SHIVANI CHANDRA

Intimate Partner Violence in Pune, India: A Cross-Sectional Study

INTIMATE PARTNER VIOLENCE (IPV) IN PUNE, INDIA: A COMPARISON OF MALE AND FEMALE ATTITUDES, AND USE OF THE WAST TO MEASURE IPV AMONG INDIAN MEN

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A Thesis Submitted to the School of Graduate Studies in Partial Fulfilment of the Requirements for the Degree Master of Science (Global Health)

McMaster University MASTER OF SCIENCE (2016) Hamilton, Ontario

(Global Health)

TITLE: Intimate partner violence in Pune, India: A comparison of male and female attitudes, and use of the WAST to measure IPV among Indian men

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NUMBER OF PAGES: 95

ABSTRACT

Intimate partner violence (IPV) includes physical, emotional, psychological and sexual abuse. The impact of IPV has become increasingly accepted as a significant public health problem worldwide. This manuscript thesis has two chapters which attempts to address the current gaps in IPV research in India.

The first chapter compares people's attitudes about IPV based on their gender, age, income and exposure to IPV. In order to better understand and compare men and women's attitudes about IPV, 204 self-administered surveys were collected from the in- and out-patient clinics of the Sancheti Institute for Othopedics and Rehabilitation (SIOR), a hospital in Pune, India. The results of these surveys showed that men and older generations were more likely to agree that wife-slapping was a justified response to least one of the presented scenarios, and to support normatively prescribed rights of Indian husbands to have excessive power in a marriage. Income level and experience being a victim of IPV were not associated with attitudes towards IPV or husbands' rights.

The second chapter explores the use of the Woman's Abuse Screening Tool (WAST) in a sample of 62 males. Results from the WAST indicated a 16% IPV prevalence rate.

These two papers shed light on different aspects of IPV. Results from the first paper suggest that men and older generations should be targeted for educational initiatives aimed at reducing IPV. The second paper provides a much-needed estimation

of IPV prevalence among Indian males. Together, these findings help close existing gaps in the literature regarding IPV in India.

ACKNOWLEDGEMENTS

I would like to take this time to show my deep gratitude to all the people without whom this thesis would not be possible. Firstly, I would like to thank Dr. Mohit Bhandari for his enthusiasm, confidence and patience. Whether I was in India or sitting across from him in Hamilton, he was always available to provide guidance, support and prompt feedback. His passion for research is palpable and energizing. I would also like to thank Dr. Lehana Thabane and Dr. Jason Busse for being patient with all one hundred and one of my statistics questions, and for ensuring that I analyzed my data with the highest standards.

I would like to also thank Dr. Parag Sancheti for allowing me to use the Sancheti Institute for Othopedics and Rehabilitation (SIOR) as the setting for my research. To the lovely and inspirational women at SIOR's research department, I could not have collected my data without you. Thank you for your encouragement and your friendships. Sarika Kundan Chopade, you deserve a special mention. Despite having other projects, you enthusiastically took the time every day to help with data collection for my thesis. Your resilience and positive energy continue to inspire me.

Lastly, I would like to thank my family and friends for all of their support throughout this entire process.

PREFACE

This thesis is a ‘sandwich thesis, which combines two main manuscripts prepared for publication in peer-reviewed journals. In this dissertation, the contributions of Shivani Chandra in all the papers included study conception, research question identification, study design, data analyses, interpretation of findings, and manuscript writing. The co-authors contributed to providing advice on the design, analysis, interpretation of the results, and critical revision of the drafts of the manuscripts. The work of this thesis was conducted in June 2015.

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DECLARATION OF ACADEMIC ACHEIVEMENT

The following is a declaration that the content of the research in this document has been completed by Shivani Chandra recognizes the contributions of Dr. Mohit Bhandari, Dr. Jason Busse, Dr. Lehana Thabane, Dr. Parag Sancheti, Sarika Chopade, and Dr. Harjeet Badwall in both the research process and the completion of the thesis.

LIST OF ABBREVIATIONS

CAS: Composite Abuse Scale

CTS: Conflict Tactics Scale

DHS: Demographic and Health Survey

HITS: Hurt-Insult-Threaten-Scream

IPV: Intimate Partner Violence

NFHS: National Family Health Survey

SIOR: Sancheti Institute for Orthopaedics and Rehabilitation

WAST: Woman's Abuse Screening Tool

WHO: World Health Organization

Thesis Overview

This is a manuscript-based thesis. The overall objective of this thesis is to explore intimate partner violence (IPV) in Pune, India. IPV is becoming increasingly recognized as a significant public health problem worldwide, but there are still gaps that exist in the literature, particularly within the Indian context. The first chapter will serve as a general introduction to IPV, and give a brief background of IPV within the Indian context. The second chapter will share the results of a cross-sectional study that compared men and women's attitudes about IPV in Pune, India. The third chapter will describe the results of administering the Woman's Abuse Screening Tool (WAST) to a group of Indian men to determine IPV prevalence in this population. The fourth chapter will conclude the thesis body with a discussion about the significance, implications and limitations of the two preceding chapters.

CHAPTER 1: INTRODUCTION TO INTIMATE PARTNER VIOLENCE

Overview

This introductory chapter will provide a general overview of intimate partner violence (IPV), which will serve as a base to the two studies within this thesis. Because this is a manuscript thesis, it should be noted that some content will be repeated between the introductory chapter and the two manuscript chapters. Additionally, because data for Chapters 2 and 3 was collected together from the same survey, there is repetition in both surveys' methodologies.

This chapter will provide important background information which will help to situate the next two chapters. In this chapter, we will define IPV, discuss its prevalence both globally and in India, provide the necessary cultural context of IPV in India, and review the health consequences of IPV.

Because the subtopics of Chapters 2 and 3 are different, this introductory chapter will only provide background information that the author deems to be relevant to both manuscripts. Introductory information that is specific to each manuscript's subtopic can be found in its corresponding chapter.

Definition of IPV

Tthe impact of violence against women has become increasingly accepted as a significant public health problem worldwide, and has been taken on by researchers, policymakers and governments to address women's health. Because of this, many terms and definitions for explaining violence in relationships have emerged. Several of these definitions lack transcultural applicability which is a particularly important consideration in the context of international studies, because what constitutes IPV can vary by culture (Ruiz-Perez, Plazaola-Castano, & Vives-Cases, 2007). For the purpose of this paper, we will be using the World Health Organization's (WHO) definition of IPV: "any behaviour within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship" (Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002). Acts of physical violence (such as slapping, hitting, kicking and beating), psychological and emotional abuse (such as insults, belittling, intimidation, and threats of harm), sexual violence (such as forced sexual intercourse or coercion), and controlling behaviours (such as isolating a person from their family and friends, monitoring their movements, and restricting access to financial resources and employment) are forms of IPV (WHO, 2012).

Prevalence of IPV worldwide

The WHO's 2003 multi-country study on women's health and domestic violence against women collected data on IPV from over 24 000 women in 10 countries of various cultural, and economic backgrounds, confirming that IPV is an important international

problem (Garcia-Moreno, Jansen, & Watts, 2005). All 10 countries had significant rates of IPV. 6-59% of women who had ever been in an intimate relationship reported sexual violence by their partner, and 20-75% reported emotional abuse (Garcia-Moreno, Jansen, & Watts, 2005). 13-61% had experienced physical violence by a partner, and 4-49% had been victims of severe physical violence by a partner (Garcia-Moreno, Jansen, & Watts, 2005). The Demographic and Health Survey (DHS) had similar findings in their ten-country study of physical and sexual abuse among women. Physical and sexual violence against ever-married women by their partner ranged from 17% in the Dominican Republic to 75% in Bangladesh (Hindin, Kishor, & Ansara, 2008).

The WHO's multi-country study found that different forms of IPV often coexist in the same relationship. Women who were victims of physical violence in their relationship were more likely to also experience sexual and/or emotional violence (Garcia-Moreno, Jansen, & Watts, 2005). 23-56% of women who reported experiencing physical or sexual violence had experienced both, and 61-93% of women who had reported physical violence had also endured emotional violence (Garcia-Moreno, Jansen, & Watts, 2005).

Prevalence of IPV in India

Within India, studies measuring prevalence of domestic violence have reported rates ranging widely, from 18% to 70%, due to varying study methodologies (Duvvury, Nayak & Allendorf, 2002; Hassan, Sadowski, Bangdiwala, Vizcarra, Ramiro, De Paula,

et al, 2004; ICEN, 2000; IIPS, 2007; Jejeebhoy, 1998; Jeyaseelan, Kumar, Neelakantan, Peedicayil, Pillai, & Duvvury, 2007; Krishnan, 2005; Martin, Tsui, Maitra & Marinshaw; 1999; Stephenson, Koenig, & Ahmed, 2006; Verma & Collumbien, 2003; Visaria, 2000). Nation-wide studies have revealed significant differences between states in prevalence of violence against women, but such studies are not able to reach all communities (IIPS, 2007). While focused community micro-studies do exist (Krishnan, 2005; Stephenson, Koenig, & Ahmed, 2006), they are very few in number, and focus on physical violence. Information on psychological, emotional and sexual violence in India is limited, by comparison. The few studies that have investigated psychological violence in Indian communities found that psychological violence against married women ranged from 23% to 70% (Duvvury, Nayak, & Allendorf, 2002; ICEN, 2000; Jejeebhoy, 1998; Visaria, 2000). Additionally, the large majority of Indian studies are based on information from married women who self-report their IPV experiences.

Indian society: Providing the context

India is a complex country, home to more than 1.25 billion citizens of varying religions, social and economic backgrounds (Indian Statistics, 2016). It should be acknowledged that the following may not apply to each individual of this country, and that general statements about such a rich and diverse country will always carry exceptions. Discrimination against women varies heavily by region (IIPS, 2007).

India's Patriarchal Society

In order to gain a deeper understanding of IPV in India, it is important to recognize the country's culture-specific patriarchal conceptualisation of gender roles. Indian society has been organized to afford women secondary status within the workplace and household. Various patriarchal traditions still prevail over many Indian communities, which have had direct effects on women's health, education, financial status and political involvement. Indian women have less schooling, lower rates of employment, and more health risks than their male counterparts (FSD, 2015).

India's cultural discrimination against women is reflected most clearly in India's disproportionate sex ratio of 944 women per 1000 men, which are a results of high levels of sex-selective abortions (India Online Pages, 2016). At a disadvantage from conception in the majority of Indian society, women are perceived and treated as inferior to men (Narasimhan, 1994). Within a marriage, women are expected to serve their husband. They traditionally play a submissive role to their more dominant, authoritative husband. This largely accepted dynamic make women vulnerable to IPV.

India's heavily patriarchal society can also be blamed for social stigma that male victims of IPV may experience. Despite a growing acknowledgement worldwide that there are also men who are victims of IPV, India's strong gender roles prohibit men from coming forward for fear of ridicule from their community (Felson & Pare, 2005; George, 1994; Kimmel, 2002; Kumar, 2012; Mechem, Shofer, Reinhard, Hornig, & Datner, 1999).

Health Consequences

IPV can be severely detrimental to a victim's physical health (Campbell, 2002; Campbell, et al., 2002). Women who are abused by their partners are at a significant of risk mortality; 41% of female murders are comitted by an intimate partner, and are more likely to occur in relationships where IPV is prevalent (Greenfeld, Rand, & Craven, 1998; Sharps et al., 2001). Increased risk of disability, chronic pain and negative pregnancy outcomes are also associated with IPV (Coker, Smith, et al., 2000; Plichta, 1996; Saltzman, Johnson, Gilbert, & Goodwin, 2003). Women who suffer sexual violence are at an increased risk of having a sexually transmitted disease, gynecological disorders and sexual dysfunction (CDC, 2015). Psychological consequences of IPV include depression, post-traumatic stress disorder, and suicidal behaviour (CDC, 2015).

Objectives and scope of the thesis

This thesis includes 4 chapters. Chapter 1 is an introduction to the issues covered in the thesis. As a sandwich thesis, the main contributions of the thesis are covered in Chapters 2 and 3—which are based on two stand-alone manuscripts. The overall objective of both manuscripts in this thesis is to better understand IPV in India and address gaps in the literature. The first manuscript compares men and women's attitudes towards IPV (Chapter 2). The second manuscript conducts a preliminary exploration of the Woman's Abuse Screening Tool (WAST) in a population of Indian

men, and examines the prevalence of male victims of IPV (Chapter 3). Both of these papers are based on the author's primary research.

CHAPTER 2: Intimate partner violence in Pune, India: A comparison of male and female attitudes.

ABSTRACT

Introduction: Intimate partner violence (IPV) involves physical, psychological or sexual harm. In India, gender inequality is culturally rooted in patriarchal understandings of gender roles. As a result, domestic violence against women is commonly considered an accepted practice.

Objectives: The primary objective of this study is to compare men and women's attitudes about IPV. The secondary objectives of this study are to explore the association between (1) age, (2) income, and (3) IPV exposure to attitudes about IPV.

Methods: Self-administered, cross-sectional surveys were completed by 204 individuals (101 women and 103 men) in June 2015 at the Sancheti Institute for Orthopaedics and Rehabilitation (SIOR) in Pune, India. Associations between acceptances of wife-slapping and support of patriarchal husbands' roles, and sociodemographic charactheristics were measured using odds ratios from unadjusted binary logistic regression models.

Key findings: Overall, men were 4 times more likely than women to condone wife-slapping in at least one of the survey's presented scenarios. Men were also more likely to support dominating behaviour by husbands. They were 27 times more likely than women to agree that a husband has the right to have sex with his wife when he wants, even if she may not want to. Increasing age was also associated with higher approval

rates for wife-slapping, and stronger support for traditional, patriarchal gender roles whereby husbands exercise control over their wives. No statistically significant association was found between income level and attitudes. Additionally, no statistically significant association was found between a woman's exposure to IPV and her attitudes about IPV.

Conclusion: Men and older genertaions are more likely to condone wife-slapping and patriarchal, dominating husbands' roles. Findings need to be supported by larger studies, with a more representative population sample.

INTRODUCTION

Intimate partner violence (IPV) is an increasingly recognized issue by governments and policy makers worldwide, particularly in developing countries (Heise, 1998; Jones & Horan, 1997; WHO, 2005). Defined by the World Health Organization (WHO) as "any behavior within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship", IPV includes emotional violence, sexual coercion and other dominating behaviours (Ruiz-Perez et al., 2007).

In countries like India where gender inequality is rooted in cultural understandings of gender roles, domestic violence is commonly considered an accepted practice (Koenig, et al., 2003). India's patriarchal society traditionally supports the dominance and control of women by men (Johnson & Johnson, 2001). Once a woman is married, she is expected to assume a subordinate, obedient role in the marriage, and submit to her

husband (Gangrade & Chander, 1991; Narasimhan, 1994; Puri, 1999; Shurei, 1997; Singh, 1994).

A number of demographic and socioeconomic factors have been shown to be associated with IPV. Most significantly, IPV incidence is higher among younger women, and in lower income populations (Gunter, 2007; Jayasuriya, Wijewardena, & Axemo, 2011; Jewkes, 2002). Additionally, having completed less education and residing in a rural setting are positively correlated with being at a higher risk of IPV (IIPS, 2007).

