Social Science Spectrum ISSN 2454-2806
Vol. 5, No. 3, September 2019, pp. 164-173

Intimate Partner Violence-Driven Fatal Injuries among Women in India: Empirical Evidence from National Family Health Survey 2015-2016

Suresh Jungari** Bal Govind Chauhan* & Pragati Ubale#

Abstract

Increasing evidence of violence against women in India is reported in recent studies. However, there is lack of evidence on violence-driven injuries among women in India. The current study examines the prevalence and risk factors of violence against women and violence-driven injuries in India using the fourth round of National Family Health Survey (NFHS-4) data, conducted during 2015-16. Descriptive statistics, bivariate and multivariate analysis were carried out to see the associations of injuries and socio-demographic factors. The prevalence of lifetime experience of violence-driven injuries are: cuts or bruises were the most common injuries (21.4%) of IPV, followed by severe burn (7.8 %), eye injuries/sprains/dislocations/burns (5.4%), and deep wounds/broken bones/broken teeth/any other serious injuries (3.4%). Overall, 24.6 per cent of the of IPV victims have experienced some kind an injury in lifetime. Older women aged 35-49 years (OR = 1.247; CI=1.096-1.419), having 5 or more children (OR=1.244; CI=1.010-1.532), belonging to scheduled castes (OR=1.363; CI= 1.212-1.533) and belonging to Muslim society (OR=1.229; CI=1.075-1.405) were significantly more likely to have violence-related injuries than their counterparts. The study demonstrated that considerable proportion of women experienced violence and violence-related injuries. Risk factors identified were women's lack of education, alcoholism, having more than one child and poor socio-economic household status. Violence-driven injuries are among the most prominent public health problems which need urgent attention and strategic interventions to prevent them.

Keywords: Intimate partner violence, violence against women, injuries, gender, India.

I. Introduction

World Health Organization's global estimates indicate that about 1 in 3 (35%) women worldwide have ever experienced either physical and sexual intimate partner violence (IPV) or non-partner sexual violence (WHO, 2013). Data increasingly suggests that violence against women (VAW) exists everywhere, although it varies with country, region and culture and undermines the victims' health (Heath, 2002). For ever-partnered women, the range of lifetime prevalence of physical or sexual violence or both by an intimate partner was 15 per cent to 71 per cent, with estimates in most sites ranging from 30 per cent to 60 per cent (García-Moreno et al., 2005). India has an equal prevalence of VAW as that of the global level. In 2015-16, one in three ever-married women (33%) experienced intimate partner violence (physical or sexual) which decreased (from 35 per cent) in 2005-06 (IIPS & Macro International, 2007; IIPS & ICF, 2017).

The most visible and apparent consequences of IPV are physical injuries. Physical violence perpetrated by an intimate partner could be in the form of slapping, twisting arm, pulling hair, pushing, shook, throwing something towards wife, punching, kicking, dragging, beating, choking, burning, threatening to attack with gun or knife, etc. (IIPS & Population Council, 2010). Physical violence can cause less severe injuries such as cuts, bruises and aches, and it can also cause severe injuries such as eye injuries, sprains, dislocations, burns, deep wounds, broken bones, broken teeth

** Suresh Jungari, Assistant Professor, International Institute for Population Sciences, Govandi Station Road, Deonar, Mumbai 400088, Maharashtra (India). Email: sbjungari@iipsindia.ac.in (Corresponding Author)

* Bal Govind Chauhan, Assistant Professor, Gokhale Institute of Politics and Economics, Pune 411004, Maharashtra (India). Email: balgovind.chauhan@gipe.ac.in

Pragati Ubale, PhD Scholar, International Institute for Population Sciences, Deonar, Govandi Station Road, Mumbai 400088, Maharashtra (India). Email: madhavidattatrayadf@gmail.com

