Indian Journal of Health, Sexuality & Culture
Volume (9), Issue (1), June 2023
ISSN 2581-575X
https://www.iisb.org

Review Article

Intimate partner violence among South-Asian women : A scoping review of understanding and safeguards in modern marriages

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Date of Submission:
06 April 2023
Date of Acceptance:
15 May 2023

Abstract

Intimate partner violence (IPV) is defined as a physical, sexual, or psychological form of violence by a male partner and is the most predominant form of violence against women globally. Violence always causes mental, physical, and emotional issues, causing substantial global public health concerns. Quantitative and qualitative studies were used for the review. A total of 163 research papers were identified by searching PubMed, Web of Sciences, Scopus, and Embase databases, and 14 papers were selected as relevant for the review. Among 14 studies, 12 were published in India, one from Pakistan, and one from Nepal. We found that IPV is highly prevalent with substance abuse, dowry system, male dominance, and spousal coercion leading to severe health problems. Utilising Intra Uterine devices (IUDs) as contraceptives, economic and electronic media empowerment, help-seeking behaviour as well as using the healthcare system enables safeguarding women from IPV.

Keywords:
Intimate Partner Violence, South-Asian women, Safeguarding, Marriage

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How to cite the article: Pellissary M, Mercy Bai AC. Intimate partner violence among South-Asian women : A scoping review of understanding and safeguards in modern marriages. Indian Journal of Health, Sexuality and Culture. 2023;9(1):111–129.
DOI: 10.5281/zenodo.8251448

Introduction

Intimate partner violence (IPV) is described as a physical, sexual, or psychological form of violence by a spouse or male partner. It is the most prevalent form of violence against women in every part of the world. Violence always results in mental, material, and emotional complications for an individual causing one of the substantial global public health concerns where violence against

women violates human rights. [1]The Sustainable Development Goals by the United Nations (UN) also aim to reduce IPV. [2] IPV is a crucial causality of morbidity and mortality among reproductive-aged women. [3]This violence is harsh at times, such that the victims are booted, dragged, or beaten by their spouses. Mental health disorders such as anxiety and depression are also the followers of IPV. [4] Studies indicate that more than one in three women are affected, and their children also bear the effects, particularly in the context of marriages. [5] IPV includes physical abuse, psychological abuse, sexual abuse, including marital rape, and delimited behaviours.[6] The risk factors for IPV are illiteracy, substance abuse, age, behavioural disorders, abusive partner, and acceptance of violence.[6] IPV highly affects Low and Middle-income countries regardless of ethnicity.[6] The beginning of COVID-19 has also fostered IPV, where couples are detached from families and friends, stress and depression due to lockdowns, travel restrictions, and substance abuse. National Commission for Women statistics reported that the prevalence of IPV as double during the lockdown period. [6]

Safeguarding is defined by Global Fund for Women as defending people from harm and keeping them safe.[7] World has evolved exceptionally; however, patriarchal women are distressed and mistreated. It is challenging to accomplish surveys among women to ask about IPV that they experience. Few insights are available from Demographic and Health Surveys, National Family Health Surveys (NFHS), and World Health Organization (WHO) surveys. [8] Marital rape, reproductive pressure, insertion of objects into female private parts, and sexual avoidance are forms of brutality women regularly encounter by their spouses or partners. Pregnant women are not even an exception from violence. Partner coercion and resulting violence adversely affect pregnant women and limit their ability to make decisions for their health as well as the fetus's health. Dowry-related abuse, male dominance, and substance abuse are also reasons for IPV. In South Asia, married adolescents are more vulnerable than older adults. Greatly, abuse occurs in the early years of marriage when women are less capable of resisting it.[9] An enormous amount of survivors of IPV confessed that they have experienced compelled sexual interaction by their partner during intervention counseling. [8] Since IPV is a reason for various health and mental concerns, it is necessary to protect women from the harms of violence. Incorporating community-based interventions with other health services encourages health workers to identify and promote safeguarding measures among women against IPV. Such measures are also required to be implemented at government levels along with programs that strengthen women, training, and education to recognize the forms of violence occurring to them by their spouses/partners. [6] Nurses play an integral role in determining and sustaining abused women in mental health care settings. [10] Safeguarding programs exist in the South Asian subcontinent. However, the absence of accurate measures and evaluations implemented on time makes it challenging for women to survive IPV or pursue the needful approaches for them. [9]

