violence				
Ever experienced	32.3	9.4	2.6	52.5
Never experienced	24.8	13.4	4.1	53.3
Sexual Violence				
Ever experienced	34.6	8.0	1.8	53.4
Never experienced	25.1	13.3	4.1	53.2

Source: NFHS-3 India 2005-06

It is clear from the table that higher proportion of women who experience violence are underweight (BMI<18.5) as compared to women who never experienced violence. Amongst underweight women almost 32% of women experienced domestic violence as compared to 22.8% who never experienced domestic violence. Similarly 31.8%, 32.3% and 34.6% women who were underweight experienced physical, emotional and sexual violence respectively as compared to 23.2%, 24.8% and 25.1% who never experience physical, emotional and sexual violence respectively. There is a positive association between exposure to domestic violence and malnutrition among women.

Perpetrators of domestic violence often use several types of abuse, such as physical and psychological, to control behavior of their family members (Sethuraman 2006). The withholding of food is a documented form of abuse in Indian households and is likely

correlated with the perpetration of physical violence (Raj 2006). An inadequate diet resulting from this withholding of food through psychological or emotional abuse could mediate the relation between physical domestic violence and nutrient deficiencies that cause anemia and underweight. Additionally, domestic violence is strongly associated with a woman's inability to make decisions for herself and her family, including the choice of types and quantities of food that a woman prepares as she cares for herself and her children (Sethuraman 2006). The second explanation is that the link between domestic violence and nutritional deficiencies may also involve a mediating effect of psychological stress. Women who experience domestic violence tend to have higher levels of psychological stress (Briere 2004)—a relation that has been documented among south Asian women (Fikree 1999).

Table 5.3 shows how the prevalence of anemia varies by violence status of women. Anemia is characterized by a low level of hemoglobin in the blood. Anemia usually results from a nutritional deficiency of iron, folate, vitamin B12, or certain other nutrients. This type of anemia is commonly referred to as iron-deficiency anemia and provides another important measure of malnourishment. Anemia may have detrimental effects on the health of women and children and can become an underlying cause of maternal mortality and perinatal mortality.

Table 5.3: Percentage of ever-married women 15-49 who are anemic by whether women have experienced violence by their husband ever or never.

Forms of violence	Severe Anemia	Moderate Anemia	Mild Anemia	No Anemia
Domestic Violence				
Ever experienced	1.8	15.0	38.4	42.9
Never experienced	1.5	12.0	35.3	46.6
Physical violence				
Ever experienced	1.8	15.3	38.5	43.0
Never experienced	1.5	12.9	35.5	46.3
Emotional Violence				
Ever experienced	1.9	14.9	37.8	42.6
Never experienced	1.5	13.4	36.2	45.7
Sexual Violence				
Ever experienced	1.9	15.3	40.8	40.9
Never experienced	1.5	13.5	36.0	41.8

Source: NFHS-3 India 2005-06

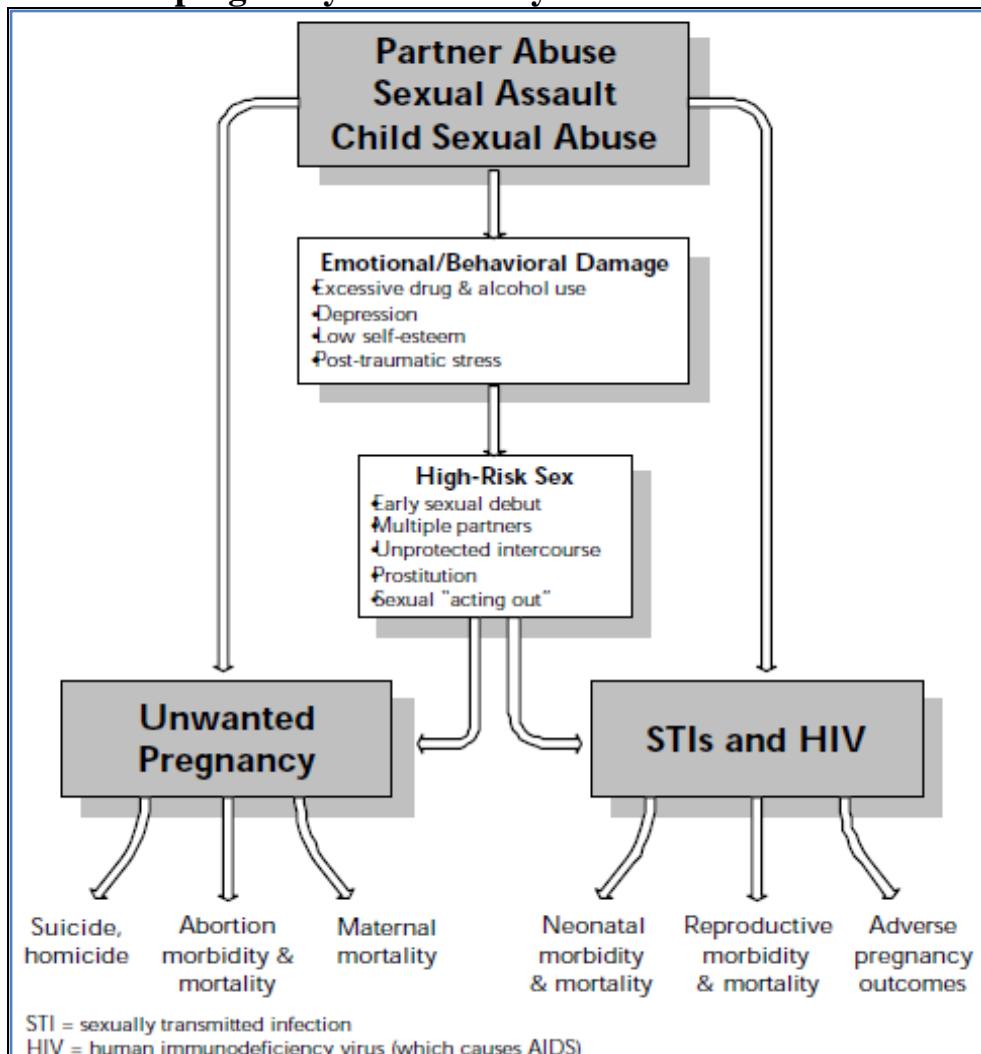
As is seen from the table higher proportions of women are anemic who experience violence as compared to women who never experience violence. 1.8% of severely anemic women experience domestic violence compared to 1.5% who never experience domestic violence. Similarly 15.0% and 38.4% of moderately anemic and mild anemic women