The belief that IPV is justified has also been reported as one of the primary indicators that IPV is being practiced (Hanson, Cadsky, Harris, & Lalonde, 1997; Heise, 1998; O'Neil & Harway, 1997). Significant proportions of men and women of developing countries justify IPV as acceptable punishment when a wife disrespects her in-laws, commits adultery, is disobedient, or commits any other normative transgression (Haj-Yahia, 2003; Hindin, 2003; Kazungu & Chewe, 2003; Khawaja, Linos, & El-Roueiheb, 2008; Koenig et al., 2003; Lawoko, 2008; Rani, Bonu, & Diop-Sidibe, 2004).

According to the 2005-06 Indian National Family Health Survey (NFHS), India is no exception. Over half of the country's men and women justified wife-slapping in at least one of the presented scenarios (IIPS, 2007). The NFHS was a nation-wide survey, collecting data on a variety of topics, including attitudes towards IPV and the prevalence of IPV. On a national level, men and women had very similar levels of acceptance towards wife-slapping: 51% and 54%, respectively (IIPS, 2007). Between provinces,

these figures ranged from 28-90%, indicating significant inter-province variation in IPV attitudes and prevalence (IIPS, 2007). Nationally, 35%, 10% and 16% of married women under 49 years reported having been physically, sexually and emotionally abused, respectively (IIPS, 2007). 34% of married women had been slapped in the year preceding the survey, which was the most commonly reported act of physical violence in a marriage (IIPS, 2007).

The primary purpose of this study is to compare men and women's attitudes about IPV. Secondarily, the association between age, income and exposure to IPV with attitudes towards IPV will be explored. Following the evidence that justification of IPV is heavily associated with perpetration of IPV (Flood & Pease, 2009), the author hypothesizes that men will be more likely than women to condone IPV against women.

METHODS

We conducted a cross-sectional study at the Sancheti Institute for Orthopaedics and Rehabilitation (SIOR) in Pune, India. Approval for the study was obtained by the Sancheti Hospital Research Ethics Board and McMaster University's Hamilton Integrated Research Ethics Board.

Eligibility Criteria

Men and women were recruited to take part in the study, using convenience sampling. SIOR's in- and out-patient clinics were selected for the high volume of individuals from all socioeconomic backgrounds that would pass through their waiting rooms. To be eligible for the study, the participant had to be (1) present at the SIOR, (2) of Indian nationality, (3) at least 18 years of age, (4) able to read and write Hindi, Marathi or English, (5) able to separate him/herself from anyone who accompanied him/her to the clinic, and (6) provide written informed consent. Additionally, in order to completed the WAST section of the survey, participants had to have been in a relationship at some point in the last 12 months. Participants who were too ill, injured or cognitively impaired to participate in the study were excluded.

Study procedures

We collected data over a 4-week period in June 2015, in SIOR's in-patient and out-patient clinics. Potentially eligible participants were approached by a female research coordinator, and asked if they would like to take part in this survey. If the individual agreed, the research coordinator confirmed the participant's eligibility, and proceeded to obtain informed consent. Participants completed surveys in a private room. Once in a secure and confidential location, the participant was provided with more information about the survey, and written consent was obtained. Consent forms were available in English, Hindi and Marathi (Appendix D). All participants were also

able to seek on-site psychologist consultation at their request following study participation.

Survey

We collected participant demographic data, the Woman Abuse Screening Tool (WAST), attitudes about when IPV may be acceptable, and attitudes about husbands' rights. Surveys were available in English, Hindi and Marathi (Appendix C). Two research coordinators worked together to collect the data; one was fluent in Hindi, Marathi and English, and the other was fluent in Hindi and English.

The WAST has successfully been established as an effective IPV-assessment tool in an Indian orthopaedic hospital setting (Sohani, et al. 2013). Known to be reliable and valid, it is an 8-item tool that screens for verbal, emotional, physical and sexual abuse within an intimate relationship. It asks questions such as "Do arguments ever result in you feeling down or bad about yourself?", "Do arguments ever result in hitting, kicking or pushing?" and "Do you ever feel frightened by what your partner says or does?". The respondents' answers are scored (1) "Never", (2) "Sometimes" or (3) "Often". A cumulative score of 13 or more on the WAST indicates exposure to IPV (Bhandari et al., 2011).

The WAST is one of the most well-documented IPV screening tools and has been used in several studies (Brown, Lent, Schmidt, & Sas, 2000; Chen, Rovi, & Washington, 2007; Fogarty & Brown, 2002; Halpern, Susarla, & Dodson, 2005; MacMillan et al.,

2006; MacMillan, Wathen, & Jamieson, 2009; McCord-Duncan et al., 2006; Mills, Avegno, & Haydel, 2005; Rabin, Jennings, Campbell, & Bair-Merritt, 2009; Vivilaki et al., 2010; Wathen, Jamieson, & MacMillan, 2008; Yut-Lin et al., 2008). The WAST has good internal reliability (Cronbach's alpha of 0.75-0.91), and good discriminant validity, effectively categorizing abused and non-abused women based on their total score (Brown, Lent, Schmidt, & Sas, 2000; Fogarty & Brown, 2002; Rabin, Jennings, Campbell, & Bair-Merritt, 2009). Brown et al. (1996) found that the WAST successfully classified 100% of the nonabused women and 91.6% of abused women. The WAST has also been proven to be an effective tool for IPV screening in Indian orthopaedic hospitals (Sohani, et al., 2013).

The survey items that assess respondents' attitudes about when IPV is acceptable, is very similar to surveys used in several studies (CSO & UNICEF, 2012; Hindin, 2003; IIPS, 2007; Smith, 1990). In this section, survey participants are asked if it is acceptable for a husband to slap his wife in various culturally relevant scenarios (e.g. if she insults his parents, comes home drunk, wears inappropriate clothing, etc.).

Most of the items in the last section of the survey were also taken from Smith (1990), and explore the acceptance of normatively prescribed rights of husbands. Respondents are asked if they agree or disagree with statements such as "a man has the right to decide whether or not his wife should work outside the home", and "a man has the right to have sex with his wife, even though she may not want to".

These self-administered written surveys were completed by all participants. This method of data collection was selected over in-person interviews, which are typically least preferred by patients (MacMillan et al., 2006). Additionally, written questionnaires normally have the least missing data (MacMillan et al., 2006).

Participant Safety

Because of the nature of the survey and its inclusion of the WAST, it was important that the survey be explained and administered in a private location. There could be repercussions to participants, specifically women, from members of their family or community if it was suspected that they had revealed negative information about their marital life. Because of this, the survey's topic was not revealed in the clinic's public setting, and was only discussed once the participant had been led to a private room, where confidentiality was guaranteed. It was also critical that they not be accompanied by anyone other than the research coordinator to the private room; failure to do so prevented the individual from participation in the study.

Only one possible participant was approached by the female research coordinator(s) at a time. Once an individual had been brought to the private room and had had the nature of the study explained in full detail, no other person who accompanied them to the hospital was approached to participate. This ensured that the nature of the survey would not be revealed to friends or family of the participant.

Data Analysis

Women who scored 13 or higher on the WAST had been exposed to IPV in the past one year, and were deemed 'IPV-positive'. The survey also asked respondents if it was justifiable for a husband to slap his wife in nine scenarios. Possible answers were 'yes', 'no', and 'depends'. For the purpose of data analysis, 'yes' and 'depends' answers were combined to express that the respondent found slapping acceptable in that particular scenario. The last section of the survey posed general questions about IPV and a husband's role. This section originally had four possible answers: 'strongly disagree', 'disagree', 'agree', and 'strongly agree'. For the analysis, 'strongly disagree' was absorbed by 'disagree', and 'strongly agree' was absorbed by 'agree'.

Sex, age, income and exposure to IPV were the four independent variables used in this study. Given the sample size of this study, the seven categories of income were dichotomized into lower income (under 20,000 Rs. per month) and higher income (20,000 Rs. per month or more).

Unadjusted binary logistic regression was used to explore associations between sociodemographic variables (sex, age and income), exposure to IPV, and attitudes towards IPV.

RESULTS

Survey Response Rate

Over the course of data collection, 11 individuals refused to complete the survey after reviewing the questions. All 11 individuals were men, and verbally expressed that they no longer wanted to participate in the study after having the nature of the survey revealed to them in the private room. When asked why they were no longer interested in participating, five men said that IPV against men was not a problem in Indian society, and that taking this survey would be a waste of their time. Four men did not approve of the study's affiliation with Canada (or the "West"), explaining that studies such as these portray Indian society in a negative and dishonest light.

Of the 215 people who were approached to participate in the study, 204 agreed to complete the survey, resulting in a response rate of 91.2%. Men and women completed 103 and 101 surveys, respectively.

Participant Characteristics

Only women who had been in a romantic relationship within the past year were eligible to complete the WAST. Of the 101 women who submitted the survey, 59 completed the screening tool. 25.4% of the women who completed the WAST had a score of at least 13, establishing them has having been exposed to IPV within the last

year. Table 1 (Appendix A) displays the prevalence of IPV and the socio-demographic characteristics of all sampled men and women.

Attitudes towards Acceptability of Physical Abuse

Figure 1 (Appendix A) presents the percentages of men and women who believe that it is acceptable for a husband to slap his wife in nine hypothetical scenarios. 23% of women did not believe that any of the offered scenarios justified wife-slapping, compared to 7% of the surveyed men. It is worth noting that for a number of hypothetical scenarios, both men and women showed similar levels of support for wife-slapping. For example, 42% and 40% of men and women, respectively, responded that it was acceptable for a husband to slap his wife if she insults him in public.

Table 2 (Appendix A) displays results of the unadjusted binary logistics regressions of respondents who believe that it is acceptable for a husband to slap his wife in various scenarios, by socio-demographic characteristics, revealing a few trends about IPV attitudes. Men were 4.04 times more likely to agree that wife-slapping was justified in at least one of the survey's proposed scenarios (95% CI = 1.65-9.92, $p<0.01$). Age was also a factor in the level of respondents' support for wife-slapping. Odds ratios ranged from 1.20 to 1.54 for increasing 10-year increments in age, and were statistically significant ($p<0.05$) in seven of the nine scenarios. There was no statistically significant difference in support between respondents based on lower and higher income levels.

Table 3 (Appendix A) presents the unadjusted logistic regression of women who screened positively for IPV, who believe it is acceptable for a husband to slap his wife in various scenarios. Although not statistically significant, the data suggested that women who have experienced IPV are less likely to justify a husband slapping his wife, than women who have not experienced IPV.

Attitudes about a Husband's Rights

Table 4 (Appendix A) presents the unadjusted logistic regression of respondents who hold certain patriarchal attitudes about husbands' prerogatives in a marriage. Men were 5.14 times more likely to believe that a man has the right to exercise violence against his wife (95% CI=1.43-18.47, $p<0.05$), and 10.03 times more likely than women to believe that a man has the right to decide whether or not his wife should work outside the home (95% CI=4.57-22.00, $p<0.01$). Men were also 4.72 times more likely to believe that they have the right to decide whether or not their wives should go out in the evening with her friends (95% CI=2.55-8.76, $p<0.01$), and twice as likely to maintain that it is sometimes important for a man to show his wife that he is head of the house (95% CI=1.12-3.58, $p<0.05$). Compared to women, men were 27.16 times more likely than women to agree that a man has the right to have sex with his wife when he wants, even though she may not want to (95% CI=3.58-205.84, $p<0.01$). Despite these significantly different attitudes of a husband's right within a marriage, men and women

did not differ significantly in their beliefs about whether domestic violence is tolerated by the general public, or if it is a common problem in their society.

In addition to male gender, increased age was also associated with the many of the same beliefs. For every increasing increment of 10 years, individuals were 1.57 times more likely to believe that domestic violence is tolerated by the general public (95% CI=1.04-2.38, $p<0.05$), and 1.48 times more likely to believe that a man has the right to decide whether or not his wife should work outside the home (95% CI=1.16-1.89, $p<0.05$). With every increase of 10 years, individuals were also 1.63 times and 1.62 times more likely to believe that a man has the right to decide whether or not his wife should go out in the evening with her friends, and that it is sometimes important for a man to show his wife that he is head of the house, respectively (95% CI=1.27-2.08, $p<0.01$ for both). Lastly, individuals were 1.77 times more likely to believe that a man has the right to have sex with his wife when he wants even though she might not want to, with every 10 year increase in age (95% CI=1.28-2.45, $p<0.01$).

Although not statistically significant, similar trends can be seen among high-income respondents. The only attitude that differed significantly ($p<0.05$) between low and high income individuals, was that high income individuals were 3.84 times more likely to believe that domestic violence is a common problem in society (95% CI=1.07-13.82).

Table 5 (Appendix A) presents a logistic regression, comparing the attitudes of IPV-positive and IPV-negative women. There is no statistically significant difference in attitudes between these two groups of women.

DISCUSSION

This study's aim was to compare men and women's attitudes about IPV. Other studies have sought to collect data about the general Indian population's attitudes towards IPV (IIPS, 2007) and while Nayak, et al.'s (2003) cross-nation study did explore the Indian gender gap in IPV attitudes, the sample population was limited to undergraduate students. To our knowledge, no other study has run comparisons of attitudes towards IPV between Indian men and women. In doing so, this study makes several important contributions in gaining contextual information about where women's attitudes about IPV fall in relation to men's.

This study found men and women to display similar levels of acceptance towards wife-slapping in individual scenarios. Overall however, men were four times more likely than women to condone wife-slapping in at least one scenario. It is therefore not surprising that men were also five times more likely to believe that husbands have the right to exercise violence towards their wives. The patriarchal nature of Indian society fosters norms that support the utilization of physical violence as a means to punish women and maintain men's sense of entitlement and ownership over women (Heise, 1998; Koenig et al. 2006). This was supported by our findings: men were ten times more

likely to believe that they had the right to control whether or not their wives could work outside the home, and five times more likely than women to believe that a man has the right to decide whether or not his wife should go out in the evening with her friends.

Our study found that men were 27 times more likely to agree that a man has the right to have sex with his wife when he wants, even if she may not want to. The province in which Pune is found, Maharastra, has one of the highest rates of rejecting women's justifications for refusing to have sex with her husband (IIPS, 2007). Until India's Protection of Women from Domestic Violence Act in 2005, it was considered within a man's legal and conjugal right to have sex with his wife, regardless of her wishes (Ministry of Women & Child Development, 2005). Marital rape was not a crime, reflecting Indian society's widely held view that it is a husband's prerogative to engage his wife in sexual relations whenever he may desire (Khan, Townsend, Sinha, & Lakhanpal, 1997; Maitra & Schensul, 2004). Further exacerbating this problem is the fact that Indian husbands do not always perceive sexual coercion as being against the wishes of their wives (Babu & Kar, 2009). Data from this study suggests that there is a significant disconnect between men's and women's attitudes about IPV, and that men are much more likely to subscribe to patriarchal ideals of husbands' rights within a marriage.

This study demonstrates that increasing age is associated with higher approval rates for wife-slapping, and stronger support for traditional, patriarchal gender roles whereby husbands exercise control over their wives. Despite the reverse association

being reported in Zimbabwian and Palestinian populations (Hindin, 2003; Khawaja, Linos & El-Roueiheb, 2008), it is encouraging that younger generations are more likely to condemn violence against women in India.

