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Association of Marital Violence with Contraceptive Use in India

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Abstract

Intimate Partner Violence (IPV) against women is a global issue (a prominent social determinant of health) and a significant public health concern. Ever married women's ever experience of spousal physical or sexual violence has declined from 37 per cent in NFHS-3 to 29 per cent in NFHS-4. However, there has been almost no change in women's experience of spousal physical or sexual violence in the 12 months preceding each survey (24% in NFHS-3 and 22% in NFHS-4). The infliction of physical violence has multi-dimensional implications. On the one side, it has a long trail of ill-effects for the victims ranging from physical, reproductive and mental health outcomes and, on the other side, it has far-reaching consequences for family planning in India. The paper throws light on the hidden factors that are obstacles to the use of contraception with any violence by using the data of women's file from NFHS-4 (2015-16). We used binary logistic regression, multinomial logistic regression and bivariate analysis for all the objectives. The key finding of the paper is that limiting methods are used more than spacing methods by women experiencing physical, sexual or emotional violence. Coordinated efforts can be undertaken to increase awareness about the adverse impact of domestic violence on contraception.

Keywords: Marital violence, contraceptive use, NFHS-4, India.

I. Introduction

The United Nations defines violence against women as "any act of gender-based violence that results in, or is likely to result in, physical, sexual, or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life." According to WHO estimates, one in every three (30%) women in the world has experienced physical and/or sexual intimate partner abuse or non-partner sexual violence at some point in her life (WHO, 2021). Intimate Partner Violence (IPV) against women is a global issue, a major social determinant of health and a major public health concern. Physical aggression, sexual coercion, verbal abuse and controlling behaviour are examples of it. According to multi-country studies, nearly one-third of all women worldwide have experienced physical and/or sexual violence by an intimate partner, with rates ranging from 15 per cent in Japan to 71 per cent in Ethiopia. The rates were particularly high in central and western sub-Saharan Africa, and South Asia. Ever married women's ever experience of spousal physical or sexual violence has declined from 37 per cent in NFHS-3 to 29 per cent in NFHS-4. However, there has been almost no change in women's experience of spousal physical or sexual violence in the 12 months preceding each survey (24% in NFHS-3 and 22% in NFHS-4). According to WHO, IPV is "behaviour within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship". The prevalence of physical violence among women is much higher than sexual and emotional violence. Domestic violence is more common in northern India than in southern India, yet it occurs throughout the country. One of the most cost-effective investments a country can make in its future is family planning. Economic development, mother and child health, education, and women's empowerment are only some of the potential benefits. Contraceptives are used by a majority of married women in the reproductive age

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range (15-49 years) in practically every region of the world. Worldwide in 2017, 63 per cent of these women used some form of contraception (WHO, 2019). In India, the family planning is characterized by high levels of knowledge and low levels of use. Beyond a woman's own ability to use contraceptives at the individual level, family and community level resources contribute to the adoption of contraceptive methods, as do cultural norms and institutions that affect autonomy, behaviour and access to health care (Chacko, 2001). In India sterilization is the most common technique of family planning, but in many states traditional birth spacing methods are preferred over contemporary alternatives.