and in extremely severe cases attempt to suicide and homicide, etc. (IIPS & ICF, 2017). Worldwide10-50 per cent women reported having been hit or physically assaulted by an intimate partner at some time or the other in their lives. A World Health Organization's (WHO) multi-country study reported that between 19 and 55 per cent of the women ever got injured due to physical IPV, often more than once (García-Moreno et al., 2005). IPV was recognized as a cause of 40–60 per cent of female deaths and maternal mortality in the United States, Bangladesh, and India (García-Moreno et al., 2005; Krug et al., 2002). India suffers a high burden of IPV, with prevalence estimates ranging from 6 per cent in one state (i.e., Himachal Pradesh) to 59 per cent in another (i.e., Bihar) (García-Moreno et al., 2005; Charlette et al., 2012). The data from India's National Family Health Survey round 4 shows that, among ever-married women who have experienced any spousal physical or sexual violence, one-fourth have sustained some kind of injury, and the percentage who have been injured is similar for women who have ever experienced spousal violence and have experienced it in the past 12 months (IIPS & ICF, 2017). Cuts, bruises or aches are the most common types of injuries (21%) (IIPS & ICF, 2017). However, 8 per cent women who experienced spousal physical or sexual violence report serious injuries like eye injuries, sprains, dislocations or burns, and 5 per cent have had deep wounds, broken bones or broken teeth (IIPS & ICF, 2017).

In a multi-country study by WHO, the interviewer was the first person to whom many abused women had ever talked about their partners' physical violence (García-Moreno et al., 2005). In the majority of the countries with available data, women who seek help of any sort are less than 40 per cent (UN, 2015). Most of them take help from family members and friends, and very few take help from formal institutions and mechanisms such as police and health services (UN, 2015). Less than 10 per cent of those women seeking help for the experience of violence sought help by appealing to the police (UN, 2015). Among all women in India who have ever experienced any physical or sexual violence, only 14 per cent have sought help to stop the violence and 77 per cent have neither sought help nor told anyone about the violence they experienced (IIPS & ICF, 2017). Help-seeking is much more common among women who have experienced both physical and sexual violence (29%) than among women who have experienced only physical violence or only sexual violence (10-12%) (IIPS & ICF, 2017). Women who have experienced violence by a previous husband only are much more likely to have sought help (26%) than women who have experienced violence only by their current husband (12%) (IIPS & ICF, 2017).

Health system infrastrucure and support are minimal to victims of violence agaist women (Black, 2011). Over half of the physically abused women (between 55% and 95%) reported that they had never sought help from formal services (health services, legal advice and shelter) or from people in positions of authority (police, women's non-governmental organisations, local leaders and religious leaders) (García-Moreno et al., 2005). Such high prevalence of women not seeking help might be because of low availability of such resources, low trust on services or stigma in the society about such services and about the women who take help from such services. Help-seeking from the medical practitioner is also possible but for that the medical practitioners should be trained for addressing and extracting such sensitive information from the victims and help them (Plichta, 2007).

A growing body of literature exists on the prevalence, risk factors and consequncesof violence agaisnt women globally. It is evident from the past research that verly little attention has been given to long term consequences of IPV-driven injuries. However, few studies focused on the exploration of short and long term injuries due to IPV in the existing literature. Hence, the current study aims to study the prevelence and risk factors of violence-driven injuires in India.

II. Data and methods

Data

Data for the present study have been extracted from National Family Health Survey (NFHS-4), conducted during 2015-16. NFHS is an Indian version of Demographic Health Survey which provides detailed information on fertility, mortality, family planning, women empowerment, communicable and non-communicable diseases, knowledge of HIV/AIDS, adult and child nutrition, maternal and child health care services and domestic violence. NFHS-4 had been conducted under the stewardship of the Ministry of Health and Family Welfare (MoHFW), Government of India and International Institute for Population Sciences (IIPS), Mumbai which was the nodal agency for the same. Details of the methodology of the survey have been discussed elsewhere (IIPS & ICF, 2017). Briefly, data were collected using a stratified two-stage cluster sample design. The 2011 census served as the sampling frame for the selection of Primary Sampling units (PSUs) in rural and urban areas using the probability proportion to size. In the second stage, in every selected rural and urban cluster, 22 households were randomly selected with systematic sampling. The response rate of the survey was 98 per cent, 97 per cent and 92 per cent for households, eligible women, and men respectively. For female, data were collected by face-to-face interviews from 6,99,686 women aged 15-49 years within the selected households resulting in a nationally representative sample. Only one eligible woman per household was randomly selected to answer the questions in the domestic violence section to comply with ethical requirements.

