Distribution Agreement

In presenting this thesis or dissertation as a partial fulfillment of the requirements for an advanced degree from Emory University, I hereby grant to Emory University and its agents the non-exclusive license to archive, make accessible, and display my thesis or dissertation in whole or in part in all forms of media, now or hereafter known, including display on the world wide web. I understand that I may select some access restrictions as part of the online submission of this thesis or dissertation. I retain all ownership rights to the copyright of the thesis or dissertation. I also retain the right to use in future works (such as articles or books) all or part of this thesis or dissertation.

Signature:

_____ _____

Nidhi Badiyani Date

Intimate Partner Violence and Help Seeking Behavior among Married Women in India

By

Nidhi Badiyani
MPH

Hubert Department of Global Health

_____

Dr. Roger Rochat
Committee Chair

Intimate Partner Violence and Help Seeking Behavior among Married Women in India

By

Nidhi Badiyani

B.D.S
DR. D.Y. Patil Dental College and Hospital
2007

Thesis Committee Chair: Roger Rochat, MD

An abstract of
A thesis submitted to the Faculty of the
Rollins School of Public Health of Emory University
in partial fulfillment of the requirements for the degree of
Master of Public Health
in Hubert Department of Global Health
2014

Abstract

Intimate Partner Violence and Help Seeking Behavior among Married Women in India

By Nidhi Badiyani

Background: Intimate partner violence (IPV) is a global public health concern with serious health consequences for its victims. Studies have found prevalence rates of 10 to 69% for IPV globally. IPV exposed women perceive barriers to help-seeking. This cross-sectional study explores help seeking behavior of currently married IPV exposed women from formal or informal sources with regard to type of violence perpetrated and individual, relationship level and socio- economic characteristics.

Methods: Data is obtained from National Health Family Survey India -3 (DHS 2005). Sample size consisted of currently married IPV exposed women in last 12 months (prior to survey) of the reproductive age (15-49 years). Weighted frequencies were calculated. Chi square tests and logistic regression analysis were conducted to understand the association between help seeking behavior and type of violence with covariates such as personal, relationship, and socio economic characteristics.

Results: From our overall sample size of 15,715 women [un-weighted], 3802 (~24%) women sought help, while 10762 (~68%) did not seek help for IPV. Help seeking behavior is associated type of violence in a fully adjusted model. For example, odds of seeking help is 2.8 times more for exposure to all three types of IPV compared to physical only (OR = 2.84 95% CI 2.392, 3.366). A higher proportion of help seekers than non- help seekers were employed .Women whose husbands had controlling behaviors and alcohol drinking habit were more likely to seek help. Help seeking varied significantly by women's education and region of residence.

Conclusions: Consistent with previous local studies, our national findings indicate low help seeking rates amongst women exposed to IPV in India. The wide variation in help seeking behavior may inform policies and interventions to prevent violence and to provide assistance to those who have been violated. Additional qualitative and formative research would better elucidate help seeking behavior of IPV exposed women in India.

Intimate Partner Violence and Help Seeking Behavior among Married Women in India

By

Nidhi Badiyani

B.D.S
DR. D.Y. Patil Dental College and Hospital
2007

Thesis Committee Chair: Roger Rochat, MD

A thesis submitted to the Faculty of the
Rollins School of Public Health of Emory University
in partial fulfillment of the requirements for the degree of
Master of Public Health
in Hubert Department of Global Health
2014

Acknowledgements

I would like to thank the handful of people who assisted me as I completed this thesis.

First and most importantly, I would like to thank Dr. Roger Rochat for his tremendous support and guidance. You are a great mentor and advisor. I am really thankful to you for believing in me and making this a wonderful thought provoking experience for me.

Luke Baertlein and Dattatraya Patil for their support. I appreciate every inch of help and analysis knowledge you all have provided.

Nishi Shah, Annum Shaikh and Milenka Jean-Baptiste for being wonderful friends throughout my course at Emory.

My family, for motivating me and being there for me always

Table of Contents

Chapter 1: Introduction:

India is the second most populous country in the world with a population of 1.2 billion people. India comprises of more than one sixth of the world's population and more than 50 % of India's current population is below the age of 25. About 72 % of the population live in villages and the rest 27.8% in towns and urban areas (Gaurav, Analava, Dinesh, S, & A, 2010). India has a rapidly growing population and has large variation in religions, ethnic groups, culture, geographic and socioeconomic characteristics. Other than poverty and illiteracy, high levels of gender disparity and disempowerment of females are pervasive in the Indian society. Customs such as female feticide, son preferences, child marriage, dowry deaths are widely prevalent in many regions (IIPS & MACRO, 2009).The overall sex ratio at birth is also skewed and is 1.12 male per female and total fertility rate is 2.51 children born per woman. (CIA, 2011). Equality and empowerment of women is one of the eight Millennium Development Goals to which India has pledged its commitment (IIPS & MACRO, 2009). The Indian society being heavily patriarchal, it's no surprise that women are often treated as the inferior gender and subjected to domestic violence. Education and economic independence are often denied to the women, thus making them more vulnerable to physical and sexual violence as they are then dependent on the men of the household and are incapable to making a living on their own. Women's age at marriage and first childbirth also play an important role as most women are married off at an early age and often don't know how to handle such situations (Kimuna, Djamba, Ciciurkaite, & Cherukuri, 2013)(WHO, 2002). Violence against women is a worldwide public health problem. It is a not only a consequence but also a cause of gender inequity (Krug, Mercy, Dahlberg, & Zwi, 2002). World Health Organization (WHO) defined Violence as "The intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group

or community that either results in or has a high likelihood of resulting in injury, death, psychological harm, mal development or deprivation." This particular definition encompasses all types of violence. Violence is categorized into three groups: self-inflicted, interpersonal, and collective. Each group is subdivided to indicate specific types of violence. Violence cannot be attributed to a single factor. Its causes are complex and occur at different levels. Interpersonal violence is further divided into two forms- Family and intimate partner violence and community violence. (Krug, Mercy, Dahlberg, & Zwi, 2002)(WHO, 2002)

Intimate Partner Violence

Intimate Partner violence (IPV) is rampant and one of the most common forms of interpersonal violence against women. The World Health Organization (WHO) defines intimate partner violence as "the range of sexually, psychologically and physically coercive acts used against adult and adolescent women by current or former male intimate partners". Physical violence includes acts of slapping, beating, arm twisting, stabbing, strangling, kicking, burning, choking, threats with an object or weapon and murder whereas sexual violence include acts of physically forcing sex against the woman's will and forced into performing unwanted sexual acts. Acts of emotional violence include being humiliated or insulted by the husband in front of others and being threatened with harmful substance(WHO, 2005). IPV, in all forms, occur every day throughout the world, affecting women of all ages, religions, socioeconomic classes and ethnicities and is associated with adverse health effects (Garcia-Moreno, Jansen, Ellsberg, Heise, & Watts). According to the WHO, efforts to eliminate domestic violence against women and its negative consequences should be based on results of more research and collaboration. The WHO 2005 report specifically called for more research on the weight and the root causes of the problem of violence against women and estimation of costs associated with the problem in order

to provide a stronger basis for action and policy change. Studies on prevalence rates indicate that between 10% and 69% of women report lifetime experience of some form of physical violence by their partners. (Stephenson, Winter, & Hindin, 2013). Strikingly, intimate partners kill 38 % of all the murdered women worldwide (WHO, 2012). South East Asia, particularly India has a huge burden of domestic violence. In South Asia, ~70% of women are married at a young age. This combined with lower education levels, early childbearing, and lack of autonomy in the household increases their vulnerability in the event that domestic violence occurs (Panchanadeswaran & Koverola, 2005). In India about 1 in 3 women face abuse at the hands of a partner (Decker et al., 2013). Approximately 40% of women in India have reported being physically abused by their husbands during their adult hood. Moreover, India accounts for 16% of the female population globally and ~76% of the South Asian female population (Ackerson, Kawachi et al. 2008). Several individual, inter-personal, community, and societal level factors increase a woman's risk to intimate partner violence. Intimate partner violence and husbands controlling behavior is highly prevalent in India, as it a strong patriarchal society with biased concepts of man-hood (Dalal & Lindqvist, 2012). There exists a regional difference in women's autonomy and empowerment. Women in northern states are more commonly observed to have less autonomy and economic opportunity as compared to women in southern states (Jejeebhoy & Sathar). More than half of the men and women in the country agree that beating wife is justified if the woman disrespects her in-laws or if she neglects her responsibilities. Such beliefs, along with acceptance and silence of women about violence is reflects in the high rates of domestic violence in the country (Kimuna et al., 2013).

There is an increasing body of research demonstrating the negative impact of violence on women's physical, mental and reproductive health (Campbell, 2002; Decker et al., 2013;

Silverman, Decker, Saggurti, Balaiah, & Raj, 2008; Winter & Stephenson, 2013). Non-fatal injuries are one of the most direct effects of violence. Health issues such as injury, chronic pain, gastrointestinal, and gynecological signs including sexually-transmitted diseases; mental disorders such as depression, and post-traumatic stress disorder are associated with abuse of women (Campbell, 2002; Winter & Stephenson, 2013). Intimate partner violence also results in unwanted pregnancies, miscarriages and is associated with detrimental outcomes to mothers and infants. Research has shown that women with a past history of IPV are 16% more likely to have low-birth-weight infants. They are also twice as likely to report having had an induced abortion; many such cases take place in unsafe conditions globally (Garcia-Moreno et al., 2013)

Help Seeking

Although IPV is widespread, less attention is given to understand the help seeking behaviors amongst the victim(WHO, 2005). Studies show that the utilization of formal or informal services varied by race and ethnicity. While nearly half of both Hispanic and African American women asked for help from a police officer, counselor or lawyer, only a third of South Asian women were seeking help for such problems (Kim & Lee, 2011). Furthermore, studies show that only when women are severely abused or abused both physical and verbally there is high levels of disclosure. Based on WHO study approximately 55% to 95% of women who have faced domestic violence by their partners had never sought help from available services.(Garcia-Moreno et al.). Studies in developing countries show that majority of the women that have been exposed to physical and sexual violence do not seek help to stop further violence being perpetrated against them. For example, in Nigeria 60% of women did not seek help, whereas in Bangladesh 66% of married women remained quiet about their experience with spousal violence, in Egypt 54% and in Sri Lanka 58% had not revealed the violence to anyone (Linos, Slopen,

Berkman, Subramanian, & Kawachi, 2013). Women are reluctant to disclose their suffering for reasons of stigma, shame, fear, guilt or simply because they do not want to be disloyal to their partners (Liang, Goodman, Tummala-Narra, & Weintraub, 2005). Just like many other developing countries, in India, domestic violence is commonly seen as a personal affair and often considered inappropriate to be discussed outside of the family. A woman is often made to overlook such problems by other women in the house right from childhood. She is often made to treat such situations as 'normal' and moreover, there is a lot of pressure on her to maintain peace within the family and the more common way is to compromise and overlook the problems. Researchers also found that women were more comfortable approaching the informal sources like women's groups or family or friends (Panchanadeswaran & Koverola, 2005).