experience domestic violence as compared to 12.0% and 35.3% respectively who never experience domestic violence. Also higher proportion (46.6%) women who never experience domestic violence as compared to 42.9% who ever experience domestic violence are non anemic. The pattern is same for all the forms of violence. Physical violence is experienced by 1.8% severely anemic women as compared to 1.5% who never experienced physical violence. Similarly 15.3% moderately anemic and 38.5% mild anemic women respectively experience physical violence as compared to 12.9% and 35.5% who never experience physical violence. For emotional violence and sexual violence the proportion of women experiencing violence for severe, moderate and mild anemic form is 1.9%, 14.9% and 37.8% and 1.9%, 15.3% and 40.8% respectively. A possible reason why no or only a weak association is found between malnourishment and violence is that the measure of violence being used does not appropriately capture the types of violence that are best known to be associated with obesity. For example, Felitti (1993) found obesity to be positively associated with childhood abuse. However, the measure of violence shown in Table 5.2 and table 5.3 captures only the experience of domestic violence. Any violence by anyone other than the spouse is excluded, thereby effectively excluding childhood abuse of any kind. As already mentioned BMI and anemia are affected by not only experience of domestic violence but also by many variables including age of the women, number of children, parity, and access to health care or antenatal care, poverty, education rural residence and HIV/AIDS or any other chronic disease. These confounders would have impact and hence the simple bivariate association without these confounders of domestic violence and BMI and anemia needs to be examined cautiously hence though domestic violence shows association with BMI and anemia it is masked with the confounding effect.

5.3 Women's Reproductive Health and Domestic Violence

Physical and sexual violence lie behind some of the most intractable reproductive health issues of our times, unwanted pregnancies, HIV and other sexually transmitted infections, and complications of pregnancy. A growing number of studies document the ways in which violence by intimate partners and sexual coercion undermines women's sexual and reproductive autonomy and jeopardize their health. Violence operates through multiple pathways to affect women's sexual and reproductive health (Figure 5.1).

Figure 5.1 Violence against Women: Direct and indirect pathways to unwanted pregnancy and sexually transmitted infections.



Source: Heise et al., 1995

Physical and sexual violence can put women at risk of infection and unwanted pregnancies directly, for example, if women are forced to have sex, or fear using contraception or condoms because of their partners' reaction. A history of sexual violence in childhood also can lead to unwanted pregnancies and STIs indirectly by increasing sexual risk-taking in adolescence and adulthood (Kishor and Johnson 2004). The WHO Multicentre study on domestic violence and women's health highlighted the cross-sectional association between violence and women's sexual and reproductive health including sexual risk behaviors (WHO 2005a). A retrospective cohort study from the US reported that incident STI during pregnancy were significantly associated with history of sexual violence after adjustment for age, ethnicity and marital status (Johnson and Hellertedt 2002). This association of violence and STI/RTI has also been described using data from the National Family Health Survey -2 from Kerala state in southern India (Prasad *et al.* 2005). The

association between violence and STI gains additional significance in light of the findings of a community-based study from southern India that reported low treatment-seeking behavior in women with RTI/STI due to stigma, embarrassment and lack of knowledge (Sudha, Morrison and Zhu 2007). This is a reflection of the low status of women that makes them further susceptible to family violence. Another prospective study from Australia reported an increased risk of abnormal pap smear and vaginal or endo-cervical infection in women reporting intimate partner violence (Quinlivan and Evans 2001). The WorldSafe study conducted in four countries (Chile, Egypt, India and Philippines) reported on the mental health consequences of intimate partner violence and found that violence increased risk of attempted suicide in all the communities studied (Vizcarra *et al.* 2004). Significant proportions of Indian women (e.g., 40% of rural women) report symptoms consistent with STIs (Rani and Bonu 2003). But India (like other regions) has a 'culture of silence' on women's reproductive ill health (Dixon-Mueller and Wasserheit 1991). Symptom reporting and treatment seeking are reduced by lack of awareness of normal physical states, embarrassment, dearth of female health providers, and stigma (Prasad *et al.* 2005). In rural India, few symptomatic women (about 30.9%) seek treatment (Rani and Bonu 2003). This substantial disparity has implications for women's reproductive health including fertility, STIs, and HIV (Prasad *et al.* 2005). Lack of sexual autonomy associated with the experience of domestic violence can have several different fertility-related outcomes, including a large number of births, births that are unwanted and low contraceptive use, especially in relation to expressed need for fertility control (Kishor and Johnson 2004). Each of these outcomes is examined in relation to women's violence status using NFHS-3 data and discussion below.

Fertility

Many studies have found that violence toward women is more common in families with many children (Ellsberg 1999; Jejeebhoy 1998; Martin *et al.* 1999; Tjaden 2000). Researchers have long assumed that having many children increases women's risk of being abused, perhaps by increasing levels of stress within the family or provoking more marital disagreements. Recent research in Nicaragua, however, suggests that the relationship may be the reverse, with domestic violence increasing the likelihood that a woman will have many children. The study found that abused women were twice as likely as other women to have four or more children. But 50% of all physical abuse began within the first two years of the relationship, and 80% began within four years (Ellsberg 1999). The fact that violence preceded having many children suggests that violence is a risk factor for having many

children, rather than a consequence. A large-scale survey among married men in Uttar Pradesh, India, demonstrates directly that forced sex can lead to unintended pregnancies. Men who admitted having forced their wives to have sex were 2.6 times more likely than other men to have caused an unplanned pregnancy (Martin *et al.* 1999).