This study reported a 25% IPV prevalence rate which is similar but somewhat lower than previous studies that have found an IPV prevalence rate closer to 30-35% in female Indian populations (IIPS, 2007; 2006; Sohani, et al. 2013). However, unlike other studies (Khawaja, Linos, & El-Roueiheb, 2008), no association was found between a woman's exposure to IPV and her attitudes about IPV. Additionally, there was no association between income level and attitudes about IPV. Despite the majority of previous studies reporting that higher socioeconomic status acts as a protective buffer against IPV (Hindin, 2003; Jeyaseelan, Kumar, Neelakantan, Peedicayil, Pillai, & Duvvury, 2007; Martin, Tsui, Maitra, & Marinshaw, 1999), attitudes about IPV were not more liberal among the high income respondents.

Attitudes have a fundamental relationship with the perpetration of IPV. In addition to being associated with the prevalence of IPV, attitudes about IPV also impact how women respond to this victimization, and how the community and presiding institutions respond to IPV (Flood & Pease, 2009). For this reason, a significant shift in attitudes about IPV is required on an individual and societal level. In order to do this, education initiatives about healthy gender roles within a marriage may prove necessary. Considering men's higher propensity to believe that being a husband allows for extremely dominating behaviour, they should be targeted in education initatives.

Already, it seems that a natural trend towards more progressive thinking is occurring. Perhaps due to increased levels of education and exposure to different global ideologies, younger Indians have more liberal views about gender equality than their older counterparts. This is a hopeful sign for the future of India and its women. We hope that with the steady retirement of traditionally patriarchal beliefs which are the foundation of IPV in India, their new generations will usher in greater gender equality.

Limitations

One major limitation of this study was the setting. Despite using the not-for-profit wing of SIOR, which serves patients from all socioeconomic backgrounds, the hospital itself is private. Also, the NFHS reported that IPV prevalence varies widely by state (IIPS, 2007). For these two reasons, the sample population may not have been representative of the greater Indian population. Another limitation was the use of self-administered surveys, which required that participants be literate. Consequently, uneducated individuals of the lowest socio-economic class were not represented in our sample population, despite being at considerable risk of IPV (Gonzaláles-Brenes, 2004; Heise, 1998; Yllo, 1983). This study also had methodological strengths, including wide inclusion criteria, an evenly distributed sample population with regards to age and socioeconomic background, and the respondents' ability to complete the surveys in complete privacy.

CONCLUSION

Men and older generations are more likely than women and younger generations to condone wife-slapping and dominating husbands' roles. This study did not find income or female exposure to IPV to produce any statistically significant differences in attitudes about IPV or patriarchal gender roles. Further research with a larger and more representative population sample is needed to verify these findings.

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APPENDIX A

Table 1: IPV prevalence and socio-demographic characteristics of all sampled men and women

Variables	Women with a WAST score of 13 or higher	Total women who completed WAST	Males	Females	Total
Age group					
18-30	1 (5.6%)	18	39	50	89
31-50	13 (35.1%)	37	46	42	88
51+	0 (0%)	3	18	8	26
Income					
High income	13 (33.3%)	39	54	33	87
Low income	2 (10.0%)	20	48	68	116
Total	15 (25.4%)	59	103	101	204

Figure 1: Percentage of men and women who believe it is acceptable for a husband to slap his wife in various scenarios

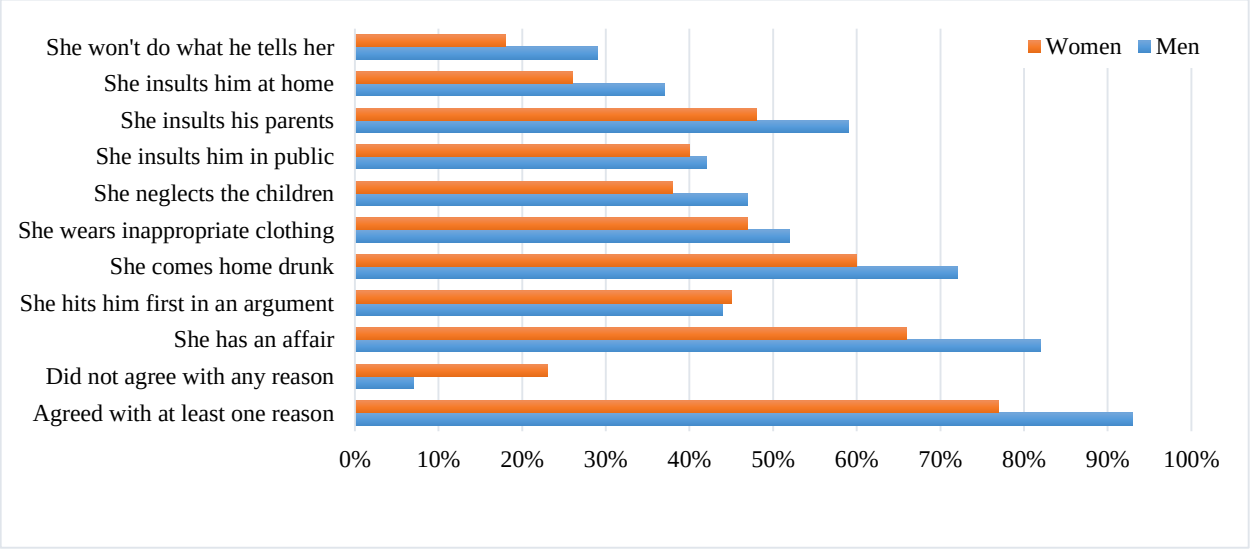

Table 2) Logistic regression of respondents who believe that it is acceptable for a husband to slap his wife in various scenarios, by socio-demographic characteristics

	Male Gender	**Age by Increasing Increments of 10**	**High Income**
It is acceptable for a husband to slap his wife when:	Unadjusted OR (95% CI)		
She won't do what he tells her.	1.90 (0.98-3.68)	1.35 (1.05-1.73) *	0.88 (0.45-1.70)
She insults him at home.	1.69 (0.93-3.07)	1.53 (1.20-1.95) **	0.96 (0.53-1.75)
She insults his parents.	1.60 (0.92-2.79)	1.20 (0.96-1.50)	1.20 (0.69-2.10)
She insults him in public.	1.11 (0.64-1.95)	1.41 (1.11-1.77) **	1.02 (0.58-1.80)
She neglects the children	1.45 (0.83-2.53)	1.55 (1.22-1.97) **	1.53 (0.87-2.68)
She wears inappropriate clothing.	1.27 (0.73-2.19)	1.35 (1.07-1.71) **	1.06 (0.61-1.85)
She comes home drunk.	1.67 (0.93-3.01)	1.58 (1.20-2.09) **	1.46 (0.80-2.66)
She hits him first in an argument.	0.97 (0.56-1.68)	1.21 (0.97-1.51)	0.88 (0.50-1.54)
She has an affair.	2.24 (1.18-4.28) *	1.52 (1.13-2.05) **	1.42 (0.74-2.72)
Percentage who did not agree with any reason.	0.25 (0.10-0.61) **	0.61 (0.41-0.90) *	0.52 (0.23-1.21)
Percentage who agreed with at least one reason.	4.04 (1.65-9.92) **	1.65 (1.11-2.47) *	1.92 (0.83-4.42)

*p<0.05, **p<0.01

Table 3) Logistic regression of IPV-positive respondents who believe that it is acceptable for a husband to slap his wife in various scenarios.

	IPV-Positive Women
It is acceptable for a husband to slap his wife when:	Unadjusted OR (95% CI)
She won't do what he tells her.	0.85 (0.20-3.62)
She insults him at home.	0.60 (0.14-2.47)
She insults his parents.	0.46 (0.13-1.56)
She insults him in public.	0.66 (0.19-2.25)
She neglects the children	0.36 (0.09-1.47)
She wears inappropriate clothing.	0.88 (0.27-2.83)
She comes home drunk.	1.39 (0.41-4.74)
She hits him first in an argument.	1.53 (0.47-5.01)
She has an affair.	0.93 (0.27-3.25)
Percentage who did not agree with any reason.	4.12 (0.48-35.27)
Percentage who agreed with at least one reason.	1.54 (0.25-9.39)

*p<0.05, **p<0.01

Table 4) Logistic regression of respondents who hold the following attitudes about IPV in society, sorted by sociodemographic characteristics

	Male Gender	**Age by Increasing Increments of 10**	**High Income**
	Unadjusted OR (95% CI)		
A man has the right to exercise violence against his wife.	5.14 (1.43-18.47)*	1.29 (0.91-1.84)	1.20 (0.45-3.26)
Domestic violence is tolerated by the general public.	1.57 (0.69-3.58)	1.57 (1.04-2.38)*	2.24 (0.90-5.59)
Domestic violence is a common problem in our society.	0.48 (0.17-1.33)	0.92 (0.63-1.34)	3.84 (1.07-13.82)*
A man has the right to decide whether or not his wife should work outside the home.	10.03 (4.57-22.00)**	1.48 (1.16-1.89)**	0.97 (0.53-1.80)
A man has the right to decide whether or not his wife should go out in the evening with her friends.	4.72 (2.55-8.76)**	1.63 (1.27-2.08)**	1.35 (0.77-2.40)
Sometimes it is important for a man to show his wife that he is head of the house.	2.00 (1.12-3.58)*	1.62 (1.27-2.08)**	1.03 (0.58-1.83)
A man has the right to have sex with his wife when he wants, even though she may not want to.	27.16 (3.58-205.84) **	1.77 (1.28-2.45)**	1.38 (0.57-3.35)

*p<0.05, **p<0.01

Table 5) Logistic regression of IPV-positive respondents who hold the following attitudes about IPV in society.

	IPV-Positive Women
	Unadjusted OR (95% CI)
A man has the right to exercise violence against his wife.	--
Domestic violence is tolerated by the general public.	0.83 (0.14-4.82)
Domestic violence is a common problem in our society.	0.31 (0.04-2.42)
A man has the right to decide whether or not his wife should work outside the home.	2.50 (0.49-12.76)
A man has the right to decide whether or not his wife should go out in the evening with her friends.	2.98 (0.87-10.23)
Sometimes it is important for a man to show his wife that he is head of the house.	1.29 (0.39-4.31)
A man has the right to have sex with his wife when he wants, even though she may not want to.	--

-- Too few cases answered positively to this statement. Cannot be included in the model.
*p<0.05, **p<0.01

CHAPTER 3: Use of WAST to measure intimate partner violence in Indian men

ABSTRACT

Introduction: The vast majority of the research in intimate partner violence (IPV) focuses on female victims. Very limited data exists on IPV against men in India.

Objective: To use the Woman's Abuse Screening Tool (WAST) to measure IPV in Indian men.

Methods: 62 men completed the WAST as part of a larger cross-sectional study in June 2015 at the Sancheti Institute of Orthopaedics and Rehabilitation (SIOR).The prevalence of IPV was determined based on a score of 13 or more on the WAST.

Discussion: 16.1% of men (n=10) screened positively for IPV with the WAST.

Conclusion: Currently, no IPV screening tool for men's use in India exists. The WAST has potential to be used in this setting, but further studies are required to investigate if it is valid in the male, Indian population. Additionally, our results suggest that male victimization may be far more common than previously understood. The lack of research on male victims of IPV in India needs to be addressed by future studies.

INTRODUCTION

Intimate partner violence (IPV) is an internationally recognized public health concern. The World Health Organization (WHO) defines IPV as "any behaviour within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship", including physical violence (e.g. slapping, pushing, kicking), psychological or emotional abuse (e.g. humiliation, intimidation) and sexual coercion (Harvey, Garcia-Moreno, & Butchart, 2007; Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002). Possible outcomes of IPV include increased risk of physical trauma, mental health problems, suicidal behaviour, drug abuse, and economic instability (Campbell, Jones, et al., 2002; Capaldi & Owen, 2001; Patel, Rodrigues, & DeSouza, 2002; Plitcha, 2001; Ridley & Feldman, 2003; Saltzman, L.E., Fanslow, J.L., McMahon, P.M., & Shelley, 2002).

The vast majority of IPV literature focuses on the female victim; comparatively, very little research has been conducted assessing IPV in male populations. Several factors contribute to this discrepancy. Firstly, there is equal if not greater social stigma against male victims of IPV, who often feel pressure to keep their abuse hidden for fear of being perceived as weak and feeling emasculated (George, 1994; Felson & Pare, 2005; Kimmel, 2002; Kumar, 2012; Mechem, Shofer, Reinhard, Hornig, & Datner, 1999). This stigma may be stronger in India's patriarchal society, which supports the husband's role as a dominant and authoritative partner to a submissive wife (Johnson & Johnson, 2001; Gangrade & Chander, 1991; Shurei, 1997; Singh, 1994). Secondly, the

prevalence and severity of IPV is reportedly higher among women than men (Feder & Henning, 2005; Whitaker, Haileyesus, Swahn, & Saltzman, 2007).

However, studies that focus specifically on physical aggression have suggested that men and women have similar rates of assaulting their partners (Cercone, Beach, & Arias, 2005; Straus & Gelles, 1986; Straus, 2005; Swan, Gambone, Caldwell, Sullivan, & Snow, 2008). Archer's meta-analytic review (2000) found that women were more likely to be physically violent with their partners than men. In response, critics of Archer's findings explained the results of his study by separating IPV into two categories: 1) "intimate terrorism" which is the systemic control of men over women, and 2) "situational couple violence" which is the outcome of an escalating conflict and can be perpetrated by either sex (Flynn & Graham, 2010; Johnson, 1999; Johnson, 2005). Whereas men and women can both perpetrate "situational couple violence", only men can commit the more severe "intimate terrorism". Despite having conflicting reports on domestic violence and IPV, it is clear that IPV is not exclusively unidirectional against women, and that men can also be victims.

There is very limited data on IPV against men in India. Previously, no studies have asked men to report on their own experiences as victims of IPV. However, India's National Family Health Survey (NFHS) did ask women to self-report as perpetrators of IPV; 1% of married women reported initiating physical violence against their husbands (IIPS, 2007). By contrast, the International Dating Violence Study self-reporting surveys found that female university students from Pune, India were more likely to physically

assault their parnters than men (Strauss, 2004). Not only is literature on the male prevalence of IPV limited and contrasting, but investigators commonly ask women to self-report as perpetrators, and focus solely on physical violence which is only one of four IPV components.

IPV Screening Tools

The focus of IPV research on women is reflected in the number of IPV screening tools that have been developed for women compared to men. Of the 32 IPV screening tools recognized by the Centre for Disease Control and Prevention, 12 were designed to screen women and men, and only 1 was specific to the male population (RADAR for Men) (Basile, Hertz, & Back, 2007). The Conflict Tactics Scale-2 (a refined version of the original CTS) and the Hurt-Insult-Threaten-Scream (HITS) screening tools have also been used to measure IPV in male populations in the past (Jaeger et al., 2008; Mills, Avegno, & Haydel, 2005; Shakil, Donald, Sinacore, & Krepcho, 2005).