In a study that was conducted in Mumbai, the economic capital of the country, women described fear as the main barrier for them to disclose their abuse incidents. In addition to this, few were aware of the services that were available to them to seek help in both legal and medical ways. The study further indicates that informal services were more sought after than the formal ones. While fewer than 5% of women had been screened for violence in the health care setting, about 67% were willing to disclose abuse if asked (Decker et al., 2013). Due to few studies and other limitations, there are no reliable estimates in the country of the weight of spousal violence against women or the help–seeking behavior of abused women.

Research Purpose:

To date, little is known about the nuances of help-seeking patterns, including the nature and usefulness of help received, or experiences with informal or formal sources of support within the Indian context. This paper focuses on examining the association between type of intimate partner violence - verbal, physical, and sexual IPV and help-seeking behavior among married Indian

women of reproductive age (age 15-49). We aim to examine all combinations of IPV types (verbal alone; physical alone; sexual alone; verbal and physical; verbal and sexual; physical and sexual; verbal and physical and sexual) with help seeking behavior. This study will provide an understanding on patterns and determinants of help seeking behavior in India in order to help health care providers, policy makers and social service sectors, move towards elimination of violence against women by designing and implementing preventive and treatment strategies.

Chapter 2: Literature Review

Intimate Partner Violence

Spousal violence/intimate partner violence (IPV) is globally recognized as a violation of women's health and human rights and affects a large % of women throughout the world(WHO, 2005). Acts of any physical, verbal or sexual coercion abuse by partner is referred to as Intimate Partner Violence. Physical abuse is a very common form of violence and has an immediate impact, whereas verbal abuse could be targeted toward damaging the psychological identity of the victim, thereby rendering her incapable of making decisions. It has been observed that this perception of being controlled has kept many women in abusive relationships (Anderson et al., 2003). Approximately 15% to 71% of women worldwide have ever experienced partner violence, according to the WHO Multi-country Study on Women's Health and Domestic Violence (Djikanović et al., 2012). In most countries, sexual violence by the partner was considerably less prevalent than physical violence, except in Ethiopia, Bangladesh, and Thailand city, where women reported more sexual than physical partner violence (Garcia-Moreno et al.). It is a global epidemic and this issue needs to be addressed due to its deep impact on an individual and society. It has been associated with having adverse outcomes on a women's physical , psychological and reproductive health (Campbell, 2002). South Asia has a high prevalence rate of partner abuse, India specifically ; where issues such as honor killings and dowry death manifests with significant health and human rights implication (Ahmad, Driver, McNally, & Stewart, 2009)

IPV in India

India suffers a huge burden of violence against women. The prevalence estimates vary , ranging from 6% in Himachal Pradesh [Northern State] to 59% in Bihar[East State] (Garcia-Moreno

et al.). Several factors in India make the women more susceptible to IPV. Violence against women in India begins before birth, as sex-selective abortions, female feticides, and infanticides, which continues throughout their lives (Patel). According to the most recent National Survey , 40% of a representative sample of Indian women of reproductive age had experienced physical (35%), sexual (10%), or emotional (16%) violence by their husband (NFHS., 2007)

India is deeply rooted in cultural norms of patriarchy, religions, customs, age old beliefs, and multigenerational families which have put women in a subservient position (Pandey, Dutt, & Banerjee, 2009). In India, women get married at a very early age, and their ties to their natal family get weakened after marriage. Moreover, child bearing at a young age, familial norms, being submissive and acceptance are other factors which makes them more at risk to violence. On an average the first episode of spousal violence occurs within the first five years of marriage. Despite this, few women seek help when faced with domestic violence .This is believed to be due to their own and broader societal tolerance and acceptance of violence and social stigma associated with being divorced or separated (Krishnan, Subbiah, Khanum, Chandra, & Padian, 2012)

Risk Factors:

Socioeconomically disadvantaged women and women living in rural areas are more at risk to exposure to violence. About 52% of women in the lowest wealth quintile reported experiencing physical, sexual, or emotional spousal violence as compared with 21% in the highest wealth quintile (Krishnan, Subbiah, Khanum, Chandra, & Padian, 2012). Education is a protective factor for women against spousal violence. Individual education could provide her with financial independence and is aligned more liberal norms and values pertaining to women's rights and less acceptance of violence as a means of resolving conflicts (Boyle, Georgiades, Cullen, & Racine,

2009). Previous nationally representative study consisting of married women sample, showed that women with no formal education were 4.5 times more likely (95% confidence interval [CI] =3.37, 6.25) to report lifetime IPV and 5.6 times more likely (95% CI=3.53, 8.92) to report recent IPV compared with those schooled for more than 12 years (Ackerson et al., 2008). However, this protective association can be modified based on household and the communitywide educational contexts. Substantial variation in risk of IPV could also be accounted by type of residence and individual-level associations between IPV and women's education can also be modified by type of residence (Boyle et al., 2009). Urban women were more exposed to emotional and less severe physical violence while rural women were more exposed to sexual violence (Dalal , 2011). Husband's education can have varied effects on IPV based on a woman's education level. For example several studies show that women married to men with no education are more at risk to IPV, since these men use violence as a means to assert their authority and feel justified in controlling the actions of their wives (Ackerson et al., 2008). However, women married to more educated husbands also experienced significantly higher risks of forced sexual intercourse. This could be in the view existing in the Indian society that since husbands have more years of schooling it is his prerogative while the wife is obliged to engage in sexual relations when he desires (Koenig, Stephenson, Ahmed, Jejeebhoy, & Campbell, 2006). Certain relationship factors are also associated with higher prevalence on IPV in India. A spousal age difference of 5 years or less, longer duration of marriage and presence of children are significantly associated with higher risk to IPV (Koenig Stephenson, Ahmed, Jejeebhoy, & Campbell, 2006). Son preference is a common sociocultural norm and has been identified as a determinant of women's risk of IPV experience in India (Sabarwal, McCormick, Subramanian, & Silverman, 2012). Although the United Nations strongly recommended economic

empowerment of women as a protective factor for violence against women, studies from several countries including India found that the working status of women in India is not a protective factor for violence against women (Sabri, Renner, Stockman, Mittal, & Decker, 2014) (Dalal, 2011). Moreover, husband's problem of alcohol drinking, jealousy, suspicion, control, and emotionally and sexually abusive behaviors were also related to an increased likelihood of women experiencing severe IPV and injuries (Pandey et al., 2009) (Sabri, Renner, Stockman, Mittal, & Decker, 2014).

Health Effects

Abused women suffer many adverse consequences of the violence- i.e. negative impact on health, diminished quality of life and limited working ability. Health consequences are not only physical injuries and bruises but includes a range of mental, reproductive and sexual diseases (Djikanović et al., 2012). Further, frequent episodes of victimization of women is observed to result in chronic ill health and social issues which include chronic physical symptoms, depression, suicide attempts, addictions, poor pregnancy outcomes and a negative impact on children's health and behavior (Ahmad, Driver, McNally, & Stewart, 2009). Studies also show that battered women have more injuries in the head, face, neck, thorax, breasts, and abdomen than women injured in other ways .The injuries, fear, and stress due to intimate partner violence has been associated with chronic health problems such as chronic pain or disorders related to central nervous system, neurological or gastrointestinal symptoms. Also, battered women are more prone to gynecological problems which include sexually-transmitted diseases such as HIV, vaginal bleeding or infection, fibroids, decreased sexual desire, genital irritation, pain on intercourse, chronic pelvic pain, and urinary-tract infection (Campbell, 2002). Among married Indian women, physical violence combined with sexual violence from husbands has been

associated with an increased prevalence of HIV infection. There is a possibility that this could be due to husbands extra marital risk behavior since studies show approximately 90% of HIV-positive Indian women are reported to be married and monogamous (Silverman et al., 2008). A range of mental health outcomes associated with IPV includes depression, sleep problems, anxiety, mental distress, posttraumatic stress disorder (PTSD), and suicidal attempts (Stephenson et al., 2013). Other studies have looked at the associations between multiple forms of violence and poor mental health. A study in north Goa, India, found that physical or sexual partner violence partially mediated the association between the partner's excessive alcohol use and the female's common mental disorders, defined as nonpsychotic affective disorders, such as depression or anxiety (Nayak, Patel, Bond, & Greenfield, 2010).

Help Seeking Behavior

Several individual, familial, economic, and cultural factors influence women's decisions to seek help and support in the face of violence (Liang et al., 2005). Informal and formal social services have been shown to improve abused women's health, inclination to seek help and ability to protect them. Informal sources such as friends, family and neighbors are believed to often provide emotional and financial support to the IPV exposed women. Formal support consists of help provided by the police, lawyers, social service agency staff and health services and mental health professionals. Help seeking has been identified as a protective factor for victims of abuse and is associated with fewer mental and physical health problems (Liang et al., 2005). However, still majority of the women don't seek help. In the WHO Multi-country Study on Women's Health and Domestic Violence, the percentage of women who had never sought help from agencies or authorities varied between 55% and 95% (Djikanović et al., 2012)

Previous research shows some of the reasons for not seeking help included social stigma; shame, guilt, children's well-being; lack of social support; and knowledge gaps and myths (Ahmad, Driver, McNally, & Stewart, 2009). Previous literature on help-seeking suggests two internal conditions fundamental for seeking support i.e. (1) recognizing the issue and (2) understanding that the problem won't go without seeking help from others. Women did not seek help since they believed that the violence was bearable or 'normal' or had ended. Other reasons for not seeking help were fear of undesirable consequences of seeking help and lack of faith in institutions. Help seeking behavior by battered women is influenced by various interpersonal and sociocultural norms. For example, in Asian culture, maintaining the privacy of familial matters, fear of divorce and gender roles may prevent many women from seeking help outside the family or friends circle, even when they understand the IPV as a problem (Liang et al., 2005). Moreover, the level of supportiveness and availability of friends and family may influence a woman's ability or decision to seek and use formal support. (Liang et al., 2005). Similarly, in rural communities due to existence of poverty , high rates of unemployment and substandard or isolated housing, problems are evident in accessing help for domestic violence (Liang et al., 2005).