In the past, India's family planning programmes were more concerned with managing population increase than with improving women's reproductive rights and choices. This resulted in the explicit advocacy of sterilization which was almost entirely directed at women. Government policy has since changed as laid out in the Family Planning 2020 action plan, which still promotes sterilization with monetary compensation (both for individuals undergoing the procedure and for the health providers) but reversible modern contraception methods are also included. Target 5.6 of the Sustainable Development Goals, advocated by the United Nations and adopted by 193 nations, is to ensure universal access to sexual and reproductive health and reproductive rights for all women. To address their need for family planning, provision of a wide range of safe, effective and affordable contraceptive methods is essential (Ewerling et al., 2021). IPV has been linked to different types of contraception, with it is more common among pill users but less common among condom users. The use of IUDs has increased recently, allowing this kind of contraception to be considered. The ability of a woman to make her own family planning decisions is an important part of her reproductive autonomy and is crucial to increasing contraceptive use and reducing unwanted pregnancy. In a multi-country analysis of the impact of domestic violence on women's health, women who had experienced abuse had greater fertility levels, more undesired births and a lower capacity to use contraception consistently, according to Kishor and Johnson (2004). They discovered that a woman's capacity to take contraceptives was directly hampered by a lack of sexual autonomy and control in an environment where violence is feared as a result of contraceptive use and to avoid subsequent unwanted pregnancies. From 2006 to 2018, the contraceptive prevalence rate and use of modern contraceptive methods increased slowly. The findings of this study showed that having a higher educational level and a higher wealth index enhanced the likelihood of using contraception. Media exposure to family planning and spousal communication were protective factors that encouraged women to use contraception to avoid unwanted pregnancy (Nguyen et al., 2021).

Several studies have focused on the correlates of intimate partner violence. A study published in *Lancet* observed that women's gender-related factors, education and employment status are associated with spousal violence (Ewerling et al., 2021). Its findings demonstrate that nearly three in every four (72%) partnered women in need of contraception in India use a modern method. The results showed that the highest share of Short acting reversible contraceptive (SARC) and Long acting reversible contraceptive (LARC) use were found among women with higher socio-economic status, education and empowerment levels. Importantly, this study was able to uncover how women meet their need for family planning across both kinds of contraception and dimensions of empowerment. Considerable research has been conducted which has revealed negative effects of gender-based violence (GBV) on sexual autonomy, unwanted pregnancy and induced abortion. Two per cent of first-time mothers (2.4%) reported spousal physical violence while pregnant. Women who reported abuse during pregnancy were less likely to subsequently use male-controlled contraception than no contraception and more likely to use female-controlled vs. male-controlled spacing contraception (McDougal et al., 2020). The magnitude of the positive relationship between physical and sexual violence and contraceptive use decreases in the presence of legal regulations against domestic violence (Fan et al., 2020). Among the 1001 women included, 109 (10.9%) reported experiencing physical IPV and 27 (2.7%) reported experiencing sexual IPV in the past 12 months. Women experiencing physical IPV were significantly less likely to use condoms than women not experiencing violence. There was a trend towards increased IUD use among women experiencing physical IPV compared with those not experiencing physical IPV, but this did not reach statistical significance (Chen et al., 2020).

There is increasing research on how intimate partner violence influences contraceptive decision-making with the recognition that these decisions are influenced by marital power imbalances as well as access and acceptability. Unfortunately, there is lack of information on contraceptive options in the aftermath of gender-based violence during pregnancy. There are an estimated 7.8 million women in India affected by violence during pregnancy, and an ongoing, heavy reliance on female sterilization as the dominant form of contraception (McDougal et al., 2020). Contraception aids help in delaying, spacing and limiting pregnancies; decrease healthcare expenses and ensure that more girls finish their education, enter and stay in the workforce, resulting in gender balance at workplace. In 2015, the United Nations established the 2030 Agenda for Sustainable Development, which included a global goal to stop "…all kinds of violence against women and girls in both public and private realms." In 2016, the World Health Assembly passed Resolution 69.5 which called for a global plan of action to increase the health system's involvement in a national multisector response to interpersonal violence, particularly against women and young girls. Despite all of these directives, 49 countries have yet to create an official domestic violence policy. This paper examines the usage of contraceptive methods among women who have experienced any kind of spousal violence.

II. Data and methods

The present study utilizes the data of women's file from NFHS-4 (2015-16). It is used for assessing the information on marital violence with contraceptive use. The NFHS is a nationally representative, cross-sectional and demographic and health survey similar in design to the general format adopted for Demographic and Health Surveys (DHS) worldwide. Domestic violence was also one of the components of this survey where only one eligible woman from each household was selected and interviewed. Data on contraception was also collected in NFHS-4 under district module.

