

Domestic Violence and Women's Mental Health in Rural India

Domestic violence represents the most pervasive form of violence that women in developing countries experience. Despite increasing attention to and prioritization of this issue internationally over the past decade, understanding of the precipitating factors for domestic violence and its consequences for women and their families remain limited. The absence of more definitive information and understanding of the determinants and risk factors for domestic violence remains a major impediment to the formulation of effective prevention programs that can address this serious social and public health problem.

Evidence from developing countries indicates that domestic violence represents a serious concern. Some of the highest levels of domestic violence have been reported from the South Asia region. Additionally, women from developing countries are at greater risk than men to suffer from mental disorders, or depressive and anxiety disorders. Depressive and anxiety disorders are common mental disorders which are typically encountered in community and primary care settings, and are the most frequent cases of mental illness in the population.

This study examines the impact of physical domestic violence on mental health among rural married women (age 15-39) in four states of India: Bihar and Jharkhand in the North, Maharashtra in the West, and Tamil Nadu in the South. An objective of this paper is to contribute to the currently limited body of empirical evidence on the impact of domestic violence on women's mental health. In doing so, we identified the range of individual measures of domestic violence, and community level measures of attitudes toward violence and gender that may shape the relationship between domestic violence and women's mental health. A greater understanding of the relationship between domestic violence and mental health has the potential to highlight the health consequences of domestic violence, and can inform the targeting of public health interventions to women experiencing domestic violence.

The states of Bihar, Jharkhand, Maharashtra and Tamil Nadu vary widely across a range of indicators related to socio-economic and women's status, with a principal demarcation between the North Indian states of Bihar and Jharkhand (formerly one state) and the states of Maharashtra and Tamil Nadu, situated in Western and South India, respectively. Our study population consists of the 6217 women who were interviewed at the NFHS-2 Follow-up Survey and who have complete information on the mental health module. In Bihar and Jharkhand, the percentage of illiterate women was higher than in Maharashtra and Tamil Nadu. In addition, in Bihar and Jharkhand, the mean age of marriage, percentages of women who can take their child to the hospital, who reside in homes without electricity, or who use modern contraceptive were all lower compared to Maharashtra and Tamil Nadu.

The 2002-2003 National Family Health Survey-2 (NFHS-2) Follow-up Survey is used for analysis. The sampling frame for the NFHS-2 Follow-up survey consists of all respondents interviewed in the original 1998-1999 NFHS-2 study in four Indian states: Bihar and Jharkhand (originally Bihar at the time of the NFHS-2 survey), Maharashtra and Tamil Nadu. The data were collected via questionnaires among rural women (age 15-39). The survey instrument includes questions pertaining to respondent background characteristics, reproductive behavior and intentions, quality of family planning care, use of family planning methods and services, an event calendar covering the intervening months between the baseline (NFHS-2) and Follow-up study (to assess intervening pregnancies, pregnancy outcomes, and monthly contraceptive use status), antenatal care and immunization, women's status, pre-marital pregnancy planning, general mental health and domestic violence.

An innovative feature of the NFHS-2 Follow-up Survey is the inclusion of the 12 item General Health Questionnaire (GHQ). The GHQ includes questions pertaining to ability to concentrate or enjoy daily activities, and feelings of worry, anxiety, depression, and self-worth. The GHQ is one of the most widely used and validated screening

questionnaires for the detection of common mental disorders in primary care and community settings.

We examine a continuous outcome measuring the respondent's score on the GHQ (range 0-12). A multi-level linear model is applied, with random intercepts fitted for the community, and district. The key covariate of interest in the model is whether the woman reports she experienced physical, sexual or physical and sexual violence from her husband in the 12 months prior to the survey. The model also controls for background demographic, socioeconomic, fertility, and household characteristics.

A systematic relationship is evident between women's reports of violence during the preceding year and their crude mean score on an index of number of negative responses to the 12 mental health questions in the GHQ (mean index score: 4.6 versus 2.2)

Our results indicate that domestic violence is strongly inversely related to women's mental health in all four study states. We also observe significantly elevated risks of common mental disorders (depressive and anxiety disorders) in women exposed to domestic violence. The two principal domestic violence outcome variables that are used for our analysis are 'physical/sexual violence' - whether the husband physically assaulted or engaged in coercive sexual relations with his wife during the 12 months prior to the NFHS-2 Follow-up Survey; and 'physical/sexual battering' - defined as six or more reported episodes of physical or sexual violence during the 12 months prior to the Follow-up Survey. The use of this range of domestic violence measures ensures that the correct temporal ordering of the violence and the outcome were considered in the analysis. These results also demonstrate that rates of physical or sexual violence against wives in the year preceding the Follow-up Survey ranged from 13 percent in Maharashtra to 32 percent in Jharkhand; rates of battering ranged from 7 percent in Maharashtra to 18 percent in Tamil Nadu.

The study finds evidence to suggest a relationship between the experiencing of physical domestic violence to a woman's mental health. This could have reproductive health

implications as domestic violence during or before pregnancy can lead to adverse birth outcomes. Thus, public health interventions need to focus on these associations between domestic violence and women's mental health as they can have consequences on different aspects of overall women's health.