Several studies have pointed out that help is sought by women only when spousal physical violence becomes severe or frequency of such episodes increase. In one such study on help seeking behavior amongst women in Serbia, we learnt that the severity of violence and the impact of the violence on children are the most important triggers for them to seek help after experiencing IPV. This is consistent with the findings coming from population-based studies conducted in New Zealand and Bangladesh. Children's well-being and safety are very important to women and the need to protect are believed to be the strongest drive for seeking help (Djikanović et al., 2012; Naved, Azim, Bhuiya, & Persson, 2006). In another study in Nigeria, a

woman's experience witnessing violence perpetrated by her father against her mother was positively associated with help seeking (Linos et al., 2013)

Help Seeking in India

In India, IPV is considered socially acceptable as it is viewed as a private matter between married couples. Majority of the women remain silent about their abuse. The help-seeking rates in India are very low which could be attributed to cultural norms, gender roles and notions of patriarchy. Research has shown that women with strong patriarchal beliefs are less likely to approve of seeking help from formal sources and more likely to consider partner abuse a matter to be dealt (Kamat, Ferreira, Mashelkar, Pinto, & Pirankar, 2013). Apart from the severity of injuries or threats, important factors which affect are availability of both formal and informal sources for help and women's perception of their effectiveness. Studies showed that those women who sought help mostly turned to informal sources. The larger the network of friends and family, the easier it is for the women to approach them. Informal help from family members and neighbors was the dominant form of help received by victims. However, it was sought only when the women were unable to hide what they were experiencing or when their bruises were visible (Decker et al., 2013). Help seeking rates from formal sources was in very insignificant numbers. Several barriers such as low awareness of formal support services or lack of intention to use them, inaccessibility of these, resulted in limited qualitative data concerning formal support services. Moreover, negative experiences were reported by those who had sought help from formal services (Decker et al., 2013) (Kamat, Ferreira, Mashelkar, Pinto, & Pirankar, 2013). Several themes of perceived barriers have been observed amongst the Indian women. Fear of social repercussion and increased violence, social stigma, fear of divorce by husband discouraged the women from revealing abuse to family and neighbors. Another dominant theme

was women's' helplessness since they were unemployed and financially dependent on their husbands which led to their acceptance. In order to maintain harmony in the house and avoid conflict, marital obligations expected the women to remain silent about it and not inform anyone (Decker et al., 2013). Acceptance of IPV has also been negatively associated with women's help-seeking (Sudha & Morrison, 2011). Economic empowerment was positively associated with help seeking. One such study in India demonstrates that working women have sought more help for IPV related issues which implies that economic empowerment, along with higher education, may be positively associated for disclosure of abuse (Dalal, 2011) . Formal sources were viewed as not very helpful with limited capacity to intervene. Lack of development of shelter homes and other support systems for victimized women has also been linked as a barrier to poor utilization of formal systems of help. Considering the challenges involved in seeking help from formal sources, women are more comfortable to receive support from family and friends. Women usually turned for formal help from health services only after experiencing pronounced mental and physical health problems (Kamat et al., 2013).

We thus hypothesize that a woman's decision to seek help will be associated with type of violence. We also examine the individual, relationship, socio- economic, and demographic influences on women's decisions to seek help and support in the face of violence. Help-seeking behavior of women in India has received scant attention and there is a dearth of research in this domain. This article seeks to address this gap in knowledge by exploring patterns of help-seeking behaviors among currently married abused women, particularly by type of Intimate partner violence as well as several other influential characteristics in the last 12 months.

Chapter 3: Manuscript

Abstract

Background: Intimate partner violence (IPV) is a global public health concern with serious health consequences for its victims. Studies have found prevalence rates of 10 to 69% for IPV. IPV exposed women perceive barriers to help-seeking. This cross-sectional study explores help seeking behavior of currently married IPV exposed women from formal or informal sources with regard to type of violence perpetrated and individual, relationship level and socio- economic characteristics.

Methods: Data is obtained from National Health Family Survey India -3 (DHS 2005). Sample size consisted of currently married IPV exposed women in last 12 months (prior to survey) of the reproductive age (15-49 years). Weighted frequencies were calculated. Chi square tests and logistic regression analysis were conducted to understand the association between help seeking behavior and type of violence with covariates such as personal, relationship, and socio economic characteristics

Results: From our overall sample size of 15,715 women [un-weighted], 3802 (~24%) women sought help, while 10762 (~68%) did not seek help for IPV. Help seeking behavior is associated type of violence in a fully adjusted model. For example, odds of seeking help is 2.8 times more for exposure to all three types of IPV compared to physical only (OR = 2.84 95% CI 2.392, 3.366). A higher proportion of help seekers than non- help seekers were employed. Women whose husbands had controlling behaviors and alcohol drinking habit were more likely to seek help. Help seeking varied significantly by women's education and region of residence.

Conclusions: Consistent with previous local studies, our national findings indicate low help seeking rates amongst women exposed to IPV in India. The wide variation in help seeking behavior may inform policies and interventions to prevent violence and to provide assistance to those who have been violated. Additional qualitative and formative research would better elucidate help seeking behavior of IPV exposed women in India.

Introduction

Violence against women is a worldwide public health problem of growing concern. It is not a consequence but also a cause of gender equity (Krug et al., 2002). Violence cannot be attributed to a single factor. Its causes are complex and occur at different levels. Intimate Partner violence is most rampant and one of the most common forms of interpersonal violence against women. The World Health Organization defines intimate partner violence (IPV) as "the range of sexually, psychologically and physically coercive acts used against adult and adolescent women by current or former male intimate partners". IPV, in all forms, occur every day in all parts of the world, affecting women of all ages, religions, socioeconomic classes and ethnicities and is associated with adverse health effects (Garcia-Moreno et al.). Studies on prevalence rates indicate that between 10% and 69% of women report lifetime experience of some form of physical violence by their partners (Stephenson, Winter, & Hindin, 2013). There is a huge burden of domestic violence in South East Asia, and particularly India. India is uniquely affected where in an estimated 1 in 3 women facing abuse at the hands of a partner (Decker et al., 2013). Several individual, inter-personal, community, and societal level factors increase a women's risk to intimate partner violence. Intimate partner violence and husbands controlling behavior is highly prevalent in India, as it a strong patriarchal society with biased concepts of man-hood.(Dalal & Lindqvist, 2012). There is an increasing body of research demonstrating the negative impact of violence on women's physical, mental and reproductive health. (Campbell, 2002; Decker et al., 2013; Silverman et al., 2008; Winter & Stephenson, 2013). However, despite such high rates of IPV in India, very few women seek assistance for it. In India, domestic violence is commonly seen as a personal affair and often considered inappropriate to be

discussed outside of the family. Existing factors in India such as rigid gender roles, age old beliefs, marriage obligations, customs, familial norms and social blindness towards spousal violence lead to silent acceptance of spousal violence by these women. Other than that, women are reluctant to disclose their suffering for reasons of stigma, shame, fear, guilt or simply because they do not want to be disloyal to their partners or have conflicts in the family (Kimuna et al., 2013). To date, little is known about the nuances of help-seeking patterns. This study will provide an understanding on patterns and determinants of help seeking behavior in India in order to help health care providers, policy makers and social service sectors, as a step towards eliminating violence against women by developing preventive and treatment strategies.

Background

Spousal violence/intimate partner violence (IPV) is globally recognized as a violation of women's health and human rights and affects a large % of women throughout the world (WHO, 2005). Acts of any physical, verbal or sexual coercion abuse by partner is referred to as Intimate Partner Violence. In most countries, sexual violence by the partner was considerably less prevalent than physical violence, except in Ethiopia , Bangladesh , and Thailand city, where women reported more sexual than physical partner violence (Garcia-Moreno et al.) It is a global epidemic with adverse outcomes on a woman's physical, mental and reproductive health. (Campbell, 2002). South Asia has a high prevalence rate of partner abuse, India specifically where issues such as honor killings and dowry death manifests with significant health and human rights implication (Ahmad et al., 2009; Garcia-Moreno et al.)

India suffers a huge burden of violence against women. The prevalence estimates ranging from 6% in Himachal Pradesh [Northern State]to 59% in Bihar[East State] (Garcia-Moreno et al.). Several factors in India make the women more susceptible to IPV. Violence against women in

India begins before birth, as sex-selective abortions, female feticides, and infanticides which continue throughout their lives. In India, women get married at a very early age, their ties to their natal family are considerably weakened after marriage, child bearing at a young age, familial norms, being submissive and acceptance are other factors which makes them more at risk to spousal violence (Krishnan, Subbiah, Khanum, Chandra, & Padian, 2012)

According to the most recent National Family Health Survey (NFHS), 40% of a representative sample of Indian women of reproductive age had experienced physical (35%), sexual (10%), or emotional (16%) violence by their husband (NFHS., 2007)

India is deeply rooted in cultural norms of patriarchy, religions, customs ,age old beliefs, and multigenerational families which have put women in a subservient position (Pandey et al., 2009). In spite of high prevalence of IPV worldwide, still majority of the women don't seek help. In the WHO Multi-country Study on Women's Health and Domestic Violence, the percentage of women who had never sought help from agencies or authorities varied between 55% and 95% (Djikanović et al., 2012). Studies show in Asian culture, maintaining the privacy of familial matters, fear of divorce and gender roles may prevent many women from seeking help outside the family or friends circle, even when they understand the IPV as a problem (Liang et al., 2005). In India, IPV is considered socially acceptable as it viewed as a private matter between married couples. Majority of the women remain silent about their abuse. The help-seeking rates in India are very low which could be attributed to cultural norms, gender roles and notions of patriarchy. Studies showed that those women who sought help mostly turned to informal sources. Informal help from family members and neighbors was the dominant form of help received by victims (Decker et al., 2013). Help seeking rates from formal sources was in very insignificant numbers. Several barriers such as low awareness of formal support services or lack of intention to use

them, inaccessibility of these resources, resulted in limited qualitative data concerning formal support services. Moreover, those who had sought formal services often reported negative experiences (Decker et al., 2013) (Kamat et al., 2013).