The WAST

The Woman's Abuse Screening Tool (WAST) is one of the most well-documented, validated IPV screening tools and has been used in numerous studies (Brown, Lent, Schmidt, & Sas, 2000; Chen, Rovi, & Washington, 2007; Fogarty & Brown, 2002; Halpern, Susarla, & Dodson, 2005; MacMillan et al., 2006; MacMillan,

Wathen, & Jamieson, 2009; McCord-Duncan et al., 2006; Mills, Avegno, & Haydel, 2005; Rabin, Jennings, Campbell, & Bair-Merritt, 2009; Vivilaki et al., 2010; Wathen, Jamieson, & MacMillan, 2008; Yut-Lin et al., 2008). Originally developed to be administered by family physicians to identify female victims of IPV, the WAST is an eight-item survey that screens for verbal, emotional, physical and sexual abuse (Brown, Lent, Brett, Sas, & Pederson, 1996).

In Rabin et al.'s systematic review of IPV screening tools (2009), the WAST was found to have good internal reliability, and good discriminant validity. In a purposive sample of abused and nonabused women, the WAST successfully classified 100% of nonabused women and 91.7% of the abused women (Brown et al., 1996).

This instrument has previously only been administered in female populations. The purpose of this study is use the WAST in the male population investigate the prevalence of IPV among Indian males.

METHODOLOGY

We administered a cross-sectional survey at the Sancheti Institute for Orthopaedics and Rehabilitation (SIOR) in Pune, India. Originally completed by men and women, this study focuses on the male population who completed the WAST.

Approval for the study was obtained by the Sancheti Hospital Research Ethics Board and McMaster University's Hamilton Integrated Research Ethics Board.

Eligibility Criteria

Respondents were recruited to take part in the study using convenience sampling. SIOR's in- and out-patient clinics were selected for the high volume of individuals from all socioeconomic backgrounds that would pass through their waiting rooms. To be eligible to complete the WAST, the participants had to be (1) present at the SIOR, (2) of Indian nationality, (3) at least 18 years of age, (4) able to read and write Hindi, Marathi or English, (5) able to separate themselves from anyone who accompanied them to the clinic, (6) have been in a relationship within the last 12 months, and (7) provide written informed consent. Participants who were too ill, injured or cognitively impaired to participate in the study were excluded. For the purpose of this study, we will be focusing on surveys completed by men.

Study procedures

Potentially eligible participants were approached by a female research coordinator in SIOR's in-patient and outpatient clinics over a 4-week period in June 2015. They were asked if they would like to part in a health survey. If the individual agreed and the participant's eligibility was confirmed, the respondent was brought to a private room and provided with more information about the survey. Written consent was obtained; consent forms and surveys were available in English, Hindi, and Marathi (Appendix C and D). Information about the on-site psychologist was also provided.

Survey

Two research coordinators worked together to collect the data; one was fluent Hindi, Marathi and English, and the other was fluent in Hindi and English. Available in English, Hindi and Marathi, the original survey was composed of various IPV-related sections but the focus of this paper will be based on the demographic and WAST portions of the self-administered, written survey.

The WAST has successfully been established as a valid IPV-assessment tool in an Indian orthopaedic hospital setting (Sohani, et al. 2013). It is an 8-item tool that screens for verbal, emotional, physical and sexual abuse within an intimate relationship. It asks questions such as "Do arguments ever result in you feeling down or bad about yourself?", "Do arguments ever result in hitting, kicking or pushing?" and "Do you ever feel frightened by what your partner says or does?". The respondents' answers are scored (1) "Never", (2) "Sometimes" or (3) "Often". A cumulative score of 13 or more on the WAST indicates exposure to IPV (Bhandari et al., 2011).

Participant Safety

Because of the nature of the survey and its inclusion of the WAST, it was important that the survey be explained and administered in a private location. The survey's topic was not revealed in the clinic's public setting, and was only discussed once the participant had been led to a private room, where confidentiality was guaranteed. It was also critical that they not be accompanied by anyone other than the

research coordinator to the private room; failure to do so precluded the individual from participating in the study.

Only one possible participant was approached by the female research coordinator(s) at a time. Once an individual had been brought to the private room and had had the nature of the study explained in full detail, no other person who accompanied them to the hospital would be approached to participate. This ensured that the nature of the survey would not be revealed to friends or family of the participant.

Data Analysis

Of the 103 men who were surveyed, 65 had been in an intimate relationship within the past 12 months and were eligible to complete the WAST. In total, 62 men completed the WAST. This sample size was the result of the limited period of time the investigators had for data collection.

A score of 13 or more on the WAST resulted in the individual screening positively for IPV. The frequency of each selected answer was also calculated to distinguish which kinds of violence were most often experienced by the victims.

RESULTS

Demographics

In total, 62 men completed the WAST and their age range was 21 to 66 years. The mean age of survey respondents was 43.9 (SD 10.2) years. 61 of the 62 (98.4%) respondents were married and one (1.6%) was in a relationship, but not married.

WAST Scores

The results of the WAST are displayed in Table 1 (Appendix B). Ten men (16.1%) screened positively for IPV and received a score of 13 or more on the WAST. The mean score was 10.5 (95% CI 9.6-11.3).

32.3% of male respondents described their relationship as having some tension, and 35.5% marked that they had some difficulty working out arguments with their partner. Almost 10% (9.7%) of men said they often felt down or badly about themselves following an argument, and 22.6% of men said that this sometimes happened. 6.5% of men stated that arguments sometimes resulted in them being hit, kicked or pushed, and 8.1% reported that this occurred in their relationship often. 17.7% of men were sometimes frightened of their partner, and 12.9% and 6.5% were sometimes or often physically abused by their partner, respectively. Rates of emotional abuse were higher, with 30.6% and 9.7% of men reporting that they were sometimes or often victims of

emotional abuse, respectively. 14.5% of men stated they were sometimes sexually abused by their partner.

Figure 1 (Appendix B) displays the distribution of scores. The range of WAST scores was 8 to 22. Eight was the lowest possible score one could receive in the WAST and was also the most common score, achieved by 22 (35.5%) of the survey participants. The majority of men (71%, n=44) scored 10 or less. Based on the internal results from this survey, which was also originally distributed among women, the distribution of WAST scores is different in men and women. The range of scores among female respondents was 8 to 17. Female respondents had a more even score distribution (Figure 2, Appendix B). Men, however, had more polarizing scores- most of them either scored 8 which was the lowest possible score, or the scored over 13 (all the way up to 22). This suggests that men who do experience IPV are more likely to experience it more severely than women.

DISCUSSION

The purpose of this study is to examine the results of the WAST, specifically the prevalence rate of IPV among the Indian male population.

The WAST was selected over other screening tools such as RADAR for Men, CTS-2, and HITS for the following reasons. RADAR for Men is a screening protocol which provides questions for the health care provider to orally ask male patients. Based their answers, the provider categorizes men as current/past IPV victims/perpetrators.

Jaeger et al. (2008) found that there were considerable differences in victim and perpetrator identification based on the sex of the person administering RADAR for Men (p=0.04). Female doctors identified perpetration and victimization in 10% and 10% participants, respectively, versus 27% and 45%, respectively, for male doctors. The WAST is a written questionnaire and does not require interpretation on the survey administrator's part.

The CTS-2 was not selected because of its length. It consists of 78 questions on physical, sexual, emotional and psychological questions, scored 0 (never) to 6 (occurred more than 30 times in the past year). By comparison, the WAST only has 8 items and thus takes far less time to complete which is an important consideration, especially in a hospital setting. Lastly, the 4-item HITS tool was not considered because it does not include any questions assessing the occurrence of sexual violence against the respondent. Sexual violence is one of the main components of IPV, and administering a survey without questions on all aspects of IPV would limit its accuracy in identifying all victims of IPV.

There is no current IPV screening tool that has been validated for men's use in India. 62 of 65 possible survey participants completed the self-administered questionnaire, yielding a high response rate. This is a positive sign that the WAST is easily administered in the Indian male population.

Though not traditionally considered victims of IPV, our data suggests that a significant proportion of Indian men (16%) have experienced IPV within the last year.

12.9% of men admitted that their partner sometimes abuses them physically, and 6.5% said that this is occurs often in their relationship. Data pertaining to IPV among Indian males is limited; emotional, psychological and sexual violence have not been studied in this population. Any existing data reports solely on physical violence, relies on Indian women's self-reports to identify themselves as perpetrators, and ranges widely from 2-41% (IIPS, 2007; Strauss, 2004).

The International Dating Violence Study found significantly high rates of physical violence perpetrated by female students against their boyfriends in Pune, India. Of all 31 sites around the world, rates of injury perpetration by their partner were highest for Pune students, at 20% and 12.5% for overall and severe injury perpetration, respectively (Strauss, 2004). For both categories, females had higher rates of perpetrating injuries against their dating partner: 22.4% and 13.9% of women perpetrated overall and severe injuries, respectively, compared to men's rates of 13.0% and 8.7%, respectively. The study also found that rates of overall assault perpetration were 33.3% among men and 41.2% among women, and rates of severe assault perpetration were 12.5% among males and 25.8% among females. Generally, results suggested that male and female university students have a similar prevalence of perpetrating physical violence. In most countries, men were more likely to be the perpetrators, but in India, women had higher rates of perpetrating physical violence than men. This controversial result is also supported by other studies which show that women have similar rates of physically assaulting partners as men (Archer, 2000; Felson, 2002; Moffitt, Caspi, Rutter, & Silva, 2001, Strauss, 1999).

It is important to note, however, that women will oftentimes perpetrate physical violence against their partners in self-defense. Several studies have shown that the vast majority of domestically violent women have also be victims of violence (Cercone, Beach, & Arias, 2005; Orcutt, Garcia & Pickett; Swan et al., 2005; Temple, Weston, & Marshall, 2005). Self-defense is one of the most frequently stated motives for being physically violent against their partner (Stuart et al., 2006; Swan & Snow, 2003). This may contribute to the high levels physical violence that is self-reported by women worldwide. It may be misleading that the WAST and other screening tools do not explicitly inquire about whether women's physical violence was in response to a physical altercation with their husbands. The NHFS found that only 1% of Indian women reported to having had initiated physical violence with their husband (IIPS, 2007). Not considering the context of why female respondents are physically violent against their partners may overinflate male IPV prevalence rates.

This study found that psychological and emotional abuse were the most commonly experienced types of violence among men. 30.6% of men said they were sometimes abused emotionally by their partner, and 9.7% confirmed that they experienced emotional abuse often. 17.7% of surveyed men said they were sometimes frightened by something their partner said or did. Additionally, arguments with their partners sometimes resulted in 22.7% of men sometimes, and 9.7% of men often feeling put down or bad about themselves.

12.9% and 6.5% of men said that their partners sometimes or often, respectively, abused them physically. 6.5% of men said that arguments sometimes resulted in hitting, kicking, or pushing, and 8.1% said this happened often. These rates are significantly lower than the prevalence of IPV against women in India. In the National Family Health Survey, 35% of married women under 49 years reported having been physically abused (IIPS, 2007). 34% of married women had been slapped in the year preceding the survey, and was the most commonly reported act of physical violence in a marriage (IIPS, 2007). Pune is located in the state of Maharastra, in which 27.2% of women reported having been physically abused by their husbands (IIPS, 2007).

Studies have suggested that men and women use equivalent levels of psychological aggression (Swan & Snow, 2002; Swan et al., 2005). Women are also more likely to use higher levels of moderate physical violence than is used against them by their partners, and the same level of severe violence (Swan & Snow, 2002; Swan et al., 2005). However, despite similar rates of physical violence being perpetrated by women according to some reports, women are more likely to be more severely injured and require medical attention for their injuries (Hamberger, 2005; Tjaden & Thoennes, 2000).

IPV against women is more severe than it is against men. However, it is important to understand all aspects of violence in order to better understand the issue. It is important to note that despite equivalent if not greater rates of physical violence being initiated and perpetrated by women according to some reports, women are more likely to

be more severely injured and require medical attention for their injuries (Hamberger, 2005; Tjaden & Thoennes, 2000). Oftentimes women will perpetrate physical violence against their partners in self-defense. Several studies have shown that the vast majority of domestically violent women have also be victims of violence (Cercone, Beach, & Arias, 2005; Orcutt, Garcia & Pickett; Swan et al., 2005; Temple, Weston, & Marshall, 2005). Self-defense is one of the most frequently stated motives for a woman being physically violent against her partner (Stuart et al., 2006; Swan & Snow, 2003). This may contribute to the high levels physical violence that is self-reported by women worldwide.

Many authors have suggested that men generally under-report their experience as victims of IPV due to existing social stigma against men who would allow themselves to be abused by their traditionally submissive and weaker wife (Felson, 2005; George, 1994; Kimmel, 2002; Kumar, 2012; Mechem, Shofer, Reinhard, Hornig, & Datner, 1999). Generally, Indian men are reluctant to share their experience with being victims of IPV; admitting to their victimization can open them up to ridicule and shame, as this is perceived as "feminine behaviour" (Kumar, 2012). However, high response rates for the WAST may suggest that men are willing to disclose their experiences with IPV if they can do so confidentially and anonymously on a self-administered survey.

A major limitation to consider in using the WAST tool is that because there is very limited data about IPV prevalence rates among men in India and because it ranges widely, it is difficult to assess the WAST's sensitivity in this population. However, the

WAST was generally well-received and had a nearly perfect response rate. It is clear that there is a significant lack of research in the prevalence of male victims of IPV in India. Future studies should be directed at validating the WAST in the male population, verifying that the WAST is a culturally appropriate tool for screening for IPV in the Indian population, and collecting IPV prevalence information about male victims not only from an urban hospital setting, but from various locations in order to gain a deeper understanding about the prevalence of male IPV in India as a whole.

CONCLUSION

There is very limited research on male victims of IPV in India. Designed to screen for IPV among women, the WAST was applied to the Indian male population and revealed an IPV prevalence rate of 16.1%. The authors believe that this tool has great potential in this setting, but further studies are required to verify the sensitivity and specificity of this tool in the population of Indian men.