Of the total women (N = 6,99,686) within the NFHS-4 survey, 83,397 eligible women were selected for the domestic violence module. Of these, the data were collected from 79,729 (95.6%) women who were currently or formerly married or cohabiting with a male partner. Domestic violence module revealed that, 19,186 women (30.4%) had ever been exposed to any physical, sexual and psychological violence. The NFHS domestic violence questionnaire was used to collect data from the selected women in accordance with the World Health Organization's ethical and safety recommendations for research on domestic violence (WHO, 2001).

Outcome variables

Traumatic physical significance of the IPV (physical or sexual) was the main health outcomes of the study. It was assessed using answers to questions asked to the women (e.g. "ever had bruises because of husband's act?") regarding the lifetime history of the following indicators:(i) bruises; (ii) injuries, sprains, dislocations or burns; (iii) wounds, broken bones, broken teeth or other serious injuries; and (iv) severe burns. Participants who reported having ever experienced anyone of these (cuts, bruises, or aches; eye injuries, sprains, dislocations, or burns; or deep wounds, broken bones, broken teeth, or any other serious injury as a result of their husbands' violence) were classified as having experienced any violence-related injury.

Apart from the violence-related injury, lifetime abuse (any IPV: physical or sexual) was the outcome variables of interest. It was derived from responses to questions asked to respondents about whether they had ever experienced one or several of the following acts of abuse by a current or former husband or intimate partner such as: (i) pushed, shook her or threw something at her; (ii) twisted her arm or pulled her hair; (iii) slapped her or twisting her arm; (iv) punched her with his fist or with something that could hurt her; (v) kicked her, dragged her, or beat her up; (vi) tried to choke her or burn her on purpose; (vii) threatened her or attacked her with a knife, gun or any other weapon; (viii) physically forced her to have sexual intercourse with him even when she did not want to; (xi) forced her to perform any sexual act she did not want to; and (x) forced her with threats or in any other way to perform any sexual acts she did not want to do. Finally, the any IPV was determined by any physical or sexual violence prepared by husband or intimate partner against women.

Predictor variables

The socio-economic and demographic variables were included as independent variables in the study. These included age (15-24 years, 25-34 years and 35-49 years), place of residence (urban and rural), education level (no education, primary, secondary and higher), marital status (married, widowed/divorced/separated), number of living children (0, 1-2, 3-4 and 5+), caste (schedule tribes, schedule castes, OBCs, others), religion (Hindu, Muslim, others), wealth quintile (poorest, poor, middle, rich, richest), husband drink alcohol (no and yes), work status (not working and working); and media exposure (no and any media exposure).

Statistical analysis

Bivariate and multivariate analyses were carried out to see the significant effect of the independent variables on outcome variable. In bivariate analysis, chi-square test was applied to see the significant relationship between dependent and independent variables. In multivariate analysis, logistic regression was applied to see the significant independent effect of predictor variable on outcome variable. The regression result is presented in terms of odds ratio with 95 per cent confidence interval.

III. Results

Table 1 shows national and state-wise prevalence of violence and violence-driven injuries. It is clear that nearly one in three women experienced physical or sexual violence (IIPS & ICF, 2017). Manipur ranks first (53%) in the percentage of women suffering from physical or sexual violence. The percentage of women suffering from physical and sexual violence is concentrated in South Indian states such as Telangana (43%), Andhra Pradesh (40%) and Tamil Nadu (40.6%). Northern states such as Bihar (43%), Uttar Pradesh (36.5%) and Haryana (32.0%) and eastern states such as West Bengal (32.8%), Odisha (35.2%) and Jharkhand (34%) are also in the list of higher percentage of female victims of physical or sexual victimisation. Jammu-Kashmir is one of the safest states among all as women victimised of physical or sexual violence as well as who experienced injuries as a result of IPV were the least there.

Table 1: State wise prevalence of Intimate partner violence (physical or sexual) and any injury in India and major states, 2015-16