Several themes of perceived barriers have been observed amongst the Indian women. Fear of social repercussion and increased violence, social stigma, fear of divorce by husband discouraged the women from revealing abuse experience to family and neighbors. Another dominant theme was women's helplessness since they were unemployed and financially dependent on their husbands which led to their acceptance. In order to maintain harmony in the house and avoid conflict, marital obligations expected the women to remain silent and accept it without informing anyone (Decker et al., 2013). Acceptance of IPV has also been negatively associated with women's help-seeking (Sudha & Morrison, 2011). Economic empowerment was positively associated with help seeking (Dalal, 2011). Given the challenges involved in seeking this and other kinds of formal support, it is viewed that women are more comfortable to receive from family and friends. This article seeks to address this gap in knowledge by exploring patterns of help-seeking behaviors among currently married abused women, particularly by type of Intimate partner violence as well as several other influential characteristics in the last 12 months.

Methods

Data Source: We used the data from the National Family Health survey 3 [DHS survey 2005-2006] in India, a cross sectional survey of 124,385 ever married women residing in 109,041 households. Women of reproductive age (15-49) from all 29 Indian states were included in the survey. A separate module of questions on domestic violence was included as a part of women's questionnaire. Information on sexual, emotional and physical violence perpetrated by husbands

on their wives as well as violence by other household members was obtained. Participants were selected through a stratified, multistage, cluster sampling design. Information on sampling and data collection is mentioned in detail and covered by some studies previously (Kamat et al., 2013). Our sample size was limited to only currently married women and consists of 65,610 respondents. To maintain confidentiality and quality of data, only one woman from every household who is eligible was selected randomly in our study sample. Our analytic sample was further restricted to only those women who were exposed to IPV. IPV was defined as exposure to either one or all kind of spousal /partner emotional, physical or sexual violence. IPV was assessed by asking the behavior specific questions to the women, related to each type of violence. Physical violence was assessed based on positive response to the following questions asked- Did your husband ever (i) Push, shake or throw something at you? (ii) Slap you? (iii) Punch you with his fist or something harmful? (iv) Kick or drag you? (v) Try to strangle or burn you? (vi) Threaten or attack you with a knife, gun, or any other weapon? (vii) Twist your arm, pull your hair? Sexual violence was determined by response to the question whether husband ever did the following things: (i) physically force to have sexual intercourse with him even when you did not want to? (ii) Force you to perform any sexual acts you did not want to? Verbal IPV was defined as exposure of either of following questions (i) did your husband ever say or do something to humiliate you in front of others? (ii)Did your husband ever threaten to hurt or harm you or someone close to you? (iii) Did your husband ever insult you or make you feel bad about yourself? Our sample was limited to only those showed a positive response to IPV in the last 12 months prior to this survey, to obtain an accuracy of self-reported information. All responses as ‘yes’ in the last 12 months were coded as (1) whereas those responding ‘no’ in last 12 months were coded as (0). Our analytic sample was further restricted to 15,715 female survey

participants based on completion of both Help seeking behavior response and provision of IPV data specifically.

Measures: Outcome Variable: Help Seeking

We explore the help seeking behavior of women exposed to intimate partner violence in the last 12 months. Women who sought either formal or informal help were considered positive for help seeking behavior and their responses were coded as Yes= 1 whereas those who did not seek any form of help were coded as No= 0. Thus, our outcome help seeking is a binary variable (0, 1). Informal sources of help were those when help was sought from own family, husband's family, neighbors, friends. Formal sources of help were those from religious leaders, lawyers and doctors or some organizations.

Independent variables: Several background variables were used to examine the association between type of violence and help- seeking behavior.

Violence was defined as emotional, physical and sexual. Type of violence was violence was categorized into 7 groups using different combinations of emotional, physical and sexual into one kind only or two kinds or all three. Wife's age, education, employment, age at marriage and her partner's age, education, alcohol drinking habits, and controlling behavior were explored. Those characteristics in common to both was wealth index, religion, caste, state, marital duration, age difference, type of residence, number of living children and number of living sons. Violence related variable was family history of abuse.The wife's age was classified into seven age groups (15 – 19, 20 – 24, 25 – 29, 30 – 34, 35 – 39, 40 – 44 and 45 – 49) whereas for husband's it was classified in a similar manner but into 8 groups, the last one including those having age above 50 plus years. Education was classified into four groups: no education, primary

education, secondary, and higher education. Wife's age at first marriage ranged from 3 years to 30+ years and was categorized into 6 groups and her employment was classified as yes or no. Place of residence was urban or rural. States were grouped into 6 regions (North, South, East, West, Northeast and Central). Place of residence and region reflect the heterogeneous structure of the country. The wealth level variable indicated the wealth of the household where the woman lives and was classified according to the wealth scores that were formed based on household assets. The household wealth index is measured into five levels ranging from the poorest to the richest. Marital duration was grouped in 6 categories that ranged from 0 years to 30+ years. Number of living children and living sons, age difference between wife and husband were amongst the others which were categorized. In India there exists a caste system. The Indian population varies widely in socio- economic conditions, beliefs and culture based on the religion and caste. We grouped caste into 4 categories-scheduled castes (SC), scheduled tribes (ST), other backward classes (OBC) and others who are not within these three groups. Religion was classified into Hindus, Muslims; Christians, and the fourth other religions (Sikh, Buddhist, Jain, and those without any religious affiliations). In the Indian subcontinent, control of wives by their husbands is a salient social custom. Positive responses to the following 6 variables indicated controlling behavior by husband: husband jealous if wife talks to other men, husband accuses wife of unfaithfulness, husband does not permit his wife to meet her girl- friends, husband tries to limit wife's contact with her family, husband insists on knowing where wife is, and husband does not trust his wife with monetary affairs. The relationship between number of these control issues and help seeking behavior was assessed. History of family abuse (wife's parent's house) was classified as yes or no.

Data Analysis

Using SAS 9.3, univariate descriptive analyses were initially performed to assess the frequency and percentages in population groups. Bivariate associations using chi square test were performed to identify the significant predicators of help seeking as well as intimate partner violence. Those variables which showed a significant association with both help seeking and intimate partner violence were considered as potential confounders and were included in our multivariate model. Even though women's age and education – these two variables were not significantly associated in our data, but were included in the model since they were significant based on previous literature (Boyle et al., 2009). Multivariable logistic regression models were fitted for binary outcome variable of help seeking - the crude association model included only the types of IPV- a categorical variable measuring all combinations of IPV types. The following set of model – all inclusive - included type of IPV while controlling for several other factors shown to be associated with help seeking behavior in studies along with interaction terms of most variables with exposure. Model diagnostics were performed to assess model fit. All models were checked for multi-collinearity through condition indices/variance decomposition factors. After removing all non-significant variables in backward selection method, final model included covariates such as women's age, education, employment, number of living children, age at marriage, religion, caste, region, household wealth index, marital duration, husbands control issues and alcohol drinking habit. Apart from exposure and confounding variables, the final model also included women's age, education and interaction terms for education and region.

Results

Of the sample of 65,610 women who answered the domestic violence module for DHS 2005 dataset, 15,715 (~24%) un-weighted number of women were exposed to any form of spousal violence in the last 12 months and were currently married). From our overall sample size of

15,715 women [un-weighted], 3802 (~24%) women sought help, while 10762 (~68%) did not seek help for IPV. For the purpose of this study, we calculated weighted frequencies. This led to overall weighted sample size of 14,467 women. 7.3 % of respondents did not report information on help seeking.

Description of Sample: 76.7% of the study population belonged to Hindu religion, 14% Muslims, 6.5% were Christians, and 2.8% were of other religion. Other backward castes were major part of the population with 34.8%, while both scheduled caste (SC) and other castes were approximately similarly distributed. Majority of the women (91%) in our sample were mothers and had children. Among almost 78% of the couples, wife was up to 9 years younger than husband, and three-quarters (75%) of couples were residing in rural areas of India. Distribution of population was approximately similar in all wealth index levels except those which belonging to the highest wealth quintile showed less % of victims. 43 % women were currently employed; conversely 54% of women were uneducated. Current age of women followed normal distribution with median in 25-29 age groups. Based on our sample, we observe that about 58% of women were married at an early age between 15- 19 years. Since previous studies and our study show that physical intimate partner violence was most common type of violence (42% in our sample), we have used it as a reference to compare help seeking for other types of violence.

Following is the distribution of types of violence in our sample i.e. exposed to spousal violence (15,715) women: Emotional Violence (12.1%), Sexual Violence only (7.3%), Physical only (42.2%), Emotional and Sexual Violence (1.4%), Emotional and Physical Violence (20.2%), Sexual and Physical (7.7%), Emotional and Sexual and Physical (9.1%).

Pattern of help seeking was corresponding to the levels of education as well as employment in women. Help seekers were more likely than non- help seekers to be employed. More than half (57 %) of abused women who were married by age of 15-19 sought help for IPV. Family history of abuse, husbands control issues and alcohol drinking habit were significantly associated with help seeking behavior. Approximately 40% of the women who sought help for IPV had a family history of abuse. Over 75% of women had husbands with fewer than 2 control issues, while only 5% of women were facing husbands with 5-6 control issues and not seeking help. 48% of women with issues related to husband's alcohol drinking problems did not try to seek help. The help seeking pattern varied by woman's education and region (p value<0.0001). There was seen a reluctance in help seeking amongst the eastern states. Also, a notable decline in violence exposure and subsequently help seeking was observed in women belonging to the highest wealth index.

Based on bivariate associations (Table 2), following variables were found to have a significant association with both the outcome- help seeking and exposure type of IPV: women's employment status, number of living children, her age at marriage, marital duration, husbands control issues and alcohol drinking habits. Woman's age and education were also considered confounders based on previous literature. Besides these, the socio-economic variables religion, caste, region and household wealth index were also found to be significant. These variables were later tested for interaction with IPV exposure variables. Education and Region were found to be effect modifiers, and their interaction with type of IPV was significant.