Although NFHS-4 provides information at the district level, the survey includes a section on domestic violence only at the state level. Data were collected from only one woman in each household. Women who had ever been physically, emotionally or sexually abused by their current husbands in the past 12 months were categorized as having experienced any spousal violence. To calculate physical violence, the currently married women were asked seven questions such as did their husbands (a) slap? (b) twist the arm or pull the hair? (c) push, shake or throw something at them? (d) punch with their fist or with something that could hurt? (e) kick, drag or beat? (f) try to choke or burn on purpose? and (g) threaten or attack with a knife, gun, etc.? If a woman reported that she had experienced any of the above acts by her husband, it was considered as an incident of physical violence. Similarly, for the computation of emotional violence, currently married women were asked if their husbands: (a) say or do something to humiliate them in front of others? (b) threaten to hurt or harm them or someone close to you? and (c) insult them or made them feel bad? If one of the answers by a woman was affirmative, it was considered as a case of emotional violence. As for sexual violence, women were asked if they had been: (a) ever physically forced into unwanted sex by husbands/partners? (b) ever forced into other unwanted sexual acts by husbands/partners? and (c) ever physically forced them to perform unwanted sexual acts? If the response was positive for one of the questions, it was considered as a case of sexual violence. The contraceptive use has been recoded as non-users, limiting methods and spacing methods.

The study examined the possible association between contraceptive use and spousal violence by doing cross-tabulation. Binary and multivariate logistic regressions were used to obtain unadjusted and adjusted odds ratios by controlling a number of explanatory factors such as caste, religion, education, mass media exposure, wealth, employment, marital status and women's empowerment variables. The P-value of less than 0.05 was considered statistically significant at 95 per cent of the confidence interval. The odds ratio larger than one represents a greater likelihood of the outcome than the reference category in the multiple logistic regression analysis. All the statistical estimations were done using STATA 17.0. Appropriate sampling weights were used in estimations.

III. Results

Table 1 shows that the highest number of non-users have experienced sexual violence in the last 12 months. Women who use more limiting methods have experienced more physical violence. The experience of sexual violence is higher in women using spacing methods. Among the limiting methods, female fertilization is mostly used by women experiencing violence in the last 12 months.

Table 1. Percentage distribution of contraceptive methods by different types of violence in India

Contraceptive methods	Physical violence	Sexual violence	Emotional violence	Any violence
Non-users	47.8	51.2	49.3	48.0
Limiting methods	37.2	32.8	36.7	36.7
Female sterilization	36.8	32.7	36.5	36.5
Male sterilization	0.3	0.2	0.3	0.3
Spacing Methods	15.1	16.0	13.9	15.3
Pill	3.9	4.4	3.7	4.0
IUD	1.5	1.4	1.3	1.5
Injections	0.2	0.2	0.2	0.2
Condom	4.4	4.4	4.1	4.4
Rhythm/Periodic abstinence	2.9	2.8	2.0	2.8
Withdrawal	2.2	2.7	2.5	2.4
Lactational Amenorrhea Method	0.1	0.1	0.1	0.1

Table 2 shows that 48 per cent women experiencing any violence or any physical violence did not use any contraception. Limiting methods are used more than spacing methods by women who experienced violence. Spacing methods were used by 15 per cent women experiencing physical violence and 37 per cent used limiting methods. Fifty-one per cent women experiencing sexual violence did not use contraception. Spacing methods were used by 16 per cent of women

Table 2. Percentage distribution of contraceptive methods use vis-a-vis different types of violence, India, NFHS-4