States	IPV (physical or sexual)	N	Any injury	N
Andhra Pradesh	43.0	1,060	21.3	462
Arunachal Pradesh	30.6	1,299	21.1	380
Assam	24.4	2,630	18.8	669
Bihar	43.1	4,087	27.3	1,865
Chhattisgarh	36.4	2,133	26.6	782
Gujarat	19.9	3,257	18.3	646
Haryana	32.0	1,941	25.7	637
Jammu and Kashmir	9.3	3,307	15.1	343
Jharkhand	34.0	2,673	26.8	895
Karnataka	20.5	2,230	26.7	477
Kerala	14.3	1,463	22.9	221
Madhya Pradesh	32.8	5,354	25.0	1,780
Maharashtra	21.1	2,677	21.7	625
Manipur	53.1	1,137	11.8	638
Meghalaya	28.3	721	25.8	185
Nagaland	12.8	860	16.7	117
Delhi	26.8	374	27.0	115
Odisha	35.2	3,132	27.0	1,124
Puducherry	34.5	479	22.4	158
Punjab	20.1	1,721	22.5	359
Rajasthan	24.9	3,604	20.3	943
TAMIL NADU	40.6	3,550	23.8	1,491
Uttar Pradesh	36.5	7,454	26.4	2,790
Uttarakhand	12.6	1,406	27.8	184
West Bengal	32.8	1,722	26.6	582
Telangana	43.0	795	23.0	351
Total	30.9	66,013	24.6	19,459

Note: Percentages are weighted and numbers are unweighted.

Though Uttarakhand has less percentage of violence, it is also a state with the highest percentage of women suffering from injuries from IPV, which might be a sign of severe violence. Bihar ranks second in both high prevalence of physical and sexual violence as well as any injury owing to violence. A majority of the states have high prevalence of violence together with high prevalence of injuries.

The lifetime prevalence of IPV was 31 per cent at the national level (Table 2). Most women who experienced IPV were 35-49 years old (32.7%), belong to rural areas (34%), had no education (41%), were widowed/divorced/separated (40.4%), belong to schedule castes, followers of Hindu religion, belonging to the poorest wealth quintile (43.6%), whose husbands were alcoholics (52.1%), were working (39.2%) and were not exposed to media (39.7%).

Table 2: Selected characteristics and Prevalence of IPV (physical or sexual) in India, 2015-16

Background characteristics	IPV	Total	p-value
Age			
15-24	25.5	10,489	
24-34	31.5	27,568	0.000
35-49	32.6	27,956	
Place of residence			
Urban	25.1	19,469	0.000
Rural	34.0	46,544	
Education level			
No education	41.0	22,028	
Primary	37.4	9,669	0.000
Secondary	25.4	28,187	
Higher	13.4	6,129	
Marital status			
Married	30.3	62,716	0.000
Widowed/divorced/separated	40.3	3,297	
Number of living children			
0	20.8	6,136	
1-2	28.3	35,452	0.000
3-4	37.3	19,977	
5+	40.0	4,448	
Caste			
Schedule tribe	33.5	12,108	
Schedule caste	38.4	11,686	0.000
OBCs	32.0	25,574	
Others	22.9	13,449	
Religion			
Hindu	31.7	49,546	
Muslim	28.2	8,614	0.000
Others	25.9	7,853	
Wealth quintile			
Poorest	43.6	12,838	
Poor	38.1	13,992	
Middle	32.7	13,790	0.000
Rich	26.6	13,142	
Richest	17.1	12,251	
Husband drinks alcohol			
No	22.3	45,122	0.000
Yes	52.1	20,891	
Work status			
Not working	28.1	49,355	0.000
Working	39.2	16,658	
Media exposure			
No	39.7	14,314	0.000
Any exposure	28.7	51,699	
Total	30.9	66,013	

The prevalence of lifetime experience of violence-related injuries is presented in Table 3. Cuts or bruises were the most common injuries (21.4%) of IPV, followed by severe burns (7.8 %), eye injuries, sprains, dislocations or burns (5.4%) and deep wounds, broken bones, broken teeth or other serious injuries (3.4%). Around 24.6 per cent of the of IPV's victims have experienced any kind injuries in lifetime. A majority of women who had any injury due to IPV were 35-49 years old (25.8%), belong to rural areas (25%), had no education (27.8%), were widowed/divorced/separated (39.6%), belong to schedule tribes (27.8%), belong to the poorest wealth quintile (28.9%), whose husbands were alcoholics (32.2%), were working (28.1%) and not exposed to media (27.6%).