Using NFHS-3 data, to compare fertility between women who have experienced violence and women who have not, the mean number of children ever born to ever married women by age group and the ever-experience of violence was analysed. Table 5.4 shows that ever-married women age 15-49 that have ever experienced violence have a higher number of children ever born than women who have never experienced violence. Since the likelihood of having ever experienced violence varies by age, table 5.4 also shows the mean number of births by age group. Overall, these data show unequivocally that fertility for women who have experienced violence is higher than that for women who have not. As is clear from table 5.4 the mean number of children born by women who ever experience domestic violence is 3.08 as compared to 2.49 who never experience domestic violence. Similarly the mean number of children born by women experiencing physical, emotional and sexual violence is 3.15, 3.01 and 3.03 as compared to 2.49, 2.64 and 2.67 for women who never experience violence respectively. As per age also the pattern of fertility is higher for women experiencing violence then who never experience violence.

Table 5.4: Mean number of children ever born to ever-married women age 15-49 by age in years, according to whether they have ever experienced violence by their husband or not

Experience of violence by husband	Age Group							Ever married woman 15-49
	15-19	20-24	25-29	30-34	35-39	40-44	45-49	
Domestic Violence								
Ever experienced	0.81	1.77	2.74	3.35	3.71	3.94	4.15	3.08
Never experienced	0.52	1.39	2.18	2.74	3.03	3.25	3.54	2.49
Physical violence								
Ever experienced	0.85	1.82	2.78	3.40	3.78	4.02	4.20	3.15
Never experienced	0.52	1.40	2.20	2.75	3.03	3.26	3.55	2.49
Emotional Violence								
Ever experienced	0.82	1.74	2.71	3.23	3.55	3.79	3.90	3.01
Never experienced	0.58	1.49	2.33	2.91	3.23	3.44	3.72	2.64
Sexual Violence								
Ever experienced	0.73	1.76	2.81	3.34	3.78	4.10	4.19	3.03
Never experienced	0.59	1.50	2.34	2.92	3.23	3.44	3.71	2.67

Source: NFHS-3 India 2005-06

Unwanted pregnancies

Violence against women, especially by their husbands, is a serious public health issue that is associated with physical, reproductive and mental health consequences. Unintended pregnancy, defined as a pregnancy that was not wanted at the time of conception. Nearly one in four women in the United States report experiencing violence by a current or former spouse or boyfriend at some point in her life (Black and Breiding 2008), with adolescents and young adults at highest risk for intimate partner violence (Silverman *et al.* 2001). Studies have highlighted the association between partner violence and unintended pregnancy (Cripe *et al.* 2008). Recent evidence suggests these associations co-occur with reproductive control, i.e., male partners' attempts to control a woman's reproductive choices. Abused women face compromised decision-making regarding, or limited ability to enact, contraceptive use and family planning, including fear of condom negotiation (Stephenson 2007). Women's lack of control over her reproductive health is increasingly recognized as a critical mechanism underlying abused women's elevated risk for unintended pregnancy (Shrier *et al.* 1998). One specific element of abusive men's control that may, in part, explain the association of partner violence with unintended pregnancy is overt pregnancy coercion and direct interference with contraception. Some males use verbal demands, threats and physical violence to pressure their female partners to become pregnant (Lang *et al.* 2007; Miller *et al.* 2007). Reproductive control may also take the form of direct acts that ensure a woman cannot use contraception — birth control sabotage — including flushing birth control pills down the

In many parts of the world marriage is interpreted as granting men the right to unconditional sexual access to their wives and the power to enforce this access through force if necessary (Sen 1999). Women who lack sexual autonomy often are powerless to refuse unwanted sex or to use contraception and thus are at risk of unwanted pregnancies. Women who are pregnant find themselves especially vulnerable to gender-based violence. Surveys of battered women in the Latin American region point to a significant number experiencing beatings during pregnancy. The effects of this violence on these women have been shown to include serious effects on their reproductive health status. According to available studies, women who experience violence during this critical stage in their reproductive life are likely to run twice the risk of miscarriage and four times the risk of having a low-birth-weight baby (Stark *et al.* 1991). These risks are further complicated because most women in developing countries have poor health to begin with due to malnutrition, inadequate health care and the burdens of the gender division of labour. Other pregnancy complications that may be

associated with abuse are pre-eclampsia and premature labour. Around the world, as many as one woman in every four is physically or sexually abused during pregnancy, usually by her partner (Ballard 1998; Curry 1998; El-Zanaty *et al.* 1996; Johnson 1996; Nelson and Zimmerman 1996). Estimates vary widely, however. Within the US, for example, estimates of abuse during pregnancy range from 3% to 11% among adult women and up to 38% among teenage mothers (Curry 1998). Some of this variation is likely due to differences in how the questions were asked, how often, and by whom (Gazmararian 1997).

NFHS-3 collected information from respondents regarding their last pregnancy. The women were asked whether, the last birth given by them was wanted then, wanted later, or not wanted at all. Table 5.5 shows the percent distribution of last birth according to whether mothers have ever experienced violence by husband/partner or not. It is clear from the table that women who have experienced violence are consistently less likely to say that their birth was wanted when it was conceived, compared with women who have never experienced violence.

Table 5.5: Percent distribution of last birth according to whether the mother has ever experienced violence by her husband or not.

Mother's experience of violence by husband	Wanted then	Wanted later	Not wanted at all	Total
Domestic Violence				
Ever experienced	73.5	10.7	15.8	100
Never experienced	80.5	10.2	9.2	100
Physical violence				
Ever experienced	73.5	10.1	16.4	100
Never experienced	80.1	10.5	9.4	100
Emotional Violence				
Ever experienced	71.8	11.2	16.9	100
Never experienced	79.0	10.2	10.7	100
Sexual Violence				
Ever experienced	71.4	11.7	16.9	100
Never experienced	78.7	10.2	11.1	100

Source: NFHS-3 India 2005-06

Almost 73.5% of women reporting domestic violence say that the birth of last child was wanted when it was conceived compared to 80.6% of women who never experienced domestic violence. Also 73.5% of women reporting physical violence say that the birth of last child was wanted when it was conceived compared to 80.1% of women who never experienced physical violence. Similarly 71.8% and 71.4% of women reporting emotional and sexual violence respectively say that the birth of last child was wanted when it was

conceived compared to 79.0% and 78.7% of women who never experienced emotional and sexual violence respectively. The table also clearly brings out the fact that higher proportion of women reporting violence say that they never wanted the last child. Almost 16% of women reporting domestic violence never wanted the last child born as compared to 9.2% who never experienced domestic violence. The trend is same for all the other forms of violence. 16.4%, 16.9% and 16.9% of women reporting physical, emotional and sexual violence respectively say the last child was not wanted as compared to 9.4%, 10.7% and 11.1% of women who never experienced physical, emotional and sexual violence respectively.