Marital violence	Non-users	Users	Limiting methods	Spacing methods
Physical violence				
Any form of physical violence	47.8	52.2	37.2	15.1
Ever been pushed, shook or had something thrown	48.7	51.3	36.9	14.4
Ever been slapped	47.5	52.5	36.9	15.6
Ever been punched or hit by something harmful	49.1	50.9	36.8	14.1
Ever been kicked or dragged	49.3	50.7	38.2	12.6
Ever been strangled or burnt	55.2	44.9	34.3	10.6
Ever been threatened by a knife/gun or other things	55.2	44.8	38.7	6.2
Ever had arm-twisted or hair pulled	51.5	48.5	35.5	13.0
Sexual violence				
Any form of sexual violence	51.2	48.8	32.9	16.0
Ever been physically forced into unwanted sex	50.6	49.4	33.1	16.3
Ever been forced into other unwanted sexual acts	51.2	48.8	33.8	15.0
Ever been physically forced to perform sexual acts	50.7	49.3	33.1	16.2
Emotional violence				
Any form of emotional violence	49.5	50.5	37.0	13.4
Ever been humiliated	48.7	51.3	38.3	13.0
Ever been threatened with harm	51.9	48.1	35.9	12.2
Ever been insulted or made to feel bad	49.2	50.8	36.9	14.0
Any form of phy. or sex. or emo. Violence	48.0	52.1	36.7	15.3

experiencing sexual violence, and 33 per cent women use limiting ways. Fifty per cent women experiencing emotional violence did not use contraception. Spacing methods were used by 13 per cent women experiencing emotional violence, and 37 per cent women used limiting methods. A

higher percentage of non-users were those threatened with harm, and the lowest percentage of non-users were those who had ever been humiliated. Women using more spacing methods were those who had ever been insulted or made to feel bad.

Table 3 presents the percent distribution of currently married women who experienced violence in the last 12 months by the contraceptive method used among states/UTs. Results suggest that among the users, the percentage of women using the limiting method was higher in Andhra Pradesh (100%), Telangana (98%) and Odisha (94%). They have experienced violence in the last 12 months. It was less common in states like Manipur where only ten per cent women used this method, and in Chandigarh and Lakshadweep, the use of the limiting methods was negligible. The usage rate of any spacing method was the highest in Chandigarh (100%), followed by Manipur (90%). Spacing methods were less common in states like Andhra Pradesh and Telangana, where the usage was just among two per cent women. States having a higher percentage of women who experienced violence in the last 12 months and were using limiting methods than in India as a whole were Chhattisgarh, Goa, Jharkhand, etc. The usage of spacing methods among women experiencing violence in the last 12 months was higher than in India as a whole in Arunachal Pradesh, Jammu & Kashmir, Meghalaya, Delhi, etc.

Table 4 shows that limiting methods were the highest among those belonging to the other backward classes (OBCs) and Hindu communities (75%) and among women in the age group 40-49 years (87%). It is used more among illiterate women, those living in rural areas and the richer households who were not exposed to mass media. Use of the limiting method was the highest in the southern region (95%). Women employed, who had freedom of movement, and widowed/separated/divorced were also more likely to use limiting methods. Seventy-two per cent women who had control over money used limiting methods. Women who had justified beating used limiting methods more. Seventy-five per cent women who participated in decision-making used limiting methods. Their use was the highest by women who had both sons and daughters. Spacing methods were more common among women belonging to other castes and the Muslim community (60%), and women in the age group 15-19 years (96%). Women with higher education used birth spacing more than women with higher education???, as were women of the richest households. Thirty per cent women exposed to mass media used these methods too. Women residing in urban areas used fewer spacing methods than women in rural areas. Birth spacing methods were more common among women in the northern region (37%). Women who were not employed and currently married were more likely to use spacing methods. Women who had freedom of movement used more spacing methods than women not allowed to go out. Thirteen per cent women who had control over money used spacing methods. Women who justified beating used more spacing methods. Thirty-one per cent women who participated in decision-making used spacing method. Its use was the highest in women who have only daughters. These were among women who experienced violence in the last 12 months.