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APPENDIX B

Table 1: Results of the WAST

WAST Survey Item			
	No tension	Some tension	A lot of tension
In general, how would you describe your relationship?	41 (66.1%)	20 (32.3%)	1 (1.6%)
	No difficulty	Some difficulty	Great difficulty
Do you and your partner work out arguments with:	38 (61.3%)	22 (35.5%)	2 (3.2%)
	Never	Sometimes	Often
Do arguments ever result in you feeling put down or bad about yourself?	42 (67.7%)	14 (22.6%)	6 (9.7%)
Do arguments ever result in hitting, kicking, or pushing?	53 (85.5%)	4 (6.5%)	5 (8.1%)
Do you ever feel frightened by what your partner says or does?	51 (82.3%)	11 (17.7%)	0 (0%)
Has your partner ever abused you physically?	50 (80.6%)	8 (12.9%)	4 (6.5%)
Has your partner ever abused you emotionally?	37 (59.7%)	19 (30.6%)	6 (9.7%)
Has your partner ever abused you sexually?	53 (85.5%)	9 (14.5%)	0 (0%)
	Negative (score 8 to 12)	Positive (score 13 or more)	
WAST screen for intimate partner violence	52 (83.9%)	10 (16.1%)	

Figure 1: Distribution of WAST scores for male population

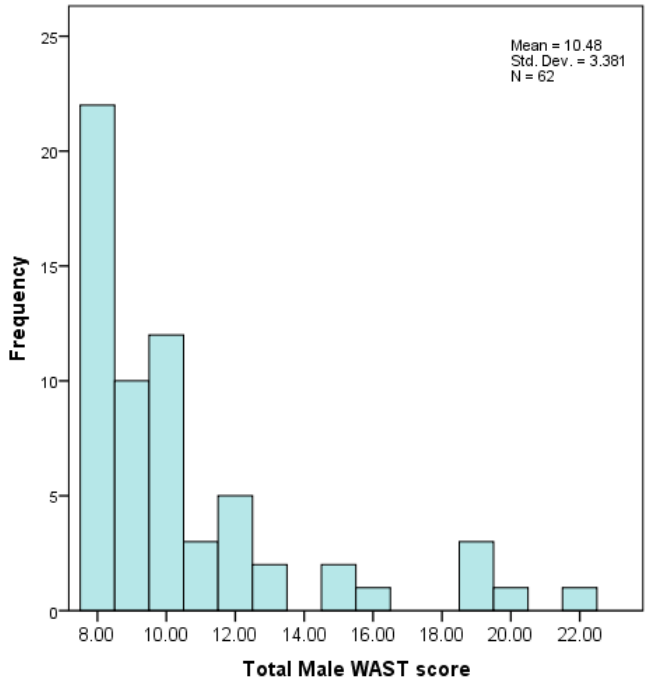
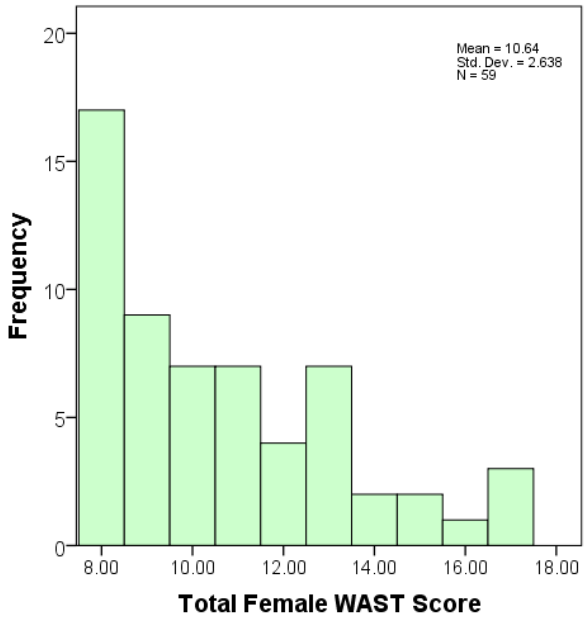


Figure 2: Distribution of WAST scores for female population



CHAPTER 4: CONCLUSION

IPV is a global public health concern. Despite receiving increased attention on the national and international stage, there are many gaps in IPV research. Two of those gaps are addressed in this thesis.

In the first manuscript, we gained a deeper understanding of the differences between men and women's attitudes about IPV against women. Perhaps unsurprisingly, men were more likely than women to condone wife-slapping in various scenarios. Men were also more likely to agree with several behaviours that are commonly accepted as husbands' normatively prescribed rights. It is encouraging that women were less likely to justify these behaviours. If women had had the same or greater levels of acceptance as men for these behaviours, this would have posed as an additional significant barrier to their empowerment. Younger generations were also more likely to reject these controlling and abusive behaviours than their older counterparts. Their denunciation of these strictly patriarchal behaviours may be in part due to increasing levels of education in India. The author is hopeful that this trend will continue, and younger generations will become increasingly intolerant of IPV, moving towards greater gender equality.

The second manuscript attempted to provide a preliminary exploration of the WAST's use in males, and gain knowledge about the prevalence of male victims of IPV in India. The WAST was successfully completed by 63 of the 65 eligible candidates, revealing a prevalence rate of 16.1% in the male population. Previous research attempting to learn about rates of IPV against men have asked women to self-report

perpetrating physical violence. This was the first study, to our knowledge, that asked men about their own experiences.

Limitations

IPV prevalence rates among women vary greatly by region (IIPS, 2007). It can therefore be inferred that attitudes about IPV, and male prevalence of IPV may also vary greatly by region. Thus, it is important to note that data from either of the manuscripts cannot be generalized to all of India. Furthermore, despite collecting data from the not-for-profit wing of the private hospital, the sample population may not have been representative of the general population, and may have belonged to a higher socioeconomic bracket.

Limited data about the male use of the WAST and male prevalence of IPV in India meant that the results of the WAST could not be strongly supported by other, similar studies with the same population.

Further Studies

Future studies should focus on validating the WAST in male populations, and look further into male prevalence of IPV in India. This constitutes an enormous gap in IPV literature, which is almost wholly focused on female victims.

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APPENDIX C

English Survey

HEALTH SURVEY

Thank you for your interest in completing this questionnaire. We greatly value your willingness to review the questions below and your responses will help us to understand issues of health and intimate partner violence.

Some of the questions may be uncomfortable for you to answer, or you may be irritated if the question has no bearing on your life. However, we ask that you try your best in answering all of the question. Your participation is important to us and for those whom would benefit from this research!

1. **What is your age in years? _____years**

2. **What is your gender?**

☐ Male
☐ Female
☐ Prefer not to disclose

3. **What is your monthly income (Rs.)?**

☐ Less than 1000
☐ 1000-2499
☐ 2500-4999
☐ 5000-9999
☐ 10,000-19,999
☐ 20,000-49,000
☐ 50,000 or more

4. What is your highest education level obtained?

- ☐ Literate but no schooling
- ☐ Primary pass
- ☐ 10th class pass but no graduation
- ☐ Graduation
- ☐ Bachelor's degree
- ☐ Master's degree
- ☐ Doctorate degree
- ☐ Professional degree (Doctor, Eng, MBA)

5. What is your marital status?

- ☐ Married
- ☐ In a relationship, not married
- ☐ Other (specify):_____
- ☐ Widowed
- ☐ Single

6. How long have you been in your current relationship? _____years

☐ N/A – Not currently in a relationship with an intimate partner.

7. What type of injury are you being treated for at the fracture clinic today?

- ☐ Fracture
- ☐ Dislocation
- ☐ Unsure
- ☐ Sprain or Strain
- ☐ Other (specify): _____
- ☐ Not here for treatment *(proceed to #10)*

8. Please describe the location of your injury.

_____

_____

. _____

9. Please describe how your injury occurred.

_____

_____

_____

Please note that an *intimate partner* is someone with whom you share a relationship as spouses, common-law partners, sexual partners, or dating partners. The following questions refer to your current or previous relationship(s) with your spouse, common-law partner, or any sexual or dating partner within the last 12 months.

10. In the past year, have you been in a relationship with an intimate partner?

☐ Yes (continue to question 11)

☐ No (skip to question 18)

11. In general, how would you describe your relationship?

☐ A lot of tension ☐ Some tension ☐ No tension

12. Do you and your partner work out arguments with:

☐ Great difficulty ☐ Some difficulty ☐ No difficulty

13. Do arguments ever result in you feeling down or bad about yourself?

☐ Often ☐ Sometimes ☐ Never

14. Do arguments ever result in hitting, kicking, or pushing?

☐ Often ☐ Sometimes ☐ Never

15. Do you ever feel frightened by what your partner says or does?

☐ Often ☐ Sometimes ☐ Never

16. Has your partner ever abused you physically?

☐ Often ☐ Sometimes ☐ Never

17. Has your partner ever abused you emotionally?

☐ Often ☐ Sometimes ☐ Never

18. Has your partner ever abused you sexually?

☐ Often ☐ Sometimes ☐ Never

A Husband's Role

19. A man has a right to exercise violence against his wife.

☐ Strongly disagree ☐ Disagree ☐ Agree ☐ Strongly agree

20. Domestic violence is tolerated by the general public.

☐ Strongly disagree ☐ Disagree ☐ Agree ☐ Strongly agree

21. Domestic violence is a common problem in our society.

☐ Strongly disagree ☐ Disagree ☐ Agree ☐ Strongly agree

22. Being a victim of violence in one's childhood makes one more prone to perpetrating violence.

☐ Strongly disagree ☐ Disagree ☐ Agree ☐ Strongly agree

23. Those who grow up in households with domestic violence are more likely to be violent citizens.

☐ Strongly disagree ☐ Disagree ☐ Agree ☐ Strongly agree

24. Need to create awareness about the existence of domestic violence.

☐ Strongly disagree ☐ Disagree ☐ Agree ☐ Strongly agree

25. Help should be available for people who exhibit abusive behavior.

☐ Strongly disagree ☐ Disagree ☐ Agree ☐ Strongly agree

26. Government should spend time and money to educate people.

☐ Strongly disagree ☐ Disagree ☐ Agree ☐ Strongly agree

27. A man has the right to decide whether or not his wife should work outside the home.

☐ Strongly disagree ☐ Disagree ☐ Agree ☐ Strongly agree

28. A man has the right to decide whether or not his wife should go out in the evening with her friends.

☐ Strongly disagree ☐ Disagree ☐ Agree ☐ Strongly agree

29. Sometimes it is important for a man to show his wife that he is head of the house.

☐ Strongly disagree ☐ Disagree ☐ Agree ☐ Strongly agree

30. A man has the right to have sex with his wife when he wants, even though she many not want to.

☐ Strongly disagree ☐ Disagree ☐ Agree ☐ Strongly agree

<u>Would you approve of a man slapping his wife if:</u>

31. She won't do what he tells her to do.

☐ Yes ☐ No ☐ Depends

32. She insults him when they are at home.

` ☐ Yes ☐ No ☐ Depends

33. She insults his parents.

☐ Yes ☐ No ☐ Depends

34. She insults him in public.

☐ Yes ☐ No ☐ Depends

35. She neglects the children.

☐ Yes ☐ No ☐ Depends

36. She wears inappropriate clothing.

☐ Yes ☐ No ☐ Depends

37. She comes home drunk.

☐ Yes ☐ No ☐ Depends

38. She hits him first when they are having an argument.

☐ Yes ☐ No ☐ Depends

39. He learns that she has been having an affair with another man.

☐ Yes ☐ No ☐ Depends

Hindi Survey

आरोग्य सर्वेक्षण

इस प्रश्नावली को पूर्ण करनेमे आपने जो दिलचस्पी दिखाई है उसके लिए धन्यवाद् | नीचे दिए गए प्रश्नों का अवलोकन कर उनके दिए गए जवाब हमारे लिए बहुत मायने रखते है और हमें आरोग्य और निकटवर्ती साथी के जुल्म के बारे में समझने (जानने) में सहाय्यक होंगे |

कुछ प्रश्नों का उत्तर देने में आपको हिचकिचाहट हो सकती है, या आपको चिढ महसूस हो सकती है अगर इस प्रश्न का आपके जीवन से कोई ताल्लुक नहीं है | फिर भी, हमारा आप से ये अनुरोध होगा कि सारे प्रश्नों के अच्छे से अच्छे प्रकार से जवाब दें | आपका सहभाग, हमारे लिए और जिन्हें इस संशोधन से फायदा हो सकता है, उनके लिए, बहुत महत्वपूर्ण है|

१. आपकी उम्र क्या है? _____ वर्ष

२. आपका लिंग क्या है?

☐ पुरुष ☐ स्त्री ☐ बताना नहीं चाहते

३. आपकी मासिक आमदनी कितनी है? (रु.)

☐ १००० से कम
☐ १००० - २४९९
☐ २५०० – ४९९९
☐ ५००० - ९९९९
☐ १०,००० - १९,९९९
☐ २०,००० - ४९,९९९
☐ ५०,००० या ज्यादा

४. आपकी अधिकतम शैक्षणिक अहर्ता क्या है?

☐ शिक्षित परंतु पाठशाला से वंचित
☐ प्राथमिक पास
☐ १० वीं पास परंतु पदवी से वंचित
☐ प्रथम पदवीधर
☐ पदवीधर
☐ पद्व्युत्तर
☐ विद्यावाचस्पती
☐ व्यवसायिक पदवी (डॉक्टर,इंजिनियर,एम्.बी.ए.)

५. आपकी वैवाहिक स्थिति क्या है?

☐ वैवाहिक ☐ विधवा

☐ संबंध है परंतु अविवाहित ☐ अविवाहित

☐ अन्य (उल्लेख करें) _____

६. आप कबसे अपने इस वर्तमान संबंध में है? _____ वर्ष

☐ संबंधित नहीं \ वर्तमान में किसी निकटम साथी से संबंध नहीं

७. अस्थिभंग अस्पताल में आज आप wप्रकार के जख्म का इलाज करवा रहे हैं?

☐ अस्थिभंग ☐ मोच या तनाव

☐ स्थान बदलना ☐ अन्य (उल्लेख करें)_____

☐ निश्चित नहीं ☐ उपचार के लिए यहाँ नहीं है

८. कृपया अपने जख्म का स्थान बतायें |

_____
_____
_____

९. कृपया आपको यह जख्म किस प्रकार हुआ इसका वर्णन करें |

_____
_____
_____
_____

कृपया यह ध्यान रखें की निकटम साथी याने ऐसा व्यक्ति जिसके साथ आपके पति-पत्नी, क़ानूनी सामाजिक साथी, लैंगिक साथी या डेटिंग (मिलन) साथी, जैसे सबंध है| नीचे गए प्रश्न आपके १२ महीनों के अन्दर के पति-पत्नी, क़ानूनी सामाजिक साथी, लैंगिक साथी या डेटिंग (मिलन) साथी, के वर्तमान या पूर्व सबंध(धों) से सबंधित है|

१०. क्या पिछले वर्ष आपके निकटम साथी के साथ सबंध थे?

☐ हां (प्रश्न ११ पर जाएँ) ☐ नहीं (प्रश्न १८ पर जाएँ)

११. आप अपने सबंध का वर्णन किस प्रकार करेंगे?

☐ बहुत तनावपूर्ण ☐ थोडा तनावपूर्ण ☐ तनावरहित

१२. आप और आपके साथी आपसी उलझने सुलझा पाते हैं?

☐ बड़ी मुश्किल से ☐ थोड़ी मुश्किल से ☐ आसानी से

१३. अपने साथी के साथ झगड़ों की वजह से आपने उदास या बुरा महसूस किया है?

☐ हमेशा ☐ कभी-कभी ☐ कभी नहीं

१४. क्या कभी झगड़ों का अंत मार, लात या ढकेलने में हुआ है?

☐ हमेशा ☐ कभी-कभी ☐ कभी नहीं

१५. क्या कभी आप आपके साथी के कहने या करने पर डरें हैं?

☐ हमेशा ☐ कभी-कभी ☐ कभी नहीं

१६. क्या आपके साथी ने कभी आपको शारीरिक प्रताड़ना दी है?

☐ हमेशा ☐ कभी-कभी ☐ कभी नहीं

१७. क्या आपके साथी ने कभी आपको मानसिक रूप से प्रताड़ित किया है?

☐ हमेशा ☐ कभी-कभी ☐ कभी नहीं

१८. क्या कभी आपके साथी ने आपपर लैंगिक अत्याचार किया है?