Multivariate results: Emotional only violence was not considered as part of the ordinal exposure variable and was removed from multivariable analysis. Crude association between all combinations of IPV variables and help seeking was examined. While, based on confounders

selected from bivariate associations a full/ all-inclusive model was created along with inclusion of interaction terms with exposure variable.

Table 3 presents' comparative crude and adjusted odds ratio estimates of help seeking behavior. In full model, other than types of IPV, all the confounders and interaction terms was included. With reference as physical violence only, adjusted odds of seeking help by currently married women who experienced sexual only violence in last 12 months (OR = 0.35, 95% CI 0.256, 0.470) or combination of emotional and sexual violence (OR = 0.96, 95% CI 0.634, 1.451) was less. Women exposed to physical violence in combination with other kinds were more likely to seek help than those exposed to physical only violence. Furthermore, odds of seeking help is 2.8 times more for exposure to all three types of IPV compared to physical only (OR = 2.84 95% CI 2.392, 3.366). Women whose husbands had controlling behaviors and alcohol drinking habit were more likely to seek help. Education and region are significant effect modifiers; that is, education and region modify the effect of type of violence on seeking behavior depending on the level of female education and her state/region of residence.

Discussion and Conclusion

IPV is highly prevalent in India and has serious impact on a women's health. Studies have shown it is a cause of various mental, physical, reproductive health disorders. This study provides an understanding of help-seeking behaviors among battered Indian women in response to IPV and specific factors that are related to help seeking. This study is based on a large nationally representative survey. Findings from this cross sectional study yielded that majority of the married women exposed to Intimate Partner/Spousal Violence in the last 12 months did not seek help (~68%) from any sources. Among those who sought help (~24%); most of them relied on informal sources. Reasons for not disclosing abuse could be attributed to fear of divorce,

financial insecurity, or other consequences such as re-victimization by partner or threat of losing children. The informal help sources, including family members, friends and neighbors, emerged as the primary support system in situations of violence in our study , which is consistent with prior evidence (Decker et al., 2013)

This quantitative study fills in the gap in India by highlighting which type of violence specifically precipitates the women to seek help and other factors and characteristics associated with help -seeking behavior. Key finding in our study was that those women who are exposed to physical violence in combination with any other violence, emotional or sexual or both have higher odds of seeking help than those exposed to emotional abuse or sexual abuse. Other notable findings were that help seeking rates varied significantly by women's education and region. The large differences in IPV and help seeking trends between states -regions emphasize the role that community context plays in IPV across India. Our strength is that unlike previous studies exploring help seeking in India, our study consists of a large nationally representative sample inclusive of randomly selected women from all states. One of the limitations of the study is that all of the measures were self-reported and could be possible bias or under reporting.

Overall, we conclude that IPV is rampant issue with deleterious medical and social consequences. In order to prevent it, immediate steps must be taken to identify help seeking patterns and offer resources and support to these victims. This study intends to contribute to a better understanding of association between types of spousal violence and help seeking behavior of the women. With this study we aim to provide a direction for developing policies and health based interventions research in settings such as rural India. However, there is still a need to for more qualitative information and formative research in understanding help seeking behavior of IPV exposed women in India.

Works Cited:

Dalal, K., & Lindqvist, K. (2012). A national study of the prevalence and correlates of domestic violence among women in India. *Asia Pac J Public Health, 24*(2), 265-277. doi: 10.1177/1010539510384499

Garcia-Moreno, C., Jansen, H. A. F. M., Ellsberg, M., Heise, L., & Watts, C. H. Prevalence of intimate partner violence: findings from the WHO multi-country study on women's health and domestic violence. *The Lancet, 368*(9543), 1260-1269. doi: http://dx.doi.org/10.1016/S0140-6736(06)69523-8

Krug, E. G., Mercy, J. A., Dahlberg, L. L., & Zwi, A. B. (2002). The world report on violence and health. *The Lancet, 360*(9339), 1083-1088. doi: http://dx.doi.org/10.1016/S0140-6736(02)11133-0

Kimuna, S. R., Djamba, Y. K., Ciciurkaite, G., & Cherukuri, S. (2013). Domestic violence in India: insights from the 2005-2006 national family health survey. *J Interpers Violence, 28*(4), 773-807. doi: 10.1177/0886260512455867

Silverman, J. G., Decker, M. R., Saggurti, N., Balaiah, D., & Raj, A. (2008). Intimate partner violence and HIV infection among married Indian women. *JAMA, 300*(6), 703-710. doi: 10.1001/jama.300.6.703

Stephenson, R., Winter, A., & Hindin, M. (2013). Frequency of intimate partner violence and rural women's mental health in four Indian states. *Violence Against Women, 19*(9), 1133-1150. doi: 10.1177/1077801213501898

Winter, A., & Stephenson, R. (2013). Intimate partner violence and symptoms of reproductive tract infections among married Indian women. *International Journal of Gynecology & Obstetrics, 121*(3), 218-223.

WorldHealthOrganization. (2005). WHO Multi-country Study on Women's Health and Domestic Violence against Women: summary report on initial results on prevalence, health outcomes and women's responses.

Kamat, U. S., Ferreira, A. M. A., Mashelkar, K., Pinto, N. R., & Pirankar, S. (2013). Domestic Violence against Women in Rural Goa (India): Prevalence, Determinants and Help-Seeking Behaviour. *IJHSR, 3*(9), 65-71.

Decker, M. R., Nair, S., Saggurti, N., Sabri, B., Jethva, M., Raj, A., . . . Silverman, J. G. (2013). *Violence-Related Coping, Help-Seeking and Health Care–Based Intervention Preferences Among Perinatal Women in Mumbai, India.* (28). Retrieved from http://jiv.sagepub.com/content/28/9/1924.abstract (9)

Djikanović, B., Lo Fo Wong, S., Jansen, H. A. F. M., Koso, S., Simić, S., Otašević, S., & Lagro-Janssen, A. (2012). Help-seeking behaviour of Serbian women who experienced intimate partner violence. *Family Practice, 29*(2), 189-195. doi: 10.1093/fampra/cmr061

Liang, B., Goodman, L., Tummala-Narra, P., & Weintraub, S. (2005). A Theoretical Framework for Understanding Help-Seeking Processes Among Survivors of Intimate Partner Violence. *American Journal of Community Psychology, 36*(1-2), 71-84. doi: 10.1007/s10464-005-6233-6

Sudha, S., & Morrison, S. (2011). Marital violence and women's reproductive health care in Uttar Pradesh, India. *Womens Health Issues, 21*(3), 214-221. doi: 10.1016/j.whi.2011.01.004

Kimuna, S. R., Djamba, Y. K., Ciciurkaite, G., & Cherukuri, S. (2013). Domestic violence in India: insights from the 2005-2006 national family health survey. *J Interpers Violence, 28*(4), 773-807. doi: 10.1177/0886260512455867

Campbell, J. C. (2002). Health consequences of intimate partner violence. *The Lancet, 359*(9314), 1331-1336. doi: http://dx.doi.org/10.1016/S0140-6736(02)08336-8

Boyle, M. H., Georgiades, K., Cullen, J., & Racine, Y. (2009). Community influences on intimate partner violence in India: Women's education, attitudes towards mistreatment and standards of living. *Soc Sci Med, 69*(5), 691-697. doi: 10.1016/j.socscimed.2009.06.039

Tables:

Table 1 presents individual, relationship level, socio-economic characteristics of women who reported exposure to spousal violence, by help-seeking status (weighted numbers).

Distribution of Help Seeking among married women exposed to IPV in last 12 months									
	Number of Women(Un-weight= 15,715) &) (weight=14,467)			**Sought Help(Un-weight= 3802& weight= 3538)**		**Did not Seek Help (Unweight=10 762 and weight=9875)**		**Missing Help Seeking (unweight=1151 & weight= 1054)**	
	N		**%**	**N**	**%**	**N**	**%**	**N**	**%**
Exposure - Type of Violence	Un-weighted	Weighted							
Emotional only	1904	1744	12.1	237	6.7	487	4.9	1020	97
Sexual only	1086	1061	7.3	73	2.1	988	10	1	0.1
Physical only	6170	6110	42.2	1229	34.7	4871	49.3	9.5	0.9
Emotional and Sexual	201	199	1.4	40	1.1	160	1.6	0	0.0
Emotional and Physical	3134	2927	20.2	1034	29.2	1893	19.2	0	0.0
Sexual and Physical	1202	1111	7.7	308	8.7	800	8.1	2	0.2
Emotional, Sexual &Physical	1448	1315	9.1	616	17.4	676	6.8	22	2.1
TOTAL	15715	14467	100	3538.0		9875		1054	
Covariates									
Women's Characteristics									
Age(in 5 year groups)									
15-19	804	973	7	206	6	693	7	75	7
20-24	2806	2683	19	632	18	1890	19	162	15
25-29	3768	3159	22	814	23	2157	22	188	18
30-34	3407	2768	19	693	20	1873	19	202	19
35-39	2468	2246	16	540	15	1528	15	179	17
40-44	1538	1631	11	395	11	1086	11	150	14
45-49	924	1006	7	258	7	648.8	7	99	9
TOTAL	15715	14467							
Highest Education Level									
None	7985	7770	54	1889	53	5438	55	443	42
Primary	2821	2623	18	666	19	1782	18	174	17
Secondary	4452	3770	26	927	26	2463	25	380	36
Higher than Secondary	457	304	2	56	2	192	2	56	5
TOTAL	15715	14467							
Employment(Currently Working)									
No	9265	8268	57	1923	54	5718	58	627	60