According to Table 5, the odds of using limiting methods are 1.08 times more likely among those women who have experienced violence than those who have not experienced it. In contrast, the odds of using spacing methods are six per cent less likely among women who have experienced it than those who have not experienced it. The odds of using limiting method are 1.09 times more likely among those women who have experienced physical violence than those who have not experienced it. In contrast, the odds of using spacing methods are seven per cent less likely among women who have experienced physical violence than those who have not experienced it. The result is not significant for limiting or spacing methods among women who have experienced sexual violence. The effect is not substantial for limiting methods among women who have experienced emotional violence. In contrast, the odds of using spacing methods are 11 per cent less likely among women who have experienced emotional violence. The odds of using limiting methods are 1.08 times more likely among those women who have experienced sexual or physical violence compared with women who have not experienced it. In contrast, the odds of using spacing methods are six per cent less likely among women who have experienced sexual or physical violence. The result is not significant for limiting methods used by women who have experienced sexual or emotional violence. In contrast,

Table 3. Percentage distribution of currently married women who have experienced violence in the last 12 months by the contraceptive method used among States/Union Territories, NFHS-4

State	Users	Users of		Among users, the percentage distribution of	
		Limiting Methods	Spacing Methods	Limiting Methods	Spacing Methods
Andaman & Nicobar	67.4	56.8	10.6	84.3	15.7
Andhra Pradesh	77.2	77.2	0.0	100.0	0.0
Arunachal Pradesh	28.8	12.0	16.9	41.5	58.5
Assam	55.4	14.5	40.8	26.3	73.7
Bihar	27.0	23.9	3.2	88.3	11.7
Chandigarh	65.7	0.0	65.7	0.0	100.0
Chhattisgarh	58.6	46.9	11.7	80.1	19.9
Dadar and Nagar Haveli	28.3	28.3	0.0	100.0	0.0
Daman and Diu	32.4	19.0	13.4	58.8	41.2
Goa	32.8	24.5	8.3	74.7	25.3
Gujarat	53.7	42.3	11.3	78.9	21.1
Haryana	69.3	48.4	20.8	69.9	30.1
Himachal Pradesh	76.6	60.3	16.3	78.8	21.2
Jammu & Kashmir	59.2	27.7	31.4	46.9	53.1
Jharkhand	37.6	32.2	5.3	85.8	14.2
Karnataka	60.4	56.7	3.7	93.9	6.1
Kerala	59.9	56.2	3.7	93.8	6.2
Lakshadweep	26.4	0.0	26.4	0.0	100.0
Madhya Pradesh	58.9	51.2	7.7	87.0	13.0
Maharashtra	68.7	59.9	8.8	87.2	12.8
Manipur	26.8	2.7	24.1	10.1	89.9
Meghalaya	18.7	5.5	13.3	29.1	70.9
Mizoram	48.9	33.3	15.6	68.1	31.9
Nagaland	27.5	5.5	22.0	20.1	79.9
Delhi	46.4	13.4	33.1	28.8	71.2
Odisha	63.2	35.0	28.1	55.5	44.5
Puducherry	65.9	61.6	4.2	93.6	6.4
Punjab	73.8	44.5	29.3	60.3	39.7
Rajasthan	63.5	44.0	19.4	69.4	30.6
Sikkim	20.1	6.2	13.9	30.8	69.2
Tamil Nadu	54.6	50.6	3.9	92.8	7.2
Tripura	68.8	14.3	54.5	20.8	79.2
Uttar Pradesh	44.3	20.4	23.9	46.1	53.9
Uttarakhand	58.6	30.8	27.8	52.6	47.4
West Bengal	73.3	29.4	43.9	40.1	59.9
Telangana	66.0	64.6	1.4	97.9	2.1
India	52.1	36.7	15.3	70.6	29.4

the odds of using spacing methods are nine per cent less likely among women who have experienced sexual or emotional violence. The odds of using limiting methods are 1.09 times more likely among those women who have experienced emotional or physical violence compared with women who have not experienced it, whereas the odds of using spacing methods are seven per cent less likely among women who have experienced emotional or physical violence.