Contraceptive Use

The high level of unwanted pregnancies associated with violence hypothesized implies a low level of contraceptive use by women coupled with a high level of need for fertility control. Lower contraceptive use among women who have experienced violence is also suggested by the higher fertility and unwantedness of the last birth, as seen earlier. Further, research on contraceptive use suggests that women are often reluctant to raise the issue of contraception with their partners for fear of reprimand or violence (Bawah *et al.* 1999; Blanc *et al.* 1996). Many women are afraid to raise the issue of contraception for fear that their partners might respond violently (Bawah *et al.* 1999, Blanc *et al.* 1996, Ezeh 1993, Folch-Lyon *et al.* 1981, Fort 1989). In some cultures husbands may react negatively because they think that protection against pregnancy would encourage their wives to be unfaithful. Where having many children is a sign of virility, a husband may interpret his wife's desire to use family planning as an affront to his masculinity (Shedlin 1991). In Kenya some men say that they oppose the use of contraception because they fear it will weaken their control over their wives (Biddlecom 1998). A woman's perception of her husband's attitude toward family planning strongly influences whether or not she will use contraception, according to studies in Ghana, Indonesia, Kenya, the Philippines, and elsewhere (Biddlecom 1997; Ezeh 1993; Lasee and Becker 1997). Across 13 Demographic Health Surveys (DHS) an average of 9% of married women with unmet need for family planning, that is, women who want to avoid pregnancy but are not using any contraceptive method, cite their husbands' disapproval as the principal reason that they do not use contraception (Bongaarts and Bruce 1995). Women often use contraception clandestinely because they fear being beaten or abandoned if they do so openly. If a woman is caught in covert use of contraception, the consequences of undermining male authority can be severe. In Ghana 51% of women and 43% of men agreed

that a husband is justified in beating his wife when she uses a family planning method without his knowledge (Bawah 1999)

For the analysis information on contraceptive use is gathered from currently married women. NFHS-3 collected information on the pattern of contraceptive use and future intention of contraceptive use. Table 5.6 shows the percent distribution of currently married women who have ever experienced domestic violence and never experienced domestic violence, according to pattern of use of contraception. The table shows women according to whether they are currently using contraception or have never used any contraception at all.

Table 5.6: Percent distribution of currently married women who have ever experienced violence and never experienced violence, according to contraceptive use.

Experience of violence by husband	Currently using contraception	Non users
Domestic Violence		
Ever experienced	34.7	34.0
Never experienced	65.3	65.9
Physical violence		
Ever experienced	30.6	29.5
Never experienced	69.4	70.4
Emotional Violence		
Ever experienced	13.4	13.3
Never experienced	86.6	86.7
Sexual Violence		
Ever experienced	7.9	8.2
Never experienced	92.1	91.8

Source: NFHS-3 India 2005-06

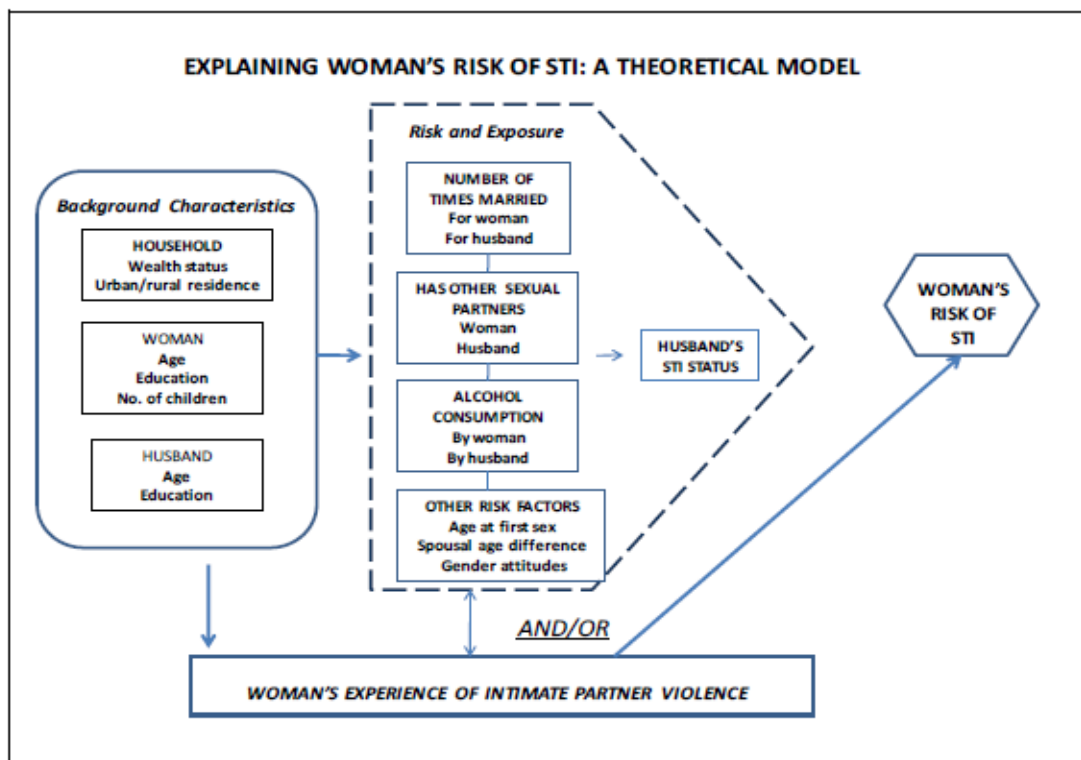
The table clearly brings out that higher percentages of contraceptive users are the women who have never experienced violence. 34.7% of women who report domestic violence use contraceptive methods as against 65.3% of women who do not report domestic violence. Similarly 30.6%, 13.4% and 7.9% women reporting physical, emotional and sexual violence do not use contraception as against higher percentage of 69.4%, 86.6% and 92.1% women use contraception who have never experienced physical, emotional and sexual violence respectively.