Table 3: Selected characteristics and prevalence of violence driven injuries in India, 2015-16

	Injury due to husband's act					
Background characteristics	Cuts, bruises, or aches	Severe burns	Eye injuries, sprains, dislocations or burns	Deep wounds, broken bones, broken teeth or other serious injuries	Any injury due to violence	N
Age						
15-24	19.6	6.0	3.9	1.8	22.3	2798
24-34	20.9	7.6	5.3	3.2	24.1	8200
35-49	22.3	8.5	5.9	4.2	25.8	8461
Place of residence						
Urban	20.4	8.1	5.2	4.3	23.6	4932
Rural	21.7	7.7	5.4	3.1	25.0	14527
Education level						
No education	24.7	8.6	6.5	3.5	27.8	8446
Primary	23.7	8.0	5.6	3.3	27.1	3322
Secondary	16.8	6.9	3.9	3.5	20.4	6866
Higher	15.2	6.8	4.4	3.1	17.5	825
Marital status						
Married	20.2	7.1	4.8	3.1	23.4	18205
Widowed/divorced/separated	35.9	16.8	12.4	8.3	39.6	1254
Number of living children						
0	20.4	8.6	6.2	4.7	23.5	1337
1-2	20.1	7.5	4.5	3.7	23.5	9452
3-4	22.6	7.9	6.2	3.3	25.9	6955
5+	24.1	8.6	6.2	1.5	26.9	1715
Caste						
Schedule tribe	24.1	9.1	6.7	3.0	27.8	3559
Schedule caste	23.3	8.2	6.5	4.0	26.7	4283
OBCs	19.5	7.8	5.0	4.1	23.2	8098
Others	21.3	6.6	3.7	1.3	23.2	2873
Religion						
Hindu	21.0	7.7	5.2	3.7	24.4	15388
Muslim	22.0	8.1	5.9	1.7	24.4	2178
Others	25.1	8.5	7.5	3.7	28.4	1893
Wealth quintile						
Poorest	25.9	9.0	6.9	2.0	28.9	5430
Poor	23.1	7.6	6.1	3.4	26.5	4811
Middle	20.9	8.0	4.5	4.4	24.6	4034
Rich	18.5	7.6	4.6	3.9	21.2	3180
Richest	13.9	5.8	3.6	3.9	17.3	2004
Husband drinks alcohol						
No	15.0	4.8	3.5	2.1	17.4	9461
Yes	28.0	11.0	7.3	4.8	32.2	9998
Work status						
Not working	20.0	7.1	5.1	2.9	23.0	13255
Working	24.3	9.4	5.8	4.5	28.1	6204
Media exposure						
No	25.4	7.6	6.4	2.2	27.6	5331
Any exposure	19.9	7.9	5.0	3.9	23.6	14128
Total	21.3	7.8	5.4	3.4	24.6	19459

Table 4: Determinants of IPV-driven injuries, 2015-16

Background characteristics	Odds ratio	95% CI
Age		
15-24®		
24-34	1.106	[0.981,1.248]
35-49	1.247***	[1.096,1.419]
Place of residence		
Urban®		
Rural	0.943	[0.855,1.040]
Education level		
No education®		
Primary	0.938	[0.820,1.072]
Secondary	0.816*	[0.690,0.963]
Higher	0.661**	[0.500,0.873]
Marital status		
Married®		
Widowed/divorced/separated	1.000	[1,1]
Number of living children		
0®		
1-2	1.270**	[1.074,1.503]
3-4	1.347***	[1.130,1.605]
5+	1.244*	[1.010,1.532]
Caste		
Schedule tribe®		
Schedule caste	1.363***	[1.212,1.533]
OBCs	1.130*	[1.009,1.266]
Others	1.208**	[1.048,1.393]
Religion		
Hindu®		
Muslim	1.229**	[1.075,1.405]
Others	1.11	[0.967,1.273]
Wealth quintile		
Poorest®		
Poor	0.934	[0.841,1.037]
Middle	0.89	[0.787,1.005]
Rich	0.791**	[0.685,0.913]
Richest	0.739**	[0.615,0.889]
Husband drinks alcohol		
No®		
Yes	1.863***	[1.725,2.013]
Work status		
Not working®		
Working	1.198***	[1.107,1.297]
Media exposure		
No®		
Any exposure	1.012	[0.919,1.114]

Note: Level of significant * $p<0.05$, ** $p<0.01$, *** $p<0.001$; ®: reference category.