IV. Discussion

This paper examines the relationship between marital violence and contraceptive use among women in economically and culturally diverse areas of India. It contributes towards a better understanding of how experiencing violence limits a woman's ability to achieve her reproductive aspirations. Few studies depict that women who have greater wealth indices typically have better housing circumstances and easier access to healthcare resources, including family planning options

Table 4. Percentage of currently married women who have experienced violence in the last 12 months by the contraceptive method used, according to background characteristics, NFHS-4.

Background characteristics	Users	Users of		Distribution among users (percentage)	
		Limiting methods	Spacing methods	Limiting methods	Spacing methods
Caste					
SC	53.8	40.3	13.4	75.0	25.0
ST	43.9	30.5	13.4	70.0	30.0
OBC	52.7	40.2	12.5	76.0	24.0
Others	55.6	30.1	25.6	54.0	46.0
Religion					
Hindu	54.4	41.0	13.4	75.0	25.0
Muslim	44.0	17.7	26.2	40.0	60.0
Christian	33.9	21.3	12.6	63.0	37.0
Others	57.2	32.9	24.3	57.0	43.0
Education level					
No education	51.8	40.8	11.0	79.0	21.0
Primary	56.3	40.4	16.0	72.0	28.0
Secondary	51.3	32.4	18.9	63.0	37.0
Higher	57.9	32.4	25.5	56.0	44.0
Mass media exposure					
Not exposed	40.9	29.1	11.8	71.0	29.0
Exposed	56.2	39.6	16.6	70.0	30.0
Wealth Index					
Poorest	41.9	30.2	11.7	72.0	28.0
Poorer	52.2	36.1	16.2	69.0	31.0
Middle	54.5	38.4	16.0	71.0	29.0
Richer	58.5	43.3	15.2	74.0	26.0
Richest	59.9	39.6	20.3	66.0	34.0
Employment					
No	49.2	32.3	16.9	66.0	34.0
Yes	58.6	47.0	11.6	80.0	20.0
Marital status					
Currently married	53.4	37.3	16.1	70.0	30.0
Widowed/divorced/separated	28.4	26.5	1.9	93.0	07.0
Age group					
15-19	14.8	0.6	14.2	04.0	96.0
20-24	29.1	9.8	19.3	34.0	66.0
25-29	47.4	27.3	20.1	58.0	42.0
30-39	63.1	45.8	17.3	73.0	27.0
40-49	56.8	49.6	7.2	87.0	13.0
Place of residence					
Urban	55.9	38.1	17.8	68.0	32.0
Rural	50.6	36.2	14.4	72.0	28.0
Region					
North	64.7	40.5	24.2	63.0	37.0
Central	51.5	35.1	16.4	68.0	32.0
East	42.3	28.6	13.7	68.0	32.0
North East	39.0	11.5	27.5	30.0	70.0
West	57.5	47.5	10.1	83.0	17.0
South	60.7	57.4	3.3	95.0	05.0
Freedom of movement					
No	46.6	31.0	15.6	67.0	33.0
Yes	55.3	40.1	15.2	73.0	27.0
Control over money					
No	47.5	33.0	14.6	69.0	31.0
Yes	56.7	40.7	16.1	72.0	28.0
Wife beating justified					
No	52.4	34.9	17.4	67.0	33.0
Yes	51.9	37.7	14.2	73.0	27.0
Decision-making power					
No	51.0	35.4	15.6	69.0	31.0
Yes	55.9	41.8	14.1	75.0	25.0
Sex composition of living children					
No child	7.4	1.7	5.8	22.0	78.0
Only sons	54.0	34.9	19.1	65.0	35.0
Only daughters	34.5	17.1	17.4	50.0	50.0
Both sons and daughters	62.4	47.8	14.6	77.0	23.0

Table 5. Results from multinomial logistic regression showing predictors among women who have used contraceptive method in India, NFHS-4.