Sexually Transmitted Disease (STDs)

An increasing body of research provides evidence that domestic violence is an important correlate of a wide range of adverse reproductive health outcomes for women, including sexually transmitted infections (STIs). However, much of the evidence pertains to the developed world and draws heavily on data from patients at STI clinics or women in domestic violence shelters (Augenbraun, Wilson and Allister 2001), leaving largely

unanswered the question of whether the positive IPV-STI association is equally applicable to women in the general population of developing countries. One of the few exceptions is a study by Kishor and Johnson (2002) that examined the association of IPV and self-reported STD/STI symptoms for a representative sample of ever-married women in Haiti, Dominican Republic, and Cambodia and found that the experience of spousal violence makes it almost twice as likely that ever-married women have had an STI; and that this relationship is not diminished by controlling for wealth or education. The hypothesized positive association of STIs and violence is based on research that finds high rates of forced sex among women who are abused by their male partners, a lesser ability to negotiate and use condoms and access counseling and testing, and a higher prevalence of risky sexual behaviors and drug use among adolescents and adults who were abused as children (Campbell 2002; Campbell and Alford 1989; Cohen *et al.* 2000; Heise *et al.* 1999). Sunita Kishor in her paper (Kishor 2009) provides the theoretical framework depicting the pathways between domestic violence and women’s risk of STIs (Figure 5.2)

Figure 5.2: Theoretical Model depicting pathways between IPV and women’s risk of STIs



Source: Kishor S, 2009

The figure shows that the proximate determinants of a woman’s risk of STIs include factors that affect her exposure to infection, including the STI status of her husband, other

sexual risk factors such as multiple sexual partners, alcohol consumption, spousal age difference, age at first sex, and factors such as spousal age difference that can affect the ability to negotiate sex with husbands. The model also focuses attention on the hypothesis that women's experience of domestic violence is also a key risk factor for STIs among women in the general population and operates independently of other risk and exposure factors. Finally, women's risk of STI will be mediated by the background characteristics of women and men because both domestic violence and the proximate determinants of STIs are likely to vary by these characteristics.

The NFHS-3 survey asks all women who have ever had sexual intercourse whether they had STD in the last 12 months, whether they had a genital sore or ulcer in the last 12 months and whether they had vaginal discharge in last 12 months. Over all a total of 786 women (1.1%) reported of having STD in the last 12 months, 1415 (2.0%) reported having genital sore/ulcer in the last 12 months and 5941 women (8.5%) reported having genital discharge in the last 12 months. Table 5.7 shows how the prevalence of STDs varies by the violence status of women. Almost 54% of women who experienced domestic violence report of having STD in last 12 months as compared to 34.9% of women who never experienced domestic violence. Similarly 49.4%, 25.4% and 14.0% of women report STD in last 12 months who had experienced physical, emotional and sexual violence respectively as compared to 30.6%, 14.0% and 8.3% women who never experienced physical, emotional and sexual violence respectively (table 5.7).

Table 5.7: Percentage of ever-married women who report having an STD in the 12 months preceding the survey, according to whether they have experienced violence by their husband ever or never.

Experience of violence by husband	Percentage who had an STD in the past 12 months
Domestic Violence	
Ever experienced	53.9
Never experienced	34.9
Physical violence	
Ever experienced	49.4
Never experienced	30.6
Emotional Violence	
Ever experienced	25.4
Never experienced	14.0
Sexual Violence	
Ever experienced	14.0
Never experienced	8.3

Source: NFHS-3 India 2005-06

Table 5.8 show the percentage of ever-married women who report having genital sore/ulcer in the 12 months preceding the survey, according to whether they have experienced violence by their husband ever or never. 61.4% of women experiencing domestic violence report genital sore/ulcer as compared to 34.6% who never experienced domestic violence. The pattern is similar for all the forms of violence. Higher proportion of women report genital sore/ulcer who experienced violence compared to women who never experienced violence. 55.3%, 30.8% and 21.5% of women experiencing physical, emotional and sexual violence respectively report genital sore/ulcer respectively as compared to 30.3%, 13.8% and 8.0% who never experienced physical, emotional and sexual violence respectively.

Table 5.8: Percentage of ever-married women who report having genital sore/ulcer in the 12 months preceding the survey, according to whether they have experienced violence by their husband ever or never.

Experience of violence by husband	Percentage who had genital sore/ulcer in the past 12 months
Domestic Violence	
Ever experienced	61.4
Never experienced	34.6
Physical violence	
Ever experienced	55.3
Never experienced	30.3
Emotional Violence	
Ever experienced	30.8
Never experienced	13.8
Sexual Violence	
Ever experienced	21.5
Never experienced	8.0

Source: NFHS-3 India 2005-06

Table 5.9 show the percentage of ever-married women who report having genital discharge in the 12 months preceding the survey, according to whether they have experienced violence by their husband ever or never.

Table 5.9: Percentage of ever-married women who report having genital discharge in the 12 months preceding the survey, according to whether they have experienced violence by their husband ever or never.