☐ हमेशा ☐ कभी-कभी ☐ कभी नहीं

<u>एक पति की भूमिका:</u>

१९. पुरुष को अपनी पत्नी पर जुल्म करने का अधिकार है|

☐ पूर्णतः असमहत ☐ असहमत ☐ सहमत ☐ पूर्णतः सहमत

२०. घरेलु जुल्म सामान्य जनता सहन करती है|

☐ पूर्णतः असमहत ☐ असहमत ☐ सहमत ☐ पूर्णतः सहमत

२१. घरेलु अत्याचार हमारे समाज की आम समस्या है|

☐ पूर्णतः असमहत ☐ असहमत ☐ सहमत ☐ पूर्णतः सहमत

२२. अपने बचपन में हुआ जुल्म का शिकार व्यक्ति एक और जुल्म का शिकार हो सकता है|

☐ पूर्णतः असमहत ☐ असहमत ☐ सहमत ☐ पूर्णतः सहमत

२३. जो घरेलु अत्याचार होनेवाले घरों में पलते है वे बहुतांश अत्याचारी नागरिक होते हैं|

☐ पूर्णतः असमहत ☐ असहमत ☐ सहमत ☐ पूर्णतः सहमत

२४. होनेवाले घरेलु अत्याचार के बारेमें जागरूकता लानेकी जरुरत है|

☐ पूर्णतः असमहत ☐ असहमत ☐ सहमत ☐ पूर्णतः सहमत

२५. जिनपर अत्याचार हुये हैं ऐसे लोगों को मदद मिलनी चाहिए|

☐ पूर्णतः असमहत ☐ असहमत ☐ सहमत ☐ पूर्णतः सहमत

२६. सरकारने लोगोंको शिक्षित करनेके लिए समय और पैसा खर्च करना चाहिए|

☐ पूर्णतः असमहत ☐ असहमत ☐ सहमत ☐ पूर्णतः सहमत

२७. पुरुष को उसकी पत्नी घर के बाहर काम करे या नहीं, यह तय करने का अधिकार है|

☐ पूर्णतः असमहत ☐ असहमत ☐ सहमत ☐ पूर्णतः सहमत

२८. पत्नी शामको अपने मित्रों के साथ बाहर जाये या नहीं इसे तय करने का पुरुष को अधिकार है|

☐ पूर्णतः असमहत ☐ असहमत ☐ सहमत ☐ पूर्णतः सहमत

२९. पुरुष कभी-कभी वह इस घर का कर्ता-धर्ता है यह पत्नी को दिखाना जरुरी समझता है|

☐ पूर्णतः असमहत ☐ असहमत ☐ सहमत ☐ पूर्णतः सहमत

३०. पत्नी की इच्छा न होते हुए भी पुरुष को जब चाहे पत्नी से संभोग करने का अधिकार है|

☐ पूर्णतः असमहत ☐ असहमत ☐ सहमत ☐ पूर्णतः सहमत

<u>क्या आप समर्थन करेंगी अगर आदमी इन चीजों के लिए पत्नी को चांटा मारता है:</u>

३१. पति का कहा वह नहीं करती है|

☐ हां ☐ नहीं ☐ निर्भर करता है

३२. जब वे घर में हों तो पत्नी पति का अपमान करती है|

☐ हां ☐ नहीं ☐ निर्भर करता है

३३. वह अपने पति के माँ-बाप का अपमान करती है|

☐ हां ☐ नहीं ☐ निर्भर करता है

३४. लोगों के बीच वह पति का अपमान करती है|

☐ हां ☐ नहीं ☐ निर्भर करता है

३५. वह बच्चों का ध्यान नहीं रखती है| (वह बच्चों को दुर्लक्षित करती है|)

☐ हां ☐ नहीं ☐ निर्भर करता है

३६. वह बेढंगे कपडे पहनती है|

☐ हां ☐ नहीं ☐ निर्भर करता है

३७. वह पीकर घर आती है|

☐ हां ☐ नहीं ☐ निर्भर करता है

३८. जब आपस में झगडा होता है, वह पति को पहले मारती है| (पति पर पहले वार करती है|)

☐ हां ☐ नहीं ☐ निर्भर करता है

३९. पति को पता चलता है की उसकी पत्नी का किसी और के साथ रिश्ता (संबंध) है|

☐ हां ☐ नहीं ☐ निर्भर करता है

Marathi Survey

आरोग्यविषयक सर्वेक्षण

ही प्रश्नावली पूर्ण करण्याबाबत आपण जी इच्छा दाखविली त्याबद्दल आभार. खाली दिलेल्या प्रश्नांबाबत तुम्ही पुनःविचार करता आहात या तुमच्या मतांना आम्ही खूप किमती समजतो व त्याचा फायदा आम्हाला आरोग्याच्या बाबी व तुमच्या निकटवर्तीयाकडून झालेल्या जुलूमांच्या विषयांना समजून घेण्याबाबत आम्हाला खूप मदत होईल.

यातील काही प्रश्नांना उत्तरे देतांना तुम्ही नाराज व्हाल किंवा चीड येईल कारण त्या प्रश्नांचा तुमच्या जीवनशैलीशी काहीही संबंध नसेल. तरीसुद्धा तुम्ही अशा सर्व प्रश्नांची उत्तरे उत्तम प्रकारे देण्याचा प्रयत्न करावा असे आमचे सांगणे आहे. तुमचा सहभाग आम्हास खूप महत्वाचा आहे तसेच ज्यांना या संशोधनातून लाभ होणार आहे त्यांनाही तो तितकाच महत्वाचा आहे.

१. तुमचे वय काय आहे? _____ वर्षे

२. तुमचे लिंग कोणते आहे?

☐ पुरुष ☐ स्त्री ☐ सांगू इच्छित नाही

३. तुमचे मासिक उत्पन्न किती आहे? (रु.)

☐ १००० च्या आत
☐ १०००-२४९९
☐ २५०० – ४९९९
☐ ५०००-९९९९
☐ १०,०००-१९,९९९
☐ २०,०००-४९,९९९
☐ ५०,००० व अधिक

४. तुम्ही मिळवलेली सर्वाधिक शैक्षणिक पातळी कोणती?

☐ शिक्षित पण शाळेत गेलो/गेले नाही
☐ प्राथमिक शिक्षण उत्तीर्ण
☐ १०वी पास पण पदवी नाही
☐ पदवीधर
☐ पहिली पदवी संपन्न
☐ पद्व्युत्तर
☐ पी.एच.डी
☐ व्यवसायिक पदवी (डॉक्टर,इंजिनियर,एम्.बी.ए.)

५. तुमची वैवाहिक स्थिती काय आहे?

☐ विवाहित ☐ विधुर

☐ नातेसंबंधात पण विवाहित नाही ☐ अविवाहित

☐ अन्य (उल्लेख करा) _____

६. सध्याच्या वैवाहिक स्थितीत तुम्ही किती काळापासून आहात? _____ वर्ष

☐ लागू नाही / कोणत्याही जवळच्या नातेसंबंधात नाही

७. आज तुम्ही कोणत्या प्रकारच्या दुखापतीसाठी 'फ्रॅक्चर क्लिनीक' मध्ये आला आहात?

☐ अस्थिभंग ☐ ताण किंवा तणाव

☐ सरकलेले हाड ☐ अन्य (उल्लेख करा) _____

☐ नक्की माहित नाही ☐ येते उपचारासाठी नाही (प्र.१० कडे जा)

८. तुमच्या दुखापतीच्या जागेचे वर्णन करा.

_____
_____
_____

९. तुम्हास दुखापत कशी झाली त्याचे वर्णन करा.

_____
_____
_____
_____

कृपया नोंद घ्या: निकटवर्तीय भागीदार म्हणजे अशी व्यक्ती जिच्याबरोबर तुमचे नातेसंबंध पती/पत्नी, सामाईक कायदेशीर सहभागीदार, लैंगिक भागीदार किंवा 'डेटिंग पार्टनर' यापैकी आहेत. पुढील प्रश्न हे गेल्या १२ महिन्यात तुम्ही असलेल्या सध्याच्या किंवा पूर्वीच्या नातेसंबंधांपैकी म्हणजे तुमची/तुमचे पत्नी/पती, सामाईक कायदेशीर सहभागीदार, लैंगिक भागीदार किंवा डेटिंग पार्टनर यांच्या संदर्भातील आहेत.

१०. गेल्या वर्षभरात तुम्ही निकटवर्तीय भागीदाराच्या नातेसंबंधात आहात का?

☐ हो (प्र.११ कडे जा) ☐ नाही (प्र.१८ कडे जा)

११. सर्व साधारणपणे तुमचे नातेसंबंधाचे वर्णन कसे कराल?

☐ अति तणावपूर्वक ☐ थोडासा तणाव ☐ तणावरहित

१२. तुम्ही व तुमचा भागीदार वाद-विवादाचे निवारण कसे करता?

☐ अति कष्टाने ☐ थोड्या कष्टाने ☐ सुरळीतपणे

१३. आपल्या जोडीदाराबरोबर होत असलेल्या भांडणांमुळे आपल्याला कधी उदास किंवा वाईट वाटले आहे का?

☐ बहुतेक वेळा ☐ कधीतरी ☐ कधीच नाही

१४. वादविवादाचे रुपांतर मारामारीत, लाथ मारण्यात किंवा ढकलण्यात होते का?

☐ बहुतेक वेळा ☐ कधीतरी ☐ कधीच नाही

१५. तुमचा भागीदार जे बोलतो किंवा करतो त्यामुळे तुम्हाला भयभीत वाटते का?

☐ बहुतेक वेळा ☐ कधीतरी ☐ कधीच नाही

१६. तुमच्या भागीदाराने तुम्हास शारीरिकदृष्ट्या अत्याचार केला आहे का?

☐ बहुतेक वेळा ☐ कधीतरी ☐ कधीच नाही

१७. तुमच्या भागीदाराने तुम्हास भावनिकदृष्ट्या अत्याचार केला आहे का?

☐ बहुतेक वेळा ☐ कधीतरी ☐ कधीच नाही

१८. तुमच्या भागीदाराने तुम्हास लैंगिकदृष्ट्या अत्याचार केला आहे का?

☐ बहुतेक वेळा ☐ कधीतरी ☐ कधीच नाही

एका पतीची भूमिका:

१९. पुरुषाला त्याच्या पत्नीवर अत्याचार करण्याचा अधिकार आहे.

☐ तीव्रपणे असहमत ☐ असहमत ☐ सहमत ☐ पूर्णपणे सहमत

२०. घरगुती अत्याचार हा सर्वसामान्य जनतेकडून सहन केला जात आहे.

☐ तीव्रपणे असहमत ☐ असहमत ☐ सहमत ☐ पूर्णपणे सहमत

२१. घरगुती अत्याचार हा आपल्या समाजाचा सामाईक प्रश्न आहे.

☐ तीव्रपणे असहमत ☐ असहमत ☐ सहमत ☐ पूर्णपणे सहमत

२२. बालपणी अत्याचाराचे भक्ष्य बनलेली व्यक्ती अजून एखादा अत्याचारास प्रणव झालेली असते.

☐ तीव्रपणे असहमत ☐ असहमत ☐ सहमत ☐ पूर्णपणे सहमत

२३. कुटुंबात होणाऱ्या घरगुती अत्याचारात वाढलेली मुले पुढे अत्याचारी नागरिक होण्याची शक्यता अधिक असते.

☐ तीव्रपणे असहमत ☐ असहमत ☐ सहमत ☐ पूर्णपणे सहमत

२४. घरगुती अत्याचार हे घडतच असतात याची जाणीव करून देणे गरजेचे वाटते.

☐ तीव्रपणे असहमत ☐ असहमत ☐ सहमत ☐ पूर्णपणे सहमत

२५. अत्याचार झाला आहे असे वागणुकीतून दिसून येणाऱ्या लोकांना मदत दिली गेली पाहिजे.

☐ तीव्रपणे असहमत ☐ असहमत ☐ सहमत ☐ पूर्णपणे सहमत

२६. शासनाने लोकांना शिक्षित करण्यासाठी वेळ व पैसा खर्च करावा.

☐ तीव्रपणे असहमत ☐ असहमत ☐ सहमत ☐ पूर्णपणे सहमत

२७. आपल्या पत्नीने कामासाठी घराबाहेर जावे किंवा नाही हे ठरविण्याचा अधिकार पुरुषास आहे.

☐ तीव्रपणे असहमत ☐ असहमत ☐ सहमत ☐ पूर्णपणे सहमत

२८. आपल्या पत्नीने सायंकाळी मित्रांबरोबर बाहेर जावे किंवा नाही हे ठरविण्याचा अधिकार पुरुषास आहे.

☐ तीव्रपणे असहमत ☐ असहमत ☐ सहमत ☐ पूर्णपणे सहमत

२९. पुरुषाला आपण घरातील प्रमुख व्यक्ती आहोत हे पत्नीला कधीतरी दाखवून देणे महत्वाचे असते.

☐ तीव्रपणे असहमत ☐ असहमत ☐ सहमत ☐ पूर्णपणे सहमत

३०. पत्नीची इच्छा नसतांनासुद्धा पतीला तिच्याशी हव्या त्यावेळी संभोग करण्याचा अधिकार आहे.

☐ तीव्रपणे असहमत ☐ असहमत ☐ सहमत ☐ पूर्णपणे सहमत

<u>पुरुषाने आपल्या पत्नीला खालील परिस्थितीत थोबाडीत मारली तर तुम्ही त्यास मान्यता द्याल का? जर पत्नीने:</u>

३१. त्याने सांगितलेले काम केले नाही.

☐ हो ☐ नाही ☐ सांगता येत नाही

३२. घरी सर्वजण असतांना त्याचा अपमान केला.

☐ हो ☐ नाही ☐ सांगता येत नाही

३३. पतीच्या आई-वडिलांचा अपमान केला.

☐ हो ☐ नाही ☐ सांगता येत नाही

३४. पतीचा जनमानसात अपमान केला.

☐ हो ☐ नाही ☐ सांगता येत नाही

३५. तिच्या मुलांकडे दुर्लक्ष केले.

☐ हो ☐ नाही ☐ सांगता येत नाही

३६. अयोग्य कपडे घातले.

☐ हो ☐ नाही ☐ सांगता येत नाही

३७. मद्यपान करून घरात प्रवेश केला.

☐ हो ☐ नाही ☐ सांगता येत नाही

३८. वाद-विवाद चालू असतांना प्रथम पतीस हाणामारी केली.

☐ हो ☐ नाही ☐ सांगता येत नाही

३९. अन्य पुरुषांशी अनैतिक संबंध ठेवल्याचे पतीला कळले.

☐ हो ☐ नाही ☐ सांगता येत नाही

APPENDIX D: CONSENT FORMS

English Consent Form

Participant Information Sheet

Title of Study: *A comparison of Indian male and female attitudes on intimate partner violence (IPV) in Pune, India*

Principal Investigator:

Shivani Chandra
Department of Global Health
McMaster University
Hamilton, Canada
chandrsp@mcmaster.ca

Dr. Mohit Bhandari
Department of Surgery
McMaster University
Hamilton, Canada
bhandam@mcmaster.ca

Introduction

You are being invited to participate in a research study conducted by Shivani Chandra, who is a graduate student conducting her thesis project. You have been selected to participate because you are an individual who is 18 years of age or older, who is present at the Sancheti Institute.