Background variables	No user vs. limiting		No user vs. spacing	
	RRR	CI	RRR	CI
Violence				
No®				
Yes	1.078**	[1.028,1.130]	0.937*	[0.887,0.990]
Physical violence				
No®				
Yes	1.093***	[1.040,1.149]	0.927*	[0.874,0.983]
Sexual violence				
No®				
Yes	0.984	[0.901,1.076]	0.989	[0.894,1.095]
Emotional violence				
No®				
Yes	1.040	[0.974,1.110]	0.887**	[0.820,0.960]
Sex. or Phy. violence				
No®				
Yes	1.084**	[1.032,1.138]	0.937*	[0.885,0.992]
Sex. or Emo. violence				
No®				
Yes	1.008	[0.950,1.071]	0.913*	[0.851,0.980]
Emo. or Phy. violence				
No®				
Yes	1.088***	[1.037,1.141]	0.930*	[0.879,0.983]

Relative risk ratios; 95% confidence interval in bracket; * p<0.05, ** p<0.01, *** p<0.001; ® = Reference category.

and are able to pay for contraception (Saleem & Bobak, 2005). In general, their autonomy is greater than of poorer women. Wealthier women have greater autonomy in making-decisions pertaining to their health and are more likely to participate in decision-making with their husbands or partners. Technology advancement has helped make health intervention initiatives more effective. One method for promoting healthy behaviour is through mass media exposure, which also include raising awareness of and modifying attitudes around family planning (Jacobs et al., 2017). Our study shows that women who have experienced violence with higher education use more birth spacing and limiting methods, as are women of the richest households. Among women who have experienced violence, 30 per cent of them were exposed to mass media use spacing methods and 70 per cent of women use limiting methods. A fundamental indicator of women's socio-economic standing and a reflection of their autonomy is their level of education (Saleem & Bobak, 2005). Women with greater educational background may be more knowledgeable about sexual and reproductive health. Additionally, they have steady jobs, a higher socio-economic status in society and reside in areas with convenient access to family planning and medical facilities. Women who have experienced have is a high percentage of non-users. Contradicting this result, one study shows that women who experience physical violence from their husbands are significantly less likely to adopt contraception and more likely to have an unwanted pregnancy (Stephenson et al., 2008).

Followed by a multivariable analysis to assess contraception determinants including socio-demographic factors, this study also finds a significant association between spousal violence and contraception use in India using data from NFHS-4. Spousal violence experienced by women is an important predictor of contraception use.Women have used more limiting methods if they have experienced physical, sexual or emotional violence. State-wise analysis has been done to determine states where marital violence has affected contraception and variation in determinant factors. Limiting methods are used more than spacing methods by women experiencing physical, sexual or emotional violence. Previous studies also found a positive association between contraception and

experience of violence and argued that IPV negatively impacts women's attitudes and feelings towards their spousal relationship and/or home environment, thus decreasing any desire for future childbearing (Alio et al., 2009; Dalal, Andrews & Dawad, 2012; Salazar, Valladares & Hogberg, 2011). There may be a link between fear of pregnancy under unfavourable circumstances and the greater rate of contraceptive use among women who have suffered violence (Siddique, Zakar, Farhat & Deeba, 2019).

Limitations

Only currently married and ever married women were included in our analysis. Never-married women were excluded because they were not asked questions about marital violence. This study is also limited by the assumption that women have been selected for interviews, but women who have not been selected might also have experienced spousal violence.

V. Conclusion

Overall, our results show that marital violence affects all pathways of contraceptive use. We need to cut these pathways. The impact of contraception use presents a significant cause of concern as domestic violence is found to affect mental health and has adverse effects on the physical health of women also. This calls for immediate policy intervention by the government. Coordinated efforts can be undertaken to increase awareness about the adverse impact of domestic violence on contraception, using various channels for information dissemination such as electronic media and newspapers. The policy for women's empowerment should also be implemented by creating livelihood opportunities, running helplines and short-stay homes across the state to support victims of domestic violence. Opportunities to ensure contraceptive access should include promoting comprehensive sex education, extending the Community Health Centre Fund, increasing contraceptive care options for people, addressing discrimination and building trust in contraceptive care, and amplifying outreach efforts to combat misinformation and confusion created by continuous changes to key family planning policies.

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