Table 4 shows the determinants of violence-related injuries. Older women aged 35-49 years (OR = 1.247; CI=1.096-1.419), having five or more children (OR=1.244; CI=1.010-1.532), belonging to schedule castes (OR=1.363; CI= 1.212-1.533) and belonging to Muslim community (OR=1.229; CI=1.075-1.405) were significantly more likely to have violence-related injuries than their counterparts. The risk of violence-related injuries was significantly lower among women who had completed higher education (OR=0.661; CI= 0.500-0.873), belong to richest wealth quintile (OR=0.739; CI=0.615-0.889) and husbands/partners consuming alcohol (OR=1.863; CI=1.725-

2.013) and working status (OR=1.198; CI=1.107-1.297) significantly increased the risk of violence-related injuries.

IV. Discussion and Conclusion

The current study examined the prevalence of violence against women and intimate partners' violence driven injuries among women using the recent nationwide demographic health survey. It demonstrated that women who experienced violence were more likely to have injuries. A majority of injuries were cuts, bruises or aches which constituted 21 per cent, followed by severe burns (7.8%), eye injuries, sprains, dislocations or burns (5.4%) and deep wounds, broken bones, broken teeth, or other serious injuries (3.4%). Some of previous studies reported similar prevalence of violence-related injuries in India (Sabri et al., 2014) and among other countries (Yoshihama et al., 2007; Wong et al., 2014). However, paucity of studies reporting violence-driven injuries in India hinders comparison with previous studies. It is evident that violence induced injuries could have a negative impact on women's physical and mental health. Eventually, women with violence induced injuries possess low self-esteem and it also affects the quality of life (Alsaker et al., 2006; Kelly, 2010). Violence-related injuries have been neglected by the national and global health agenda for many years, despite being predictable and largely preventable. Available evidence shows that interventions to prevent violence-related injuries could be achieved through concerted efforts that involve, but are not limited to, the health sector (WHO, 2014). A higher incidence of violence-related injuries has implication on overall health and wellbeing of women, particularly women in reproductive age group.

State-wise prevalence of violence against women has wide variations ranging from 9.3 per cent in Jammu and Kashmir to 53.1 per cent in Manipur. However, no corresponding similarity is observed with violence and injuries in states. This may be attributed to differences in types and severity of violence. Even some higher violence reported states have lower prevalence of injuries this may be attributed to variations in the reporting of various type of violence and lack of reporting on severity of violence. Women experienced sexual violence may not have reported injuries. The sexual violence victims often under report intimate partner violence and injuries due to higher levels of stigma associated with sexual violence (Joseph et al., 2017). Further, cross-sectional studies tend to under-report minor injuries due to recall bias. Hence, studies should focus on more appropriate study designs to report the injuries of IPV.

Our study reported women's age, low education, poor households and having alcoholic husbands as risk factors. Past studies conducted in developed and developing countries reported similar risk factors of violence-related injuries (Mahapatro et al., 2012; Sabri et al., 2014). Husbands' alcoholic consumption has been reported as one of the major risk factors leading to higher violence and injuries (Sabri et al., 2014). Interventions must target the alcoholic men to address the violence against women. Health care providers' response to violence- related injuries is one of the major areas of intervention needed to avoid the further traumatization of violence and injuries. Engaging heath care providers in prevention and treatment of violence victims and violence-driven injured women is the need of the hour. It is well reported that women in India are not seeking formal legal aid for partners' violence and treatment for the injuries due to the stigma attached to the violence-victims and acceptance of violence.

Though substantial research has concentrated on the prevalence and factors of violence against women in low- and middle-income countries (LMICs), the focus on violence-driven injuries has received little attention. More research effort is needed in these areas to discover the patterns and severity of violence-related injuries and how it affects the overall quality of life and suffering of women. In future work it may be useful to study the health-seeking behaviour for violence-related injuries and expenditure on treatment. Both qualitative and quantitative research efforts should focus on violence-related injuries to facilitate the interventions in community settings.

India is a signatory to many international agreements that protect girls' and women's fundamental rights and foster the movement towards gender equity like sustainable developmental goals (SDGs). At the national level, the country has made efforts to protect women from violence which is proved by timely laws, policies, constitutional articles, acts, amendments and policy statements related to violence against women and girls (VAWG). Protection of Women from Domestic Violence Act (2005), Criminal Law (Amendment) Act (2013) and Sexual Harassment of Women at Workplace (Prevention, Prohibition and Redressal-POSH Act, 2013) are examples. The ultimate goal of these Acts and policies is to give provision to address and punish the perpetrators of violence against women in the offences such as sexual harassment, stalking, cruelty domestic violence, voyeurism, dowry death, human trafficking, rape, etc. Without addressing issues concerning violence against women and related injuries, it is difficult to achieve SDGs.