Yes	6429	6180	43	1609	46	4149	42	421	40
TOTAL	15694	14448							
Family History of Abuse									
No	9478	8650	66	1985	61	5891	67	774	81
Yes	4757	4425	34	1275	39	2964	33	186	19
TOTAL	14235	13076							
Age at marriage									
3-9	85	86	1	14	0	70	1	2	0
10-14	3368	3323	23	832	24	2294	23	197	19
15-19	9027	8408	58	2015	57	5848	59	544	52
20-24	2636	2202	15	580	16	1375	14	247	23
25-29	466	345	2	73	2	231	2	41	4
>=30	133	105	1	24	1	58	1	23	2
TOTAL	15715	14467							
Husbands Characteristics									
Age									
15-19	54	77	1	12	0	60	1	4	0
20-24	869	1006	7	234	7	703	7	68	7
25-29	2357	2224	15	510	14	1566	16	148	14
30-34	3104	2628	18	683	19	1779	18	167	16
35-39	3462	2821	20	716	20	1918	20	187	18
40-44	2518	2243	16	551	16	1530	16	162	15
45-49	1780	1829	12	425	12	1236	13	167	16
>50	1505	1577	11	388	11	1042	11	147	14
TOTAL	15649	14404							
Highest Education Level									
None	4857	4696	33	1224	35	3201	33	271	26
Primary	3099	2935	21	730	21	2033	21	170	16
Secondary	6514	5800	40	1390	40	3938	40	473	45
Higher than Secondary	1080	880	6	160.6	5	594	6	126	12
TOTAL	15550	14312							
Husbands number of Control issues									
‘0'	5978	5316	37	1005	28	3822	39	490	46
‘1-2'	5981	5605	39	1265	36	3976	40	364	35
‘3-4'	2746	2601	18	826	23	1613	16	162	15
‘5-6'	1010	945	6.5	441.8	12	464	5	39	4
TOTAL	15715	14467							
Husband Drinks Alcohol									
No	7292	7035	49	1299	37	5088	52	648	63
Yes	8402	7405	51	2239	63	4782	48	384	37

TOTAL	15694	14440							
Socio-economic Characteristics									
Religion									
Hindu	11684	10917	77	2692	78	7464	77	761	73
Muslim	2262	1996	14	437	12	1444	15	114.37	11
Christian	1030	925	7	232	7	556	6	137.3	13
Others	470	396	3	110	3	257.2	2	29	3
TOTAL	15446	14233							
Caste									
SC	3389	3032	22	845	25	2038	22	149	15
ST	2261	2249	16	523.8	15	1504	16	221	22
Other BC	5150	4815	35	1291	38	3183	34	342	34
Others	4255	3751	27	756	22	2704	28	291	29
TOTAL	15055	13847							
State- Region									
NORTH	2205	1907	13	455	13	1319	13	132	13
CENTRAL	3095	2988	21	819	23	1974	19	195	19
EAST	3207	3107	22	690	19	2263	23	155	15
WEST	1621	1549	11	316	9	1059	11	174	16
SOUTH	2873	2544	18	808	23	1569	16	167	16
NORTHAST	2714	2373	16	450	13	1692	17	231	21
TOTAL	15715	14467							
Type of residence									
Urban	6001	3742	26	897	25	2540	26	304	29
Rural	9714	10725	74	2640	75	7335	74	750	71
TOTAL	15715	14467							
Household wealth index									
Lowest	3285	3359	23	799	23	2368	24	193	18
Second	3430	3539	24	918	26	2403	24	218	21
Middle	3469	3297	23	869.3	25	2240	23	187	18
Fourth	3419	2670	19	626	18	1814	18	230	22
Highest	2112	1602	11	326	9	1050	11	226	21
TOTAL	15715	14467							
Relationship Characteristics									
Number of Living Children									
'0'	1237	1301	9	299	8	887	9	115	11
'1-2 '	6845	5988	41	1403	40	4095	42	491	47
'3-4'	5822	5295	37	1389	39	3571	36	334	32
'4 plus'	1811	1883	13	447	13	1322	13	114	11
TOTAL	15715	14467							

Number of Living Sons									
'0'	3515	3417	24	781	22	2347	24	290	28
'1-2 '	9980	9029	62	2257	64	6126	62	646	61
'3-4'	2009	1810	12	456	13	1244	13	110	10
'4 plus'	211	211	2	45	1	158	2	7	1
TOTAL	15715	14467							
Spousal Age difference									
Wife is older	423	394	3	89	3	265	3	40	4
Wife same age	447	405	3	101	3	267	3	37	4
Wife is younger'0-4 years'	5788	5318	37	1374	39	3583	36	361	34
Wife is younger'5-9 years'	6314	5854	40	1382	39	4042	41	430	41
Wife is younger' 10 or more'	2679	2434	17	573	16	1678	17	183	17
TOTAL	15651	14405							
Marital duration									
'0-4' years	2188	2241	16	472	13	1573	16	195	19
'5-9' years	3615	3186	22	780	22	2199	22	207	20
'10-14'years	3607	2906	20	776	22	1951	20	180	17
'15-19' years	2906	2487	17	618	18	1701	17	169	16
'20 to 24' years	1791	1813	12	444	13	1213	12	155	14
'25 to 29' years	1138	1296	9	324	9	869	9	103	10
'30 to 34' years	470	537	4	123	3	369	4	45	4
TOTAL	15715	14467							

Table 2 shows the significant associations of help seeking behavior –with exposure variables and other covariates.

Table 2. Association between help seeking behavior and type of violence

	Odds Ratio	**95% Confidence Interval**	**Chi-Square p-value**
Exposure - Type of Violence			**0.0001**
Physical only	**REF**		
Emotional only	1.93	(1.57, 2.380)	
Sexual only	0.29	(0.221, 0.389)	
Emotional and Sexual	0.99	(0.671, 1.485)	
Emotional and Physical	2.17	(1.89, 2.47)	
Sexual and Physical	1.53	(1.277, 1.83)	
Emotional, Sexual, and Physical	3.61	(3.14, 4.20)	
Covariates			

Woman's Characteristics			
Age(in 5 year groups)			**0.25**
15-19	0.89	(0.710, 1.114)	
20-24	**REF**	**REF**	
25-29	1.13	(0.981, 1.298)	
30-34	1.11	(0.958, 1.28)	
35-39	1.06	(0.889, 1.241)	
40-44	1.09	(0.909, 1.301)	
45-49	1.19	(0.954, 1.481)	
Highest Education Level			**0.2485**
None	**REF**	**REF**	
Primary	1.08	(0.947, 1.223)	
Secondary	1.08	(0.96, 1.216)	
Higher than Secondary	0.84	(0.597, 1.170)	
Employment(Currently Working)			**0.0058**
No	**REF**	**REF**	
Yes	1.15	(1.042, 1.276)	
Family History of Abuse			**0.0001**
NO	**REF**	**REF**	
YES	1.28	(1.148, 1.419)	
Age at marriage			**0.0171**
3-9	0.56	(0.274, 1.148)	
10-14	1.05	(0.938, 1.183)	
15-19	**REF**	**REF**	
20-24	1.23	(1.076, 1.394)	
25-29	0.92	(0.702, 1.194)	
>=30	1.18	(0.707, 1.982)	
Husbands Characteristics			
Age			**0.3036**
15-19	0.595	(0.260, 1.362)	
20-24	**REF**	**REF**	
25-29	0.98	(0.781, 1.222)	
30-34	1.15	(0.928, 1.430)	
35-39	1.12	(0.910, 1.382)	
40-44	1.08	(0.867, 1.349)	
45-49	1.03	(0.817, 1.304)	
>50	1.12	(0.876, 1.427)	
Highest Education Level			**0.0208**
None	**REF**		
Primary	0.94	(0.828, 1.067)	
Secondary	0.92	(0.827, 1.030)	

Higher than Secondary	0.71	(0.569, 0.882)	
Husbands number of Control issues			**0.0001**
'0'	**REF**	**REF**	
'1-2'	1.21	(1.079, 1.358)	
'3-4'	1.95	(1.703, 2.227)	
'5-6'	3.62	(3.045, 4.310)	
Husband Drinks Alcohol			**0.0001**
No	**REF**	**REF**	
Yes	1.83	(1.663, 2.022)	
Socio- economic characteristics			
Religion			**0.0371**
Hindu	**REF**	**REF**	
Muslim	0.84	(0.713, 0.989)	
Christian	1.15	(0.942, 1.415)	
Others	1.18	(0.891, 1.568)	
Caste			**0.0001**
SC	**REF**	**REF**	
ST	0.84	(0.713, 0.990)	
Other BC	0.98	(0.855, 1.118)	
Others	0.67	(0.583, 0.780)	
State- Region			**0.0001**
North	1.29	(1.082, 1.555)	
Central	1.56	(1.307, 1.861)	
East	1.15	(0.944, 1.391)	
West	1.12	(0.892, 1.410)	
South	1.94	(1.618, 2.318)	
Northeast	**REF**	**REF**	
Type of residence			**0.7756**
Urban	**REF**	**REF**	
Rural	1.02	(0.897, 1.157)	
Household wealth index			**0.0459**
Lowest	0.87	(0.758, 0.997)	
Second	0.98	(0.861, 1.125)	
Middle	**REF**	**REF**	
Fourth	0.89	(0.771, 1.027)	
Highest	0.8	(0.667, 0.959)	
Relationship Characteristics			
Number of Living Children			**0.0552**
'0'	REF	REF	
'1-2 '	1.02	(0.850, 1.215)	
'3-4'	1.15	(0.965, 1.380)	

'4 plus'	1.003	(0.818, 1.230)	
Number of Living Sons			**0.1991**
'0'	REF	REF	
'1-2 '	1.11	(0.992, 1.235)	
'3-4'	1.10	(0.945, 1.282)	
'4 plus'	0.85	(0.566, 1.271)	
Spousal Age difference			**0.2032**
Wife is older	0.87	(0.665, 1.149)	
Same age	0.99	(0.752, 1.307)	
Wife is younger'0-4 years'	REF	REF	
Wife is younger'5-9 years'	0.89	(0.803, 0.991)	
Wife is younger' 10 or more'	0.89	(0.780, 1.020)	
Marital duration			**0.0339**
‘0-4' years	REF	REF	
‘5-9' years	1.18	(1.014, 1.377)	
‘10-14' years	1.32	(1.136, 1.544)	
‘15-19' years	1.21	(1.036, 1.415)	
‘20 to 24' years	1.22	(1.016, 1.467)	
‘25 to 29' years	1.24	(1.008, 1.534)	
‘30 to 34' years	1.11	(0.825, 1.490)	

Table 3 presents the results of multilevel logistic regression models- (Crude and Adjusted) predicting report of help seeking, for our sample of women that had experienced IPV in last 12 months