In order to decide whether or not you want to be a part of this research study, you should understand what is involved and the potential risks and benefits. This form gives detailed information about the research study, which will be discussed with you. Once you understand the study, you will be asked to sign this form if you wish to participate. Please take your time to make your decision.

What is the purpose of this study?

Intimate partner violence, also called domestic violence, is any behaviour that is purposely inflicted by one person against another within an intimate relationship that causes physical, psychological or sexual harm. The person causing harm can be husband/wife, former husband/wife, and boyfriend/girlfriend or ex. Research has shown that women are most at risk to injury and death from their husbands or boyfriends. We are also interested in asssessing how the injuries being treated at the Sancheti Institute occurred, and if they occurred from the result of an intentional injury. Additionally, we would like to explore the different perceptions that are held about a husband's role and what is and is not considered to be acceptable behaviour.

What will my responsibilities be if I take part in the study?

If you decide to participate, we will ask you to fill out a short survey before you finish your visit to the clinic today. This survey contains questions about whether you have experienced intimate partner violence, your opinions on intimate partner violence, and will ask you to provide some demographic information. If you are also a patient at this hospital, we will also ask you for information about your orthopaedic injury. You will not be asked to come back to answer any further questions for this study.

What are the possible risks and discomforts?

Some of the questions may make you feel uncomfortable because they are asking personal questions relating to physical, emotional, or sexual abuse. If you do feel uncomfortable, please fill out the survey as best as you can. If you have not experienced abuse, some of the questions may seem irritating or unnecessary. Again, we ask that you please fill out all the questions on the survey.

How many people will be in this study?

We would like to enroll at least 100 men and women from the Sancheti Institute to participate in this study.

What are the possible benefits for me and/or for society?

By participating in this study, you will help inform the Sancheti Institute and the global scientific community of commonly held perceptions of intimate partner violence, the prevalence of injuries resulting from intentional violence, and how this may differ by gender. If you have never experienced intimate partner violence, you may only benefit from participating in this study by learning more about how serious this issue is in healthcare. If you are or have been a victim of intimate partner violence, an on-site psychiatrist has been made available for you should you wish to further discuss this issue in private.

If I do not want to take part in the study, are there other choices?

It is important for you to know that you can choose not to take part in the study. If you do not wish to participate, we respect your decision and it will in no way affect your care or treatment.

What information will be kept private?

Your data will not be shared with anyone except with your consent or as required by law. The data will be securely stored in a locked office/on a secure server/on an encrypted hard drive, etc. The data for this research study will be retained for 10 years as recommended by the Hamilton Health Sciences/FHS McMaster University Research Ethics Board.

For the purposes of ensuring the proper monitoring of the research study, it is possible that a member of the Hamilton Health Sciences/FHS McMaster University Research Ethics Board may consult your research data. By signing this consent form, you authorize such access.

If the results of the study are published, your name will not be used and no information that discloses your identity will be released or published.

Can participation in the study end early?

If you volunteer to be in this study, you may withdraw at any time. This will in no way affect the quality of care you receive at this clinic. You may also refuse to answer any questions that you do not want to answer and still remain in the study. However, your survey responses cannot be destroyed after you leave the clinic because no personal identifying information is to be kept on survey, so we will not know which one was yours.

The investigator may withdraw you from this research if circumstances arise which warrant doing so.

Will I be paid to participate in this study?

You will not be paid to participate in this study.

Will there be any costs?

Your participation in this research project does not involve additional costs to you.

If I have any questions or problems, whom can I call?

If you have any questions about the research now or later, please contact the study's Research Coordinator at 9980127981.

If you would like more information or help regarding IPV, please call Dr. Susan Zachariah, a psychiatrist at the Sancheti Institute, at +91(20) 2899 9800.

This study has been reviewed by the Hamilton Integrated Research Ethics Board (HIREB). The HIREB is responsible for ensuring that participants are informed of the risks associated with the research, and that participants are free to decide if participation is right for them. If you have any questions about your rights as a research participant, please call the Office of the Chair, Hamilton Integrated Research Ethics Board at 905.521.2100 x 42013.

This study was also reviewed by the Sancheti Institute's Research Ethics Board. If you have any additional questions, please feel free to call them at 9860299050.

Patient Information and Data Release Consent Form

Title of Study: *A comparison of Indian male and female attitudes on intimate partner violence (IPV) in Pune, India*

I have read the preceding information thoroughly. I have had the opportunity to ask questions, and all of my questions have been answered to my satisfaction. I agree to participate in this study. I understand that I will receive a signed copy of this form.

_____

Name of Participant

_____ _____

Signature Date

Consent form administered and explained in person by:

_____

Name and title

_____ _____

Signature Date

Principal Investigator of Study:

_____

Name and title

_____ _____

Signature Date

Hindi Consent Form

सहभागी के जानकारी का तख्ता

अभ्यास का शीर्षक : "पुणे(भारत) में भारतीय पुरुष और स्त्रियों की अपने निकटतम साथी के अत्याचारों के दृष्टिकोण की तुलना"

प्रमुख सर्वेक्षक:

शिवानी चंद्रा
जागतिक आरोग्य विभाग
मॅकमास्टर विश्वविद्यालय
हँमिल्टन, कॅनडा
chandrasp@mcmaster.ca

डॉ. मोहित भंडारी
शल्पचिकित्सा विभाग
मॅकमास्टर विश्वविद्यालय
हँमिल्टन, कॅनडा
bhandari@mcmaster.ca

प्रस्तावना

आपको शिवानी चंद्रा, जो पदवीप्राप्त विद्यार्थिनी अपने शोधप्रबंध प्रकल्प पर काम कर रहीं हैं, द्वारा किये जानेवाले संशोधन अभ्यास में सहभागी होने के लिए आमंत्रित किया जाता है| आपका चयन इसमें सहभाग लेने के लिए इसलिए किया गया है, क्योंकि आप संचेती संस्था में उपस्थित ऐसे व्यक्तिहैं, जिनकी उम्र १८ साल या उससे ज्यादा है|

आप इस संशोधन अभ्यास में सहभागी होना चाहतेहैं या नहीं यह तय करने के लिए आपको इस अभ्यास में क्या सम्मिलित है एवं इससे भविष्य में क्या खतरे एवं फायदे हो सकते हैं यह समझना जरुरी है| इस फॉर्म द्वारा आपको संशोधन अभ्यास की विस्तृत जानकारी मिलेगी, जिसकी आपके साथ चर्चा की जायेगी|

आपके अभ्यास के बारे में जानने के बाद अगर आप इसमें सहभागी होना चाहते हैं तो आपको इस फॉर्मपर हस्ताक्षर करने होंगे| आप अपना निर्णय लेने के लिए जितना चाहें समय ले सकते हैं|

इस अभ्यास का क्या उद्देश्य है?

निकटतम साथी के अत्याचार, जिन्हें घरेलु झगडे या अत्याचार कहते हैं, या ऐसा कोई भी बर्ताव, जो जानबूझकर एक व्यक्ति दूसरे व्यक्ति के साथ जो उसका निकटतम संबंधी है, जिससे शारीरिक, मानसिक या लैंगिक नुकसान होता है| नुकसान पहुंचानेवाली व्यक्ति पति/पत्नी, पहला पति/पत्नी, और पुरुषमित्र/स्त्रीमित्र हो सकते हैं| अनुसंधान यह बताते हैं की औरतों को उनके पति या पुरुषमित्रों से सबसे ज्यादा जख्मी होने का या मौत का खतरा होता है| इस प्रकार के जख्मों पर एवं जानबूझकर किये गए जख्मोंपर संचेती अस्पताल में किस प्रकार इलाज होता है, इसके विश्लेषण में भी हमारी रूचि है| इसीके साथ पति की भूमिका के अलग-

अलग पहलू एवं उनके कौनसे बर्ताव सामान्य एवं कबूल करनेलायक हैं एवं कौनसे नहीं इसको भी हम निश्चित करना चाहते हैं|

अगर मैं अभ्यास में सहभागी हूँ, तो मेरी क्या जिम्मेदारियाँ होंगी?

अगर आप सहभागी होने का निर्णय लेते हैं, तो हम आपको आपकी आज की अस्पताल की भेंट पूरी करने से पहले एक छोटासा सर्वेक्षण पूरा करने को कहेंगे| इस सर्वेक्षण में, क्या आप अपने निकटतम साथी के जुल्म का शिकार हैं, आपके निकटतम साथी के जुल्म के बारे में क्या विचार हैं, के बारे में प्रश्न होंगे और कुछ शास्त्रीय जानकारी देने को कहा जाएगा | अगर आप इस अस्पताल की एक रुग्ण भी हैं, तो हम आपको आपके हड्डी के जख्म की जानकारी भी पूछेंगे| इस अभ्यास के लिए पुनः और प्रश्नों के उत्तर देने के लिए आपको नहीं बुलाया जाएगा|

अध्ययन के संभाव्य खतरे एवं असुविधाएं क्या हैं?

कुछ प्रश्न आपको बेचैन अथवा परेशान कर सकते हैं क्योंकि वे व्यक्तिगत प्रश्न आपके शारीरिक, मानसिक या लैंगिक अत्याचार से संबंधित होंगे| अगर आप परेशानी महसूस करते हैं, तो कृपया जितना ज्यादा सर्वेक्षण आप भर सकते हैं भरें| अगर आपको किसी भी प्रकार की जोर-जबरदस्ती का अनुभव नहीं है, तो कुछ प्रश्न आपको क्षोभकारक एवं बेवजह लगेंगे| पुनश्च हम आपसे कृपया सर्वेक्षण के सारे प्रश्नों के जवाब देने की बिनती करते हैं|

इस अभ्यास में कितने लोग होंगे?

हम संचेती संस्था से कम से कम १०० आदमी तथा औरतों का नाम इस अभ्यास के लिए दर्ज करना चाहते हैं|

मेरे और/या समाज के लिए इससे क्या संभाव्य फायदे हैं?

इस अभ्यास में सहभागी होनेसे आप संचेती संस्था एवं जागतिक शास्त्रीय समाज को निकटवर्ती साथी द्वारा किये जानेवाले जुल्मों से, इन अत्याचारों द्वारा होनेवाले जख्मों के फैलाव से, और ये लिंग के अनुसार कैसे भिन्न हैं, इनसे अवगत कराने मदत कर सकते हैं| अगर आप अपने निकटतम साथी के अत्याचार का शिकार नहीं हैं, तो आपको आरोग्यसेवा में यह मुद्दा कितना गंभीर है इसकी जानकारी इस अभ्यास में सहयोगी होने से मिलेगी| अगर आप अपने निकटवर्ती साथी के जुल्म का शिकार हैं या थे, तो आपको वहीं मनोवैज्ञानिक उपलब्ध होगा जिसके साथ आप अगर चाहे तो गुप्ततापूर्व इस मुद्देपर चर्चा कर सकते हैं|

अगर मै इस अध्ययन में शामिल न होना चाहूँ, तो दुसरे कौनसे पर्याय उपलब्ध हैं?

यह जानना आपके लिए अत्यंत महत्वपूर्ण है की आप इस अध्ययन में सम्मिलित नहीं होना चाहते, यह पर्याय भी आप चुन सकते हैं| अगर आप सम्मिलित नहीं होना चाहते, तो हम आपके निर्णय का आदर करेंगे और किसी भी प्रकार से आपके इलाज या देखभाल पर इसका परिणाम नहीं होगा|

कौनसी जानकारी गुप्त रखी जायेगी?

आपकी अनुमति के बिना या कानूनी जानकारी के लिए आपकी जानकारी किसी को नहीं दी जायेगी| आपकी जानकारी सुरक्षितरूपसे एक तालाबंद कार्यालय/सर्वर/गुप्तभाषा हार्डड्राइव इ. पर संग्रहित की जायेगी| यह

जानकारी संशोधन अध्ययन हेतु १० वर्ष के लिए, जैसा की, हँमिल्टन हेल्थ सायन्सेस / एफ.एच.एस.)FHS(मॅकमास्टर विश्वविद्यालय संशोधन एथिक बोर्ड द्वारा नियमित है, रखी जायेगी|

संशोधन अभ्यास की योग्य रूप से देखरेख करने हेतु, हो सकता है, हँमिल्टन हेल्थ सायन्सेस / एफ.एच.एस.)FHS(मॅकमास्टर विश्वविद्यालय संशोधन एथिक बोर्ड का कोई सभासद आपके संशोधन जानकारी की मदद ले| इस अनुमतिपत्र पर हस्ताक्षर करके आप उस व्यक्ति को अधिकार दे रहें हैं|

अगर अभ्यास के परिणाम प्रकाशित होते हैं, तो आपका नाम उपयोग में नहीं लाया जाएगा और ऐसी कोई भी जानकारी, जो आपकी पहचान हो, बताई या प्रकाशित नहीं की जायेगी|

क्या अध्ययन बीच में ही छोड़ा जा सकता है?

अगर आप इस अध्ययन में आना चाहते हैं, तो आप किसी भी समय यह छोड़कर जा सकते हैं| इसका आपका इस अस्पताल में मिलनेवाली सेवाओं की गुणवत्तापर कोई असर नहीं होगा| अगर आप किसी प्रश्न का जवाब नहीं देना चाहते, तो मना कर सकते हैं और बावजूद इसके अध्ययन में रह सकते हैं| परंतु आपके अस्पताल छोड़ने के बाद आपके सर्वेक्षण के जवाब नष्ट नहीं किये जायेंगे क्योंकि सर्वेक्षण पर ऐसी कोई व्यक्तिगत पहचान की जानकारी नहीं रखी जाती, इसलिए हम यह नहीं जान पायेंगे की इसमेसे आपकी कौनसी है|

सर्वेक्षक आपको इस संशोधन से निकाल भी सकता है अगर घटनाएं ऐसा करने पर मजबूत करें तो|

क्या मुझे इस अध्ययन से आर्थिक मदद मिलेगी?

इस अध्ययन में सहभागी होने की आपको कोई धनराशी प्राप्त नहीं होगी|

क्या इस अध्ययन का कोई शुल्क होगा?

इस संशोधन प्रकल्प में शामिल होने के लिए कोई अतिरिक्त शुल्क नहीं है|

अगर मुझे कुछ प्रश्न एवं परेशानियाँ हों, तो किसे संपर्क करें?