The study demonstrated that considerable amount of women experienced violence and violence related injuries. Risk factors identified were women's lack of education, alcoholic partners, having children more than one and poor socio-economic household status. Violence-driven injuries are among the most prominent public health problems that need urgent attention and strategic interventions to prevent them are required.

References

Alsaker, K., Moen, B. E., Nortvedt, M. W., & Baste, V. (2006). Low health-related quality of life among abused women. *Quality of Life Research*, *15*(6), 959.

Black, M. C. (2011). Intimate partner violence and adverse health consequences: implications for clinicians. *American Journal of Lifestyle Medicine*, *5*(5), 428-439.

Charlette, S. L., Nongkynrih, B., & Gupta, S. K. (2012). Domestic violence in India: Need for public health action. *Indian Journal of Public Health*, *56*(2), 140.

García-Moreno, C., Jansen, H. A., Ellsberg, M., Heise, L., & Watts, C. (2005). *WHO multi-country study on women's health and domestic violence against women*. Geneva: World Health Organization.

Heath, I. (2002). Treating violence as a public health problem: The approach has advantages but diminishes the human rights perspective. *BMJ*, *325*(7367), 726-727.

India Code, Digital Repository of All Central and State Acts Retrieved from: https://www.indiacode.nic.in/

International Institute for Population Sciences (IIPS) and ICF. 2017. *National Family Health Survey (NFHS-4), 2015-16: India.* Mumbai: IIPS.

International Institute for Population Sciences (IIPS) and Macro International. 2007. *National Family Health Survey (NFHS-3)*, *2005–06: India: Volume I.* Mumbai: IIPS.

International Institute for Population Sciences (IIPS) and Population Council. (2010). Youth in India: Situation and needs 2006–2007. Mumbai: IIPS

Joseph, G., Javaid, S. U., Andres, L. A., Chellaraj, G., Solotaroff, J., & Rajan, S. I. (2017). Underreporting of gender-based violence in Kerala, India: An application of the list randomization method. *World Bank Policy Research Working Paper*, (8044).

Kelly, U. (2010). Intimate partner violence, physical health, posttraumatic stress disorder, depression, and quality of life in Latinas. *Western Journal of Emergency Medicine*, *11*(3), 247.

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.

Mahapatro, M., Gupta, R. N., & Gupta, V. (2012). The risk factor of domestic violence in India. *Indian journal of community medicine*, *37*(3), 153.

Plichta, S. B. (2007). Interactions between victims of intimate partner violence against women and the health care system: policy and practice implications. *Trauma, Violence, & Abuse*, *8*(2), 226-239.

Retrieved from: http://ncw.nic.in/important-links/List-of-Laws-Related-to-Women (NCW)

Retrieved from: https://the3dprogram.org/content/uploads/2018/09/3D-Program-Laws-and-Polices-in-India-relating-to-VAW-September-2018.pdf

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*, *54*(4), 281-300.

United Nations, 2015. The World's Women 2015: Trends and Statistics. New York: United Nations, Department of Economic and Social Affairs, Statistics Division. Sales No. E.15.XVII.8.

Violence Against Women and Girls: Law and Policy Framework in India, 3D programme for girls and women.

Wong, J. Y. H., Choi, A. W. M., Fong, D. Y. T., Wong, J. K. S., Lau, C. L., & Kam, C. W. (2014). Patterns, aetiology and risk factors of intimate partner violence-related injuries to head, neck and face in Chinese women. *BMC Women's Health*, *14*(1), 6.

World Health Organization (2013). *Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence*. World Health Organization.

World Health Organization. Injuries and violence: the facts. 2014; Geneva: WHO Department of Violence and Injury Prevention and Disability.

World Health Organization (2001). *Putting women first: Ethical and safety recommendations for research on domestic violence against women.* Geneva: Switzerland.

Yoshihama, M., Horrocks, J., &Kamano, S. (2007). Experiences of intimate partner violence and related injuries among women in Yokohama, Japan. *American Journal of Public Health*, *97*(2), 232-234.