Table 3. Adjusted association between help seeking behavior and type of violence

	Crude	**Adjusted for x, y, z (strong confounders from table 2)**
	OR (95% CI)	**OR (95% CI)**
Exposure - Type of Violence		
Sexual only	0.29(0.221, 0.389)	0.35(0.256, 0.470)
Physical only	**REF**	**REF**
Emotional and Sexual	0.99(0.671, 1.485)	0.96(0.634, 1.451)
Emotional and Physical	2.17(1.895, 2.477)	1.89(1.655, 2.177)
Sexual and Physical	1.53(1.227, 1.828)	1.63(1.344, 1.968)
Emotional, Sexual, and Physical	3.61(3.104, 4.204)	2.84(2.392, 3.366)

*Adjusting for confounders-Women's age , education, employment, children ,religion, region, caste, household wealth index, marital duration, husbands control issues, husbands drinks alcohol

Table 4. Adjusted association between help seeking behavior and type of violence STRATIFIED BY EDUCATION* SINCE EDUCATION IS INTERACTION	
	Adjusted for x, y, z (strong confounders from table 2)
	OR (95% CI)
EDUCATION='none'	
Sexual only	0.41(0.276, 0.619)
Physical only	**REF**
Emotional and Sexual	0.77(0.387, 1.521)
Emotional and Physical	1.80(1.5, 2.168)
Sexual and Physical	1.71(1.330, 2.188)
Emotional, Sexual, and Physical	2.58(2.061, 3.232)
EDUCATION = 'primary'	
Sexual only	0.31(0.159, 0.598)
Physical only	**REF**
Emotional and Sexual	2.06(1.004, 4.223)
Emotional and Physical	2.10(1.54, 2.871)
Sexual and Physical	1.61(1.036, 2.501)
Emotional, Sexual, and Physical	2.77(1.889, 4.07)
EDUCATION= 'secondary education'	
Sexual only	0.29(0.173, 0.5)
Physical only	**REF**
Emotional and Sexual	0.47(0.184, 1.227)
Emotional and Physical	2.01(1.55, 2.611)
Sexual and Physical	1.45(1.004, 2.096)
Emotional, Sexual, and Physical	3.57(2.542, 5.027)
EDUCATION= 'Higher secondary '	
Emotional only	
Sexual only	0.005(0.001, 0.044)
Physical only	**REF**
Emotional and Sexual	23.83(3.342, 169.9)
Emotional and Physical	5.82(1.977, 17.109)
Sexual and Physical	0.63(0.065, 6.114)
Emotional, Sexual, and Physical	24.86(5.303, 116.54)

Table 5. Adjusted association between help seeking behavior and type of violence STRATIFIED BY STATES/REGION* SINCE REGION IS INTERACTION	
	Adjusted for x, y, z (strong confounders from table 2)
	OR (95% CI)
REGION =' North'	
Sexual only	0.16(0.067, 0.386)
Physical only	**REF**
Emotional and Sexual	0.38(0.096, 1.521)
Emotional and Physical	2.38(1.71, 3.301)
Sexual and Physical	1.55(0.986, 2.45)
Emotional, Sexual, and Physical	4.33(2.887, 6.495)
REGION = 'Central'	
Sexual only	0.41(0.236, 0.729)
Physical only	**REF**
Emotional and Sexual	0.99(0.343, 2.897)
Emotional and Physical	1.65(1.23, 2.21)
Sexual and Physical	1.41(0.967, 2.055)
Emotional, Sexual, and Physical	1.76(1.244, 2.486)
REGION = 'East'	
Sexual only	0.19(0.107, 0.35)
Physical only	**REF**
Emotional and Sexual	0.56(0.263, 1.207)
Emotional and Physical	1.8(1.32, 2.455)
Sexual and Physical	1.26(0.84, 1.88)
Emotional, Sexual, and Physical	2.3(1.554, 3.488)
REGION = 'West'	
Sexual only	0.58(0.168, 2.001)
Physical only	**REF**
Emotional and Sexual	5.21(1.026, 26.447)
Emotional and Physical	1.67(1.105, 2.537)
Sexual and Physical	1.85(0.661, 5.174)
Emotional, Sexual, and Physical	5.92(3.088, 11.35)
REGION = 'South'	
Sexual only	0.75 (0.259, 2.198)
Physical only	**REF**
Emotional and Sexual	3.87 (0.847, 17.7)
Emotional and Physical	2.08(1.546, 2.783)
Sexual and Physical	3.28(1.908, 5.637)
Emotional, Sexual, and Physical	3.1(1.948, 4.914)

REGION = 'North-East'	
Sexual only	0.63(0.333, 1.19)
Physical only	**REF**
Emotional and Sexual	0.75(0.286, 1.973)
Emotional and Physical	2.93(2.04, 4.216)
Sexual and Physical	2.17(1.345, 3.49)
Emotional, Sexual, and Physical	4.13 (2.869, 5.948)

Chapter 4: Discussion, Conclusion and Recommendations

Discussion

This study provides an understanding of help-seeking behaviors among battered Indian women in response to IPV and specific factors that are related to help seeking.

This study is based on a large nationally representative data. Findings from this cross sectional study yielded that majority of the married women exposed to Intimate Partner/Spousal Violence in the last 12 months did not seek help (~68%) from any sources. Among those who sought help (~24%) most of them relied on informal sources. Reasons for not disclosing abuse could be attributed to fear of divorce, financial insecurity, or other consequences such as re-victimization by partner or threat of losing children. Previous literature in Indian context shows that fear of stigma, shame, related fears of jeopardizing family honor, belief that husbands have the right to abuse, cultural prohibitions, perceptions of violence as not serious were other reasons for not disclosing abuse (Panchanadeswaran & Koverola, 2005). Some battered women also interpreted their violent experiences were as a result of their own shortcomings and their guilt did not make them seek help (Liang et al., 2005). This is very significant since seeking help is vital to start the healing process of combating both physical and mental stress. Therefore it is necessary to understand the help seeking behaviors and patterns of these women in order to better conduct services and provide access to help and care accordingly. The informal help sources, including family members, friends and neighbors, emerged as the primary support system in situations of violence in our study , which is consistent with prior evidence (Decker et al., 2013). The common perception that legal services are inefficient in providing a solution or lack of awareness of existing services; inaccessibility of services in some remote places or rural India, negative experiences and delayed help from police explains women's dependency and preferred utilization of informal sources (Decker et al., 2013)(Panchanadeswaran & Koverola, 2005).

IPV is highly prevalent in India and has serious impact on a women's health. Studies have shown it is cause of various mental, physical, reproductive health disorders. Various suicidal, post-traumatic stress disorders and abortion cases are related to IPV. It not only has an impact on the women but also on her children mentally and physically. Help-seeking is a coping strategy, which is also found to have a positive association with lower levels of distress among abused women (Ahmad et al., 2009; Panchanadeswaran & Koverola, 2005). Hence, providing required resources to these women, understanding and removing the perceived barriers to disclosure is of primary importance. Previous few studies in various settings in India and Bangladesh regarding the help seeking behavior showed that women sought delayed help only after prolonged and repeated exposure to IPV or if the violence was very severe (Naved et al., 2006; Sabri et al., 2014).

This quantitative study fills in the gap in India by highlighting which type of violence specifically precipitates the women to seek help and other factors and characteristics associated with help -seeking behavior. After controlling for socio- economic, relationship and demographics predictors our findings pointed out that as compared to other types of violence, exposure to physical violence triggers the women to seek help. Those women who are exposed to physical violence in combination with any other violence, emotional or sexual or both have higher odds of seeking help than those exposed to emotional abuse or sexual abuse. In our study, about 34.7% of the women sought help for Physical only and about 30% of the women sought help for physical and emotional. This suggests that verbal and sexual abuse are not considered to be serious forms of abuse by these women and treated more like a private relationship matter. Since emotional violence is generally accompanied with physical or sexual violence, it wasn't taken into consideration during our multivariate analysis. Women may disclose physical abuse

because injuries are visible and there is a higher chance that the society might believe them. Other than the impact of physical injuries is immediate and could be threatening. Consistent with previous literature, our study showed that there was a significance difference between help seekers and non- help seekers based on their employment status (Ackerson & Subramanian, 2008). An employed woman could be more confident and financially independent, which gives her an edge to leave her partner if he abuses her. Also, in such a case, the husband might be more careful and less likely to resort to violence. Other key findings highlighted in this study were that help seeking rates varied greatly by state /region and education. Women with higher education show differences in help seeking pattern by type of violence compared to women with other level of education. The large differences in IPV and help seeking trends between states regions emphasize the role that community context plays in IPV across India. Our study shows that woman in the western region are observed to have highest odds of seeking help. Prevalence of help seeking behavior is less commonly seen in the eastern and northern regions compared to the other regions. Also, there seems a possibility that socio-economic and education levels of the community and neighborhood could modify this help seeking behavior amongst the women. Previous history of family abuse, husband's number of control issues and his alcohol drinking habits are significantly associated with women's help seeking behavior. Wealth was only a protective factor against IPV in the richest class in the society which is comprises of the smallest % of the population. The current study contributes to existing research on women who are abused in India by emphasizing on the rampant issue of wife abuse, its harmful effects on victim's health, and revealing factors associated with a women's help-seeking behavior. However, these findings need to be viewed with caution, given the limitations of the study.

Strengths

Very few studies in India explore the help seeking behavior among the IPV exposed women and most of these studies are limited to data limited to one to three states. Our study consists of a large nationally representative sample inclusive of randomly selected women from all states. Even though most of population we observe in our study sample is rural based, the results can be applicable to the country as a whole. Our sample was weighted by states. We calculated weighted frequencies. Also, findings enable comparisons across demographic or other groupings. Our study provides information on the characteristics significant to help seeking, thus helping government and social services agencies understanding the patterns on help seeking.

Limitations

One of the limitations of the study is that all of the measures were self-reported and there could be possible bias or under reporting. Further, due to secondary analysis, we were limited to variables that were available in the dataset and could not assess other potential risk factors and qualitative information on reasons of help-seeking. Also, we considered only women who were exposed to IPV in the last 12 months with the intention to get more accurate information. However, the help seeking information in the data due to IPV didn't mention the period and timeline. A large number of women exposed to IPV in last 12 months (~7.2 %) haven't responded whether they sought help or not and we cannot account for these numbers which potentially affects our results. Since the data provided women's age at marriage, it is possible that age at marriage could even include her first marriage if she was previously married. Thus, it does not give accurate numbers on marital information. Another drawback is related to the assessment of the women's satisfaction with the help they received and the behavioral reasons of what made them seek help or not. We did not investigate what they had actually expected of these services and why they were satisfied or not with the received help.