संशोधन संबंधी अगर अभी या बादमें आपको कुछ सवाल पूछने हों, तो कृपया संशोधक समन्वयक से ९९८०१२७९८१ पर संपर्क करें|

अगर आप निकटवर्ती साथी के अत्याचार से सम्बंधित अधिक जानकारी या मदद चाहते हैं तो कृपया डॉ. सुझन झकारिया, जो संचेती संस्था में मनोवैज्ञानिक हैं, से +९१(२०)२८९९९८०० पर बात कर सकते हैं|

इस अभ्यास का अवलोकन हँमिल्टन इंटीग्रेटेड रिसर्च एथिक्स बोर्ड (HIREB) द्वारा हो चुका है| HIREB इस बात के लिए जिम्मेदार है की, संशोधन से सम्बंधित खतरों से सहभागी को अवगत करायें, और सहभागी उसका सहभाग उसके लिए सही है, यह किसी दबाव बिना तय कर सकता है| अगर आपको अपने संशोधक सभासद के अधिकारों के बारे में कुछ सवाल हों तो, कृपया कार्यालय प्रमुख, हँमिल्टन इंटीग्रेटेड रिसर्च एथिक्स बोर्ड से ९०५-५२१-२१०० x ४२०१३ से संपर्क करें|

इस अभ्यास का अवलोकन संचेती संस्था के रिसर्च एथिक्स बोर्ड द्वारा भी किया गया है| अगर आपको कुछ अतिरिक्त प्रश्न हों, तो कृपया बेझिझक ९८६०२९९०५० पर संपर्क करें|

मरीज की जानकारी एवं जानकारी वितरण संमतिपत्र

अभ्यास का शीर्षक : "पुणे(भारत) में भारतीय पुरुष और स्त्रियों की अपने निकटतम साथी के अत्याचारों के दृष्टिकोण की तुलना"

मैंने पूर्णतः पहली जानकारी पढ़ ली है| मुझे प्रश्न पूछने का अवसर भी दिया गया है, एवं मेरे सारे प्रश्नों के जवाब मेरी तसल्ली होने तक दिए गए हैं| मै इस अभ्यास में सम्मिलित होने के लिए तैयार हूँ| मुझे मालूम है की इस हस्ताक्षरित पत्र की एक प्रति मुझे प्राप्त होगी|

_____ _____

सहभागी का नाम (Name of participant) तारीख (Date)

_____

हस्ताक्षर (Signature)

_____ _____

अनुमतिपत्र प्रत्यक्षरूप से दिया एवं समझाया गया – तारीख (Date

Consent form administered and explained in person by)

_____

हस्ताक्षर (Signature))

_____ _____

अभ्यास का प्रमुख सर्वेक्षक (Principle Investigator of Study) तारीख (Date)

_____

हस्ताक्षर (Signature)

Marathi Consent Form

सहभागीदाराची माहिती

अभ्यासाचे शिर्षक: भारतातील पुणे येथे होणाऱ्या निकटवर्तीयांच्या जुलुमाबाबत भारतीय स्त्री व पुरुष यांच्या दृष्टीकोणांची तुलना.

प्रमुख सर्वेक्षक

शिवानी चंद्रा

ग्लोबल हेल्थ विभाग

मॅंकमास्टर युनिव्हर्सिटी

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डॉ. मोहीत भंडारी

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मॅंकमास्टर युनिव्हर्सिटी

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प्रस्तावना

शिवानी चंद्रा एक विद्यार्थिनी असून त्या एक प्रकल्प प्रबंध करीत आहेत. तुम्ही १८ वर्षावरील व्यक्ती असून सध्या संचेती इन्स्टिट्यूट मध्ये आहात म्हणून त्यानी सुरु केलेल्या शोध अभ्यासात सहभागी होण्यासाठी तुम्हास आमंत्रित करण्यात येत आहे.

या शोध अभ्यासामध्ये भाग घ्यावयाचा की नाही हे ठरविण्यासाठी या अभ्यासात काय आहे व यातील संभाव्य धोके व फायदे कोणते आहेत हे तुम्हास माहित असणे आवश्यक आहे. या फॉर्म मध्ये शोध अभ्यासाची सविस्तर माहिती दिली असून त्या संदर्भात तुमच्याशी चर्चाही केली जाईल. हा शोध

अभ्यास एकदा तुम्हाला समजला व त्यात भाग घ्यावयाची तयारी असेल तर अशा फॉर्मवर तुम्हास सही करण्यास सांगितले जाईल. यावर निर्णय घेण्यास तुम्ही आवश्यक तेवढा वेळ घेवू शकता.

या अभ्यासाचा हेतू काय आहे ?

जिवलगाची दांडगाई, ज्याला घरगुती हिंसाचार असेही म्हणतात, म्हणजे अशी वागणूक जी मुद्दाम तुमचा जिवलग तुमच्याविरुद्ध क्लेशकारक बनवितो, अशा क्लेशकारक वागणुकीमुळे शारीरिक, मानसिक किंवा लैंगिक इजा होऊ शकते. अशी इजा करणारी व्यक्ती ही पती/पत्नी, पूर्वीचा पती/पत्नी, किंवा मित्र/मैत्रीण यापैकी कुणीही असू शकेल. संशोधनाद्वारे असे दिसून आले आहे की दुखापत/मृत्यू होण्यामध्ये स्त्रियांना त्यांच्या पतीपासून किंवा पुरुषमित्रांपासून अधिक धोका असतो. अशा दुखापतींवर संचेती इंस्टीट्यूटमध्ये कसे उपचार केले जातात याचे मूल्यांकन केले गेले आहे का व याबरोबरच पतीच्या भूमिकेतून कोणकोणत्या गोष्टी होऊ शकतात व त्यातील त्यांची कोणती वर्तणूक स्वीकारार्ह आहे किंवा नाही याचाही आम्हास पूर्ण अभ्यास करावयाचा आहे.

मी जर या अभ्यासात सहभाग घेतला तर माझी जबाबदारी काय असेल ?

या अभ्यासात सहभागी होण्याचे तुम्ही ठरवीले तर प्रथमता, तुम्ही क्लिनिकला भेट देण्याअगोदर, आम्ही तुम्हाला एक सर्वेक्षणाची प्रश्नावली भरण्यास देवू. त्यामध्ये तुमच्या इतर व्यक्तीगत प्रश्नाबरोबरच तुम्ही तुमच्या जीवलगाकडून एखाद्या हिंसाचाराचा अनुभव घेतला आहे का, असल्यास त्याबाबतची तुमची मते काय आहेत अशा प्रश्नांचा समावेश असेल. जर तुम्ही या हॉस्पिटलचे रुग्णही असाल तर तुमच्या हाडांच्या दुखापातीबद्दलही माहिती विचारली जाईल, या अभ्यासातील प्रश्नांची उत्तरे देण्यासठी तुम्हास परत बोलाविले जाणार नाही.

यातील संभाव्य धोके काय आहेत ?

विचारण्यात येणाऱ्या प्रश्नांपैकी काही प्रश्नांमुळे तुम्ही नाराज होऊ शकाल कारण हे प्रश्न तुमच्याशी झालेल्या शारीरिक, भावनिक अथवा लैंगिक त्रासाबद्दल असतील. जर तुम्ही नाराज झाला असाल तरीसुद्धा तुम्ही अधिकाधिक चांगली माहिती भरण्याचा प्रयत्न करा. जरी तुम्हाला असे अत्याचारी

अनुभव आले नसले तरीही काही प्रश्न आवश्यक नाहीत अथवा चीड आणणारे आहेत असेही तुम्हाला वाटेल. तरीसुद्धा आम्ही पुनःश्च तुम्हाला सांगतो की कृपया सर्वेक्षणाच्या सर्व प्रश्नांची उत्तरे द्यावीत.

या अभ्यासात किती व्यक्तींचा समावेश असेल?

या अभ्यासात सहभागी होण्यासाठी संचेती हॉस्पिटलमधून कमीत कमी १०० स्त्री पुरुषांना समाविष्ठ करून घेण्याची आमची इच्छा आहे.

यातून मला व समाजाला मिळणारे संभाव्य फायदे काय आहेत ?

या अभ्यासात सहभाग घेऊन तुम्ही 'संचेती इंस्टीट्यूट' व जागतिक शास्त्रीय समाजाला, ज्यामध्ये जिवलगांकडून झालेल्या अत्याचारित व्यक्ती असतात व या जाणीवपूर्वक केलेल्या अत्याचारांतून उद्भवलेल्या जखमांचा फैलाव कसा होतो व त्या लिंगांनुसार कशा बदलतात याचा अभ्यास करण्यास मदत कराल. जिवलगाच्या अत्याचाराचा जर तुम्हाला अनुभव आलाच नसेल, तर या अभ्यासातील सहभागांमुळे वैद्यकीयदृष्ट्या हा विषय किती गंभीर आहे याबद्दल अधिक शिकायला मिळेल. जर अशा प्रकारच्या जिवलगाच्या हिंसाचाराचे तुम्ही 'भक्ष्य' बनला गेला असाल तर अत्यंत खाजगीत तुम्ही ही बाब, जर तुमची इच्छा असेल, मानसशास्त्रज्ञाशी बोलू शकता जो तुम्हाला घटनास्थळी उपलब्ध करून दिला जाईल.

मी जर या अभ्यासात सहभाग घेतला नाही तर मला अन्य कांही पर्याय आहेत का ?

तुम्हास हे माहित असणे अत्यंत महत्वाचे आहे की अभ्यासात सहभागी न होण्याचा पर्याय तुम्ही निवडू शकता. जर तुम्हाला सहभागाची इच्छा नसेल तर तुमचा निर्णय आम्हास सादर मान्य आहे. तसेच तुमच्या उपचार पद्धतीत त्याचा काहीही परिणाम होणार नाही.

कोणती महिती खाजगी स्वरुपात ठेवली जाईल ?

कायद्याने आवश्यकता असेल त्यावेळी व तुमची संमती असेल त्यावेळी याशिवाय तुमची माहिती कोणासही दिली जाणार नाही. ही माहिती एका कुलूप घातलेल्या कार्यालयात/एका सुरक्षित सर्व्हरवर/एका गुप्त भाषेत लिहिलेल्या हार्ड ड्राईव्हवर सुरक्षितपणे साठविली असेल. हॅमिल्टन हेल्थ सायन्सेस / एफ.एच.एस.(FHS) मॅकमास्टर युनिव्हर्सिटी रिसर्च एथिक्स बोर्ड यांच्या शिफारसीनुसार या संशोधनाची माहिती १० वर्षे ठेवली जाईल.

संशोधन अभ्यासाची पाहणी करायच्या हेतूने, हॅमिल्टन हेल्थ सायन्सेस / एफ.एच.एस.(FHS) मॅकमास्टर युनिव्हर्सिटी रिसर्च एथिक्स बोर्डाचा एखादा सभासद या शोध अभ्यासाची माहितीबाबत चर्चा करेल. हे संमतीपत्र सही करून तसे करण्यास तुम्ही अधिकार प्रदान करीत आहात.

या शोध अभ्यासाचे निष्कर्ष जर प्रकाशित झाले तर त्या ठिकाणी कोठेही तुमच्या नावाचा उपयोग केला जाणार नाही व अशी कोणतीही माहिती खुली केली जाणार नाही जिच्यामुळे तुमची व्यक्तिगत ओळख कळेल अथवा प्रकाशित होईल.

अभ्यासातील सहभाग वेळेअगोदर संपू शकेल का ?

या अभ्यासात सहभाग घेतल्या नंतर तो तुम्हाला कोणत्याही वेळी मागे घेता येईल. तसेच तुम्हाला दिल्या जाणाऱ्या वैद्यकीय सेवेच्या गुणवत्तेवर त्याचा काहीही परिणाम होणार नाही. अभ्यास गटात विचारलेल्या प्रश्नांपैकी एक अथवा अनेक प्रश्नांची उत्तरे तुम्ही नाकारू शकता व असे नाकारूनसुद्धा तुम्ही अभ्यास गटात सहभागी राहू शकता. तथापि, तुमच्यावरील उपचार संपवून तुम्ही क्लिनीकमधून बाहेर गेला तरी तुमची माहिती मात्र तशीच ठेवली जाईल. तिचा मात्र विनाश केला जाणार नाही. पण अशा माहितीमध्ये तुमची व्यक्तिगत ओळखीची माहिती नसेल त्यामुळे कोणती माहिती कोणाची आहे हे आम्हालाही कळणार नाही.

काही विशिष्ठ प्रसंगी मात्र तशी आवश्यकता जाणवली तरच सर्वेक्षक तुमचे नाव अभ्यास गटातून कमी करतील.

यातील सहभागाबद्दल मला काही आर्थिक लाभ होईल का?

नाही, या अभ्यासातील सहभागाबद्दल तुम्हांस कोणताही आर्थिक लाभ होणार नाही.

या सहभागाबद्दल मला काही पैसे द्यावे लागतील का?

नाही. या सहभागाबद्दल तुम्हाला कोणत्याही प्रकारचा अधिक आर्थिक बोजा सोसावा लागणार नाही.

मला जर कांही प्रश्न अथवा अडचणी असल्यास मी कोणाशी संपर्क साधावा?

या अभ्यासाबाबत तुम्हास आता किंवा नंतर काही प्रश्न असतील तर अभ्यासातील संशोधक समन्वयक यांना ९९८०१२७९८१ येथे संपर्क करा. जर तुम्हास अधिक माहिती हवी असेल अथवा जिवलगाच्या अत्याचाराबद्दल मदत करावयाची असेल तर डॉ. सुझन झकारिया, संचेती इंस्टीट्यूटमधील मानसशास्त्रज्ञ यांना +९१(२०)२८९९९८०० येथे संपर्क साधा.

ह्या अभ्यासाचे हॅमिल्टन इंटिग्रेटेड रिसर्च एथिक्स बोर्ड कडून पुनरावलोकन करण्यात आले आहे. या अभ्यासाशी सलग्न असलेल्या धोक्यांबाबत सहभागी व्यक्तींना कल्पना देण्यात आली आहे याची खात्री करून घेण्याची जबाबदारी या हॅमिल्टन इंटिग्रेटेड रिसर्च एथिक्स बोर्डाची आहे. तसेच सहभागी व्यक्तीस त्याचा सहभाग योग्य आहे की नाही हे ठरविण्याचे पूर्ण स्वातंत्र्य आहे. या अभ्यासातील सहभागी म्हणून तुमच्या हक्कांबद्दल तुम्हास काही प्रश्न असतील तर हॅमिल्टन इंटिग्रेटेड रिसर्च एथिक्स बोर्डच्या कार्यालयाच्या प्रमुख व्यक्तीस ९०५.५२१.२१०० x ४२०१३ येथे संपर्क करा.

या अभ्यासाचे संचेती इंस्टीट्युटच्या रिसर्च एथिक्स बोर्ड यांच्याकडूनही पुनरावलोकन केले गेले आहे. जर तुम्हास काही अधिक प्रश्न असतील तर निःसंकोचपणे ९८६०२९९०५० वर फोन करा.

रुग्णाची माहिती व माहिती प्रसिद्धीची संमती-

अभ्यासाचे शिर्षक: भारतातील पुणे येथे होणाऱ्या निकटवर्तीयांच्या जुलुमाबाबत भारतीय स्त्री व पुरुष यांच्या दृष्टीकोणांची तुलना.

यापूर्वीची माहिती मी पूर्णपणे वाचली आहे. मला प्रश्न विचारण्याची संधी देण्यात आली होती व माझ्या सर्व प्रश्नांची उत्तरे माझे समाधान होईल एवढी दिली गेली आहे. मी या अभ्यासात सहभाग घेण्यास तयार आहे. मला कल्पना आहे की या फॉर्मची एक सही केलेली प्रत मला मिळणार आहे.

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सहभागीदाराचे नाव (Name of Participant) दिनांक (Date)

_____

सही (Signature)

_____

हे संमतीपत्र यांनी समजावून सांगितले व दिले

(Consent form administered and explained in person by)

_____

_____

सही (Signature) दिनांक (Date)

_____

अभ्यासाचे प्रमुख सर्वेक्षक (Principle Investigator of Study)

_____

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सही (Signature) दिनांक (Date)