Globally, WHO assessed a prevalence of 26% IPV in ever-married/partnered women aged 15 or more, elevated to 35% within Southern Asia in 2018. [1] Almost 60% of women have experienced IPV in their married life. [4] 2 out of 3 women disclosed that either they or any other woman they knew were victims of violence. In most cases of sexual abuse, offenders are their spouses, partners, or family members and not a stranger.[11] The most common form of violence against women is IPV. Southeast Asia victimizes 33 percent of women undergoing forms of violence from their partner at least once in their lifetime. Even though after all these sufferings, the feasibility of women reporting them is

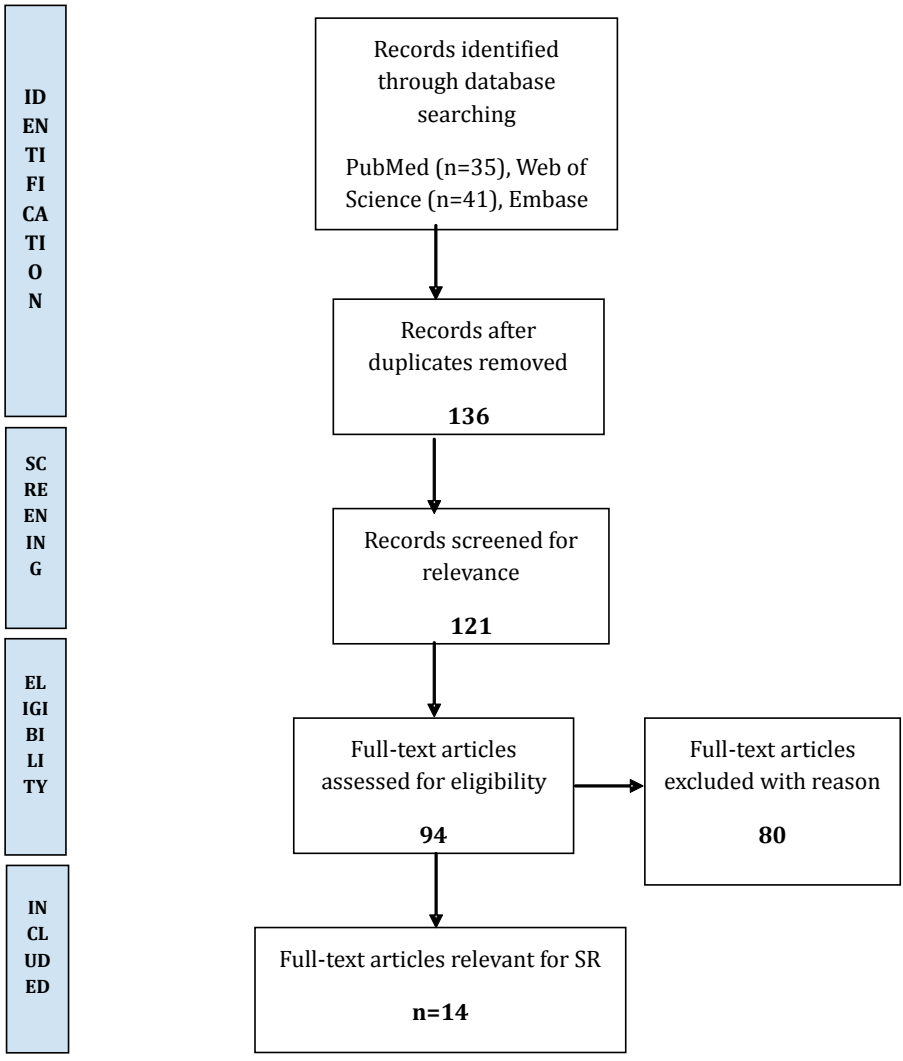
comparatively lesser fearing refusal, revenge, stigma, and blaming from family. [11] Still, countries exist where there are no laws to protect women from marital rape, including India. Legislations for safeguarding women must be assertive in every part of the world such that the UN can achieve the goal of Sustainable Development by joining the hands of countries. This review aims to identify IPV among South-Asian women, grounds, understandings, and safeguards in the context of modern marriages.

Methodology

Study design

Quantitative as well as qualitative primary research papers were included in this scoping review.

Figure 1 : Preferred reporting items for systematic reviews and meta-analyses flow chart for screening the studies for systematic search



Search strategy

The literature search was performed in databases such as PubMed, Web of Sciences, Scopus, and Embase within the time frame between January 2018 and February 2023. The search terms used were:

- Intimate partner violence, marital rape, physical violence, sexual violence, psychological violence
- Modern partnership, marriage
- Dowry system, substance abuse, male dominance
- South