Conclusion and Recommendations

Intimate Partner violence is a pervasive medical-social issue. This study contributes to a better understanding of association between type of spousal violence and help seeking behavior of the women .These findings provide direction for developing public policies and health based interventions in settings such as rural India. Although policies have been created to combat such violence, gender inequity makes the women in India still highly susceptible to IPV and barriers to disclosure .The Government of India recently launched (2006) a Protection of women from Domestic Violence Act 2005 thereby increasing opportunities for large-scale implementation of evidence-based domestic violence reduction interventions in the country. However, yet much remains to be learned about prevention strategies which may be sustainable and effective. We must continue to conduct qualitative and formative studies to explore the process through which IPV survivors define their abusive situations and seek help pattern. In addition, there is a need to decrease abuse against women and promote disclosure, as well as improve accessibility of both formal and informal services in order to help them to cope with their distress in a more efficient way and improve their productivity while on their course to emotional and financial independence.

References

Ackerson, L. K., & Subramanian, S. V. (2008). State Gender Inequality, Socioeconomic Status and Intimate Partner Violence (IPV) in India: A Multilevel Analysis. *Australian Journal of Social Issues (Australian Council of Social Service), 43*(1), 81-102.

Ahmad, F., Driver, N., McNally, M. J., & Stewart, D. E. (2009). "Why doesn't she seek help for partner abuse?" An exploratory study with South Asian immigrant women. *Social Science & Medicine, 69*(4), 613-622. doi: http://dx.doi.org/10.1016/j.socscimed.2009.06.011

Boyle, M. H., Georgiades, K., Cullen, J., & Racine, Y. (2009). Community influences on intimate partner violence in India: Women's education, attitudes towards mistreatment and standards of living. *Soc Sci Med, 69*(5), 691-697. doi: 10.1016/j.socscimed.2009.06.039

Campbell, J. C. (2002). Health consequences of intimate partner violence. *The Lancet, 359*(9314), 1331-1336. doi: http://dx.doi.org/10.1016/S0140-6736(02)08336-8

CIA. (2011). "The World Factbook: India."

doi: https://www.cia.gov/library/publications/the-world-factbook/geos/in.html.

Dalal, K. (2011). Does economic empowerment protect women from intimate partner violence? *J Inj Violence Res, 3*(1), 35-44. doi: 10.5249/jivr.v3i1.76

Dalal, K., & Lindqvist, K. (2012). A national study of the prevalence and correlates of domestic violence among women in India. *Asia Pac J Public Health, 24*(2), 265-277. doi: 10.1177/1010539510384499

Decker, M. R., Nair, S., Saggurti, N., Sabri, B., Jethva, M., Raj, A., . . . Silverman, J. G. (2013). *Violence-Related Coping, Help-Seeking and Health Care–Based Intervention Preferences Among Perinatal Women in Mumbai, India.* (28). Retrieved from http://jiv.sagepub.com/content/28/9/1924.abstract (9)

Djikanović, B., Lo Fo Wong, S., Jansen, H. A. F. M., Koso, S., Simić, S., Otašević, S., & Lagro-Janssen, A. (2012). Help-seeking behaviour of Serbian women who experienced intimate partner violence. *Family Practice, 29*(2), 189-195. doi: 10.1093/fampra/cmr061

Garcia-Moreno, C., Jansen, H. A. F. M., Ellsberg, M., Heise, L., & Watts, C. H. Prevalence of intimate partner violence: findings from the WHO multi-country study on women's health and domestic violence. *The Lancet, 368*(9543), 1260-1269. doi: http://dx.doi.org/10.1016/S0140-6736(06)69523-8

Gaurav, S., Analava, M., Dinesh, K., S, M., & A, B. (2010). Role of nonconventional remedies in rural India *INTERNATIONAL JOURNAL OF PHARMACY & LIFE SCIENCES*.

IIPS, & MACRO, I. (2009). National Family Health Survey (NFHS-3). Mumbai, Indian Institute of Population Sciences

Jejeebhoy, S. J., & Sathar, Z. A. Women's Autonomy in India and Pakistan: The Influence of Religion and Region.

Kamat, U. S., Ferreira, A. M. A., Mashelkar, K., Pinto, N. R., & Pirankar, S. (2013). Domestic Violence against Women in Rural Goa (India): Prevalence, Determinants and Help-Seeking Behaviour. *IJHSR, 3*(9), 65-71.

Kim, J. Y., & Lee, J. H. (2011). Factors influencing help-seeking behavior among battered Korean women in intimate relationships. *J Interpers Violence, 26*(15), 2991-3012. doi: 10.1177/0886260510390946

Kimuna, S. R., Djamba, Y. K., Ciciurkaite, G., & Cherukuri, S. (2013). Domestic violence in India: insights from the 2005-2006 national family health survey. *J Interpers Violence, 28*(4), 773-807. doi: 10.1177/0886260512455867

Krug, E. G., Mercy, J. A., Dahlberg, L. L., & Zwi, A. B. (2002). The world report on violence and health. *The Lancet, 360*(9339), 1083-1088. doi: http://dx.doi.org/10.1016/S0140-6736(02)11133-0

Liang, B., Goodman, L., Tummala-Narra, P., & Weintraub, S. (2005). A Theoretical Framework for Understanding Help-Seeking Processes Among Survivors of Intimate Partner Violence. *American Journal of Community Psychology, 36*(1-2), 71-84. doi: 10.1007/s10464-005-6233-6

Linos, N., Slopen, N., Berkman, L., Subramanian, S. V., & Kawachi, I. (2013). Predictors of help-seeking behaviour among women exposed to violence in Nigeria: a multilevel analysis to evaluate the impact of contextual and individual factors. *Journal of Epidemiology and Community Health*. doi: 10.1136/jech-2012-202187

Naved, R. T., Azim, S., Bhuiya, A., & Persson, L. Å. (2006). Physical violence by husbands: Magnitude, disclosure and help-seeking behavior of women in Bangladesh. *Social*

Science & Medicine, *62*(12), 2917-2929. doi: http://dx.doi.org/10.1016/j.socscimed.2005.12.001

Nayak, M. B., Patel, V., Bond, J. C., & Greenfield, T. K. (2010). Partner alcohol use, violence and women's mental health: population-based survey in India. *The British Journal of Psychiatry*, *196*(3), 192-199.

NFHS. (2007). National Family Health Survey (NFHS-3), 2005-06:

India. Mumbai, Maharashtra, India: International Institute for Population Sciences (IIPS)

and Macro International.

Panchanadeswaran, S., & Koverola, C. (2005). The Voices of Battered Women in India. *Violence Against Women*, *11*(6), 736-758. doi: 10.1177/1077801205276088

Pandey, G. K., Dutt, D., & Banerjee, B. (2009). Partner and relationship factors in domestic violence: perspectives of women from a slum in Calcutta, India. *J Interpers Violence*, *24*(7), 1175-1191. doi: 10.1177/0886260508322186

Patel, R. The Practice of Sex Selective Abortion in India: May You Be the

Mother of a Hundred Sons.

Sabri, B., Renner, L. M., Stockman, J. K., Mittal, M., & Decker, M. R. (2014). Risk Factors for Severe Intimate Partner Violence and Violence-Related Injuries among Women in India. *Women Health*. doi: 10.1080/03630242.2014.896445

Silverman, J. G., Decker, M. R., Saggurti, N., Balaiah, D., & Raj, A. (2008). Intimate partner violence and HIV infection among married Indian women. *JAMA*, *300*(6), 703-710. doi: 10.1001/jama.300.6.703

Stephenson, R., Winter, A., & Hindin, M. (2013). Frequency of intimate partner violence and rural women's mental health in four Indian states. *Violence Against Women, 19*(9), 1133-1150. doi: 10.1177/1077801213501898

Sudha, S., & Morrison, S. (2011). Marital violence and women's reproductive health care in Uttar Pradesh, India. *Womens Health Issues, 21*(3), 214-221. doi: 10.1016/j.whi.2011.01.004

WHO. (2002). World Report on Violence and Health: Summary

WHO. (2005). WHO Multi-country Study on Women's Health and Domestic Violence against Women: summary report on initial results on prevalence, health outcomes and women's responses.

WHO. (2012). World Report on Violence and Health: Summary

Winter, A., & Stephenson, R. (2013). Intimate partner violence and symptoms of reproductive tract infections among married Indian women. *International Journal of Gynecology & Obstetrics, 121*(3), 218-223.

Signature for Non-Research Projects

This cross-sectional study explores help seeking behavior of currently married IPV exposed women from formal or informal sources with regard to type of violence perpetrated and individual, relationship level and socio- economic characteristics. Data is obtained from National Health Family Survey India -3 (DHS 2005). Sample size consisted of currently married IPV exposed women in last 12 months (prior to survey) of the reproductive age (15-49 years). Weighted frequencies were calculated. Chi square tests and logistic regression analysis were conducted to understand the association between help seeking behavior and type of violence with covariates such as personal, relationship, and socio economic characteristics. From our overall sample size of 15,715 women [un-weighted], 3802 (~24%) women sought help, while 10762 (~68%) did not seek help for IPV. Help seeking behavior is associated type of violence in a fully adjusted model. For example, odds of seeking help is 2.8 times more for exposure to all three types of IPV compared to physical only (OR = 2.84 95% CI 2.392, 3.366). A higher proportion of help seekers than non- help seekers were employed Women whose husband had control issues and alcohol drinking habits were more likely to seek help. Help seeking varied significantly by women's education and region of residence. Consistent with previous local studies, our national findings indicate low help seeking rates amongst women exposed to IPV in India. The wide variation in help seeking behavior may inform policies and interventions to prevent violence and to provide assistance to those who have been violated. This study is a secondary data analysis. There is no need to submit this proposal for IRB clearance.

I have read the attached information and verify that this project is not research and therefore does not need to be submitted to the Emory University Institutional Review Board.

_____ _____

Signature of Thesis Advisor **Date**