Experience of violence by husband	Percentage who had genital discharge in the past 12 months
Domestic Violence	
Ever experienced	55.9
Never experienced	33.1
Physical violence	
Ever experienced	49.8
Never experienced	29.1
Emotional Violence	
Ever experienced	25.4
Never experienced	13.1
Sexual Violence	
Ever experienced	18.4
Never experienced	7.4

Source: NFHS-3 India 2005-06

As is clear from the table higher proportion of women experiencing violence report genital discharge as compared to women who never experience violence. 55.9% of women experiencing domestic violence report genital discharge in past 12 months as compared to 33.1% women who never experienced domestic violence. Similarly 49.8%, 25.4% and 18.4% women report genital discharge that experienced physical, emotional and sexual violence respectively as compared to 29.1%, 13.1% and only 7.4% who never experienced physical, emotional and sexual violence respectively.

The odds of reporting STD, genital sore/ulcer and genital discharge with the exposure of violence are calculated. The OR was significant and equal to 2.20 with 95% confidence interval of 1.91-2.56) of having STD for women reporting domestic violence. Similarly the OR of 3.02 with 95% confidence interval of (2.71-3.37) was also significant of having genital sore/ulcer in last 12 months for women reporting domestic violence. Also the OR of 2.55 with 95% confidence interval of (2.41-2.69) was also significant of having genital discharge in last 12 months for women reporting domestic violence.

5.4 Human Immuno Deficiency Virus (HIV) / Acquired immunodeficiency syndrome (AIDS) and Domestic violence

Human Immuno Deficiency Virus (HIV) / Acquired immunodeficiency syndrome (AIDS) is the epidemic in the latest era of globalisation. It has social and economic effects as it makes sick and dependent and finally kills, those who should be the most productive, caring and thrusting in their societies. The HIV epidemic is widely acknowledged to be a most severe health crisis of modern times. There is no cure and no vaccine. Hence AIDS not only is a leading cause of morbidity and mortality but also involves issues such as sex, drugs and intimate partner relationship. From the beginning epidemiological data indicate that more women are infected than men. In recent years, social scientists have viewed HIV transmission largely through the lens of gender, emphasizing the vulnerability of women (Seidel 1993), a view that would explain findings that in some situations, women with higher socioeconomic status actually may be at increased risk of HIV (Chao 1994).

In the year 2002 at least half of the all the people living with HIV and AIDS worldwide were women and girls. In wealthier countries, men still make up the majority of the HIV infected population. But that's not true in poorer countries. And the worldwide balance is shifting. In 2003, half of all the people newly infected with HIV were women. This gender shift is occurring most rapidly among younger people. Young women and girls make up two thirds of the people under 24 years of age who are living with HIV (Population Reference Bureau 2008).

In India the proportion of AIDS cases among women has more than tripled from 7% in 1985 to 25% in 2001. The fastest growing segment of the population infected with HIV in India is adolescent and adult women. Inadequate knowledge, inability to negotiate safer sex, and powerlessness to abstain from sex or to insist on male condom use make women and girls vulnerable to HIV (UNAIDS 2004). Some are at risk by what they think is an exclusive relationship with their HIV infected partners. The fear of violence can prevent women and girls from getting information, getting tested, or disclosing their HIV status and receiving treatment, even when they know they have been infected. In contrast to the common perception that HIV only affects injecting drug users and gay men, the overwhelming majority of infections in India occur through heterosexual sex. In large numbers of cases, women in monogamous relationships are becoming infected because their husbands have had multiple sexual partners. Women currently account for 39% of HIV infections in India, and it is thought that this figure is rising (UNDP 2006). People living with HIV in India are incredibly diverse, and many would not be considered to be members of 'high-risk groups'.

Epidemiologists' have asserted that the epidemic is heterosexually spread, and women are more vulnerable to HIV. In recent years, social scientists have viewed HIV transmission largely through the lens of gender, emphasizing the vulnerability of women, a view that would explain findings that in some situations, women with higher socioeconomic status actually may be at increased risk of HIV. Why are women at higher risk of HIV infection than men? The answer is part biology, part economics and part culture. This vulnerability is conditioned by a web of factors.

Cultural constructions of gender disempowered women, making it more difficult for them to negotiate sexuality, and legitimize the economic disempowerment of women that makes them more dependent on transactional sex. Culture adds to the risk of HIV when it requires women to be subservient. Many societies expect women to be passive and ignorant when it comes to sex, giving their men control over when and how sex happens. Any deviation from that norm may be punished by violence or the threat of violence or abandonment. Even monogamy will not protect a woman in societies where infidelity among men is permitted, even expected. Disempowerment is a continuum, extending from situations of sexual violence and slavery to more subtle forms of coercion (Ajuwon 2002). Though women are increasingly at risk of HIV transmission, even that risk is often under-reported and under-recognized. The general reasons are that many women are not getting tested, are not aware of risks, do not protect themselves and are not being protected by men. The necessity therefore arises to address women's needs so as to reduce further spread of the infection among the general population.

Biologically, women are more vulnerable to HIV because semen carries more HIV than vaginal secretions do. The folds of the vaginal lining give the virus a large mucosal surface to attack. It also has a longer survival time inside the vagina to do its work. If a man has sex with an HIV positive woman, any virus on the surface of his penis will die when he pulls out and it is exposed to air. But women do not have that relative advantage. Girls and young women are particularly at risk because immature vaginal lining is easily damaged, giving the virus an even easier route into the woman's bloodstream (Women's Studies Research Centre (WSRC) 2005).

Economics is another factor in women's relative vulnerability to the HIV risk because women's financial dependency makes it difficult -- if not impossible -- to say no to unprotected sex. In many places, women get less access than men to education, job opportunities, property and credit. Many are not able to support themselves and their children without the help of a husband or boyfriend. Without enough education and

employment opportunities, a woman may not be able to leave her male partner, even if he is putting her at risk of HIV.

Studies in India reveal a large proportion of women in monogamous marriages are increasingly susceptible to HIV. Studies in India and Africa by Washington, DC, based International Centre for Research on Women (ICRW), identify such critical gender- and sexuality-related factors. Gupta (2000) from ICRW summarises these factors as follows. First, the culture of silence that surrounds sex that dictates that ‘good’ women are expected to be ignorant about sex and be passive, makes it difficult for women to be informed about risk reduction or, even when informed, makes it difficult for them to be proactive negotiating safer sex. Second, the traditional norm of virginity for unmarried girls may paradoxically increase young women’s risk of infection because it prevents them from seeking information regarding protection out of fear that they will be thought to be sexually active. Third, because of the culture of silence that surrounds sex, accessing treatment and services for sexually transmitted diseases can be highly stigmatising for adolescent and adult women. Given such norms, it is not surprising, that studies reveal surprisingly few women have heard of AIDS. Finally, domestic violence service providers may not think to ask whether a woman is experiencing sexual violence in addition to other forms of abuse – and whether she wants to get HIV testing as part of her physical care. They may not think to talk about her sexual risk when they discuss other safety planning issues. But the need is often there.

The link between domestic violence and HIV/AIDS are explained by biological as well as sociocultural and economic factors. Ways in which HIV/AIDS and domestic violence intersects are described below.

D) Direct transmission through sexual violence:

Forced or coercive sexual intercourse with an HIV infected partner is one of the routes of transmission for HIV and sexually transmitted infections (STI) to women. The biological risk of transmission in a violent sexual encounter is determined by type of sexual exposure (vaginal, anal or oral). HIV transmission risk is also generally higher in presence of other STI and with exposure to sexual secretions and/or blood. Risk of transmission is also increased with the degree of trauma vaginal lacerations, and abrasions that occur when force is used. Where sexual violence occurs in girls and young women, risk of transmission is also likely to be higher because girls’ vaginal tracts are immature and tear easily during sexual intercourse. Evidence of direct transmission of STI and HIV following sexual violence is difficult to establish.

II) Indirect transmission through sexual risk taking:

There is growing evidence that the relationship between violence against women and HIV infection in women and girls may be indirectly mediated by HIV risk-taking behaviours. Studies show that women's experience of violence is linked to increased risk-taking including having multiple partners, nonprimary partners (or partnerships outside marriage) or engaging in transactional sex. For example, one study in South Africa showed that women who experienced intimate partner violence were two to three times more likely to engage in transactional sex than women who did not experience violence. Moreover, women who reported transactional sex and had non-primary partners had 1.5 fold higher odds of being HIV infected than those who did not report transactional sex (Dunkle 2004b). Sexual abuse during childhood and forced sexual initiation during adolescence are also associated with increased HIV risk-taking among women. For example, in the U.S.A, several studies show that experience of childhood sexual assault triggers relatively early sexual initiation, anal sex, sex with unfamiliar partners, and low rates of condom use (Maman 2000b). In Nicaragua, one study found that women who were severely sexually abused in their childhood and adolescent years made their sexual debut more than two years earlier and reported a higher number of sexual partners than those who had experienced moderate or no sexual abuse (Olson 2000).

III) Indirect transmission through inability to negotiate condom use:

While the evidence is not conclusive, research suggests that violence limits women's ability to negotiate condom use. For example, in a study from the U.S.A, African-American women who have had physically abusive partners were four times more likely to be verbally abused and nine times more likely to be threatened with physical abuse when they asked their primary partner to use condoms compared to those who did not have abusive partners (Wingood 1997). In a study in South Africa, women who experienced forced sex were found to be nearly six times more likely to use condoms inconsistently than those who did not experience coercion and, in turn, women with inconsistent condom use were 1.6 times more likely to be HIV infected than those who used condoms consistently (Pettifor 2004). On the other hand, another study from South Africa found that women who were physically abused prior to the past year were 1.5 times more likely to ask their current partners to use condoms than women who were not abused (Jewkes *et al.* 2003). Notwithstanding a lack of uniformity of the measures of condom use and violence across the cross sectional studies, it is highly plausible that partner violence is linked to inconsistent or irregular or risky behavior of condom use. Certainly, qualitative data from studies in Uganda, India, and elsewhere indicate

that women find it difficult to suggest or insist on condom use in face of or threat of violence (Go 2003, Human Rights Watch 2003).

IV) Indirect transmission by partnering with riskier/older men:

A review of over 40 studies from sub-Saharan Africa suggests that a significant proportion of adolescent girls have sexual relations with men five to ten years older than themselves (Luke and Kurz 2002). While girls are able to initially choose the older sexual partner, once in the relationship, it is the older men who control the sexual relationship including condom and contraceptive use - in some situations through the use of violence (Luke and Kurz 2002). Emerging evidence from a study conducted among young women (16-23 years) in South Africa suggests that women who have partners older than them (i.e. age difference of three or more years) have 1.6 fold higher risk of being HIV infected and young women with older partners are 1.5 times more likely to experience physical and sexual violence than women with partners in the peer age group (Jewkes 2004). The researchers suggest that partner violence may be a feature of relationships with older men and that age difference between partners increases young women's HIV risk because older men have a much higher prevalence of HIV (Jewkes 2004).

Several studies also highlight that men's use of violence is linked to their own sexual risk behavior taking putting themselves as well as their partner to the risk of STI and HIV. For example, in India, a study shows that men who have extramarital sex are six times more likely to report sexual abuse of their wives than men who remain faithful to their wives. Thus researchers concluded that abusive men were more likely to engage in extramarital sex, acquire STI, and place their wives suggestive that men's proneness to abuse is more likely to be associated with their proneness to extramarital sex and hence becomes associated with higher risk of HIV.

V) Domestic Violence as a consequence of HIV:

Violence or fear of violence has been implicated as a barrier to women seeking HIV testing. In Uganda, research indicates that women were afraid to ask for money or permission from their husbands to attend HIV/AIDS facilities or seek information and in some cases explicitly forbidden from taking HIV tests (Human Rights Watch 2003). Violence or fear of violence has also been implicated as a barrier to disclosure of HIV status among those women who do seek testing. Between 16 - 86 % of women in developing countries choose not to disclose their HIV status to their partners. On the other hand, disclosure of HIV status is considered to be important for ensuring that HIV positive individuals are able to access a range of services including prevention of mother to child transmission (pMTCT), anti-retroviral treatment

(ART), and psychosocial support (WHO 2003). For example, disclosure by HIV positive women to their sexual partners could enable couples to make informed reproductive health choices such as seeking family planning services to reduce unintended pregnancies or it could lead to changes in HIV risk behaviours. Studies on disclosure suggest that for a majority of women, their partners' reaction was sympathetic and understanding. However, between 3 - 15 % women in most studies reported negative reactions including blame, abandonment, anger, and violence. Among those who do not disclose their status, fear of violence is one of the major barriers to disclosure - reported by between 16 - 51 % women in studies from Tanzania, South Africa, and Kenya (Medley *et al.* 2004).

The present research work tried to determine the magnitude of domestic violence and exploring the link between domestic violence and HIV in Indian context. NFHS-3 collected information on the HIV status of women which was merged to the domestic violence module. Table 5.10 shows the percentage of ever-married women according to whether they have experienced violence by their husband ever or never and their HIV status. As is seen higher percentage of HIV positive women report experiencing violence as compared to women who never experienced violence. Domestic violence is experienced by 50% of HIV positive women as compared to 37.4% of HIV negative women. Similarly 45.8% of HIV positive women report physical violence as compared to 34% HIV negative women. Emotional and sexual violence is reported by 18.1% and 12.5% of HIV positive women as compared to 14.2% and 6.9% HIV negative women respectively. Thus for all the forms of violence HIV positive women experience more violence than HIV negative women. In order to make preventive programmes more effective and a deeper understanding of the link between sexually transmitted diseases and domestic violence is required. This study shows the significant association between HIV and domestic violence. Domestic violence against women, contributes considerably to women's vulnerability to HIV.

Table 5.10: Percentage of ever-married women according to whether they have experienced violence by their husband ever or never and their HIV status.

Experience of violence by husband	HIV +ve	HIV -ve
Domestic Violence		
Ever experienced	50.0	37.4
Never experienced	49.3	62.6
Physical violence		
Ever experienced	45.8	34.0
Never experienced	53.5	66.0
Emotional Violence		
Ever experienced	18.1	14.2
Never experienced	81.9	85.8
Sexual Violence		
Ever experienced	12.5	6.9
Never experienced	87.5	93.1

Source: NFHS-3 India 2005-06

The above findings from the analysis of NFHS-3 data show that women who experience violence by husband's/partner are more at risk of facing various health consequences. Overall, women who have experienced violence tend to perform more poorly on either one or both of the given nutritional status measures, than women who have never experienced violence. It is evident that women who have experienced violence are consistently less likely to say that their birth was wanted when it was conceived, compared with women who have never experienced violence. Also the contraceptive use is less in women reporting violence as compared to women not reporting violence.

To sum: Violence against women is a violation of women's human rights and prevents women from enjoying their human rights and fundamental freedoms, such as the rights to life and security of the person, to the highest attainable standard of physical and mental health, to education, work and housing and to participation in public life. Such violence perpetuates the subordination of women and the unequal distribution of power between women and men. It has consequences for women's health and well-being, carries a heavy human and economic cost, hinders development and can also lead to displacement. Violence places women at higher risk for poor physical and reproductive health. There are extensive physical health consequences of violence against women. These include malnutrition, anemia, physical injuries, such as fractures and abdominal/thoracic injuries, and chronic health conditions, including chronic pain and gastrointestinal disorders. Reproductive health consequences

include gynaecological disorders, pelvic inflammatory disease, sexually transmitted infections, including HIV, unwanted pregnancies and poor obstetric outcomes. Other gynaecological consequences include vaginal bleeding or infection, chronic pelvic pain and urinary tract infections. The analysis of the NFHS-3 data shows that higher percent of women experiencing domestic violence are malnourished in terms of underweight as compared to women who have never experienced violence. There is a positive association between exposure to domestic violence and anemic condition among women. Higher proportions of women are anemic who experience violence as compared to women who never experience violence. Unintended pregnancy is another important consequence of sexual violence. Rape increases the risk of unintended pregnancy. A woman's fear of violence from her husband or partner may make her afraid to bring up the issue of contraceptive use, leading to unintended pregnancy. Unintended pregnancy has serious repercussions. The high level of unwanted pregnancies associated with violence hypothesized implies a low level of contraceptive use by women coupled with a high level of need for fertility control. Lower contraceptive use among women who have experienced violence is also suggested by the higher fertility and unwantedness of the last birth. The analysis clearly brings out that higher percentages of contraceptive users are the women who have never experienced violence and higher percentage of women experiencing domestic violence never wanted the last child born to them.

For many women worldwide, the threat of violence exacerbates their risk of contracting HIV. Fear of violence prevents women from accessing HIV/AIDS information, being tested, disclosing their HIV status, accessing services for the prevention of HIV transmission to infants and receiving treatment and counseling, even when they know they have been infected. Studies show the increasing links between violence against women and HIV and demonstrate that HIV-infected women are more likely to have experienced violence and those women who experience violence are at higher risk for HIV. Our findings support arguments that partner physical, sexual, and emotional violence affect women's reproductive health through increased risk of STIs and likely through decreased power to negotiate self protective behaviors. NFHS-3 data reveals higher odds of reporting STD, genital sore/ulcer and genital discharge for women experiencing domestic violence. This study shows the significant association between HIV and domestic violence. Domestic violence against women, contributes considerably to women's vulnerability to HIV. For all the forms of violence HIV positive women experience more violence than HIV negative women. In order

to make preventive programmes more effective and a deeper understanding of the link between sexually transmitted diseases and domestic violence is required.

In conclusion, domestic violence adversely impacts numerous health outcomes in India. To our knowledge, this is the first large, nationally representative study using objective measures of malnutrition and measurement of domestic violence to show a robust association between domestic violence and the likelihood of malnutrition among women. Thus this research work brings out that victims of domestic violence suffer significant negative health consequences because of the physical, sexual, and emotional violence they have experienced. Elevated risks have been observed for a wide range of adverse health outcomes. Research has substantially improved our understanding of the physiology that underlies the association between domestic violence and an array of adverse health outcomes. Given the high prevalence of domestic violence in India, it is critical to address this public health problem. Domestic violence prevention and intervention can substantially decrease the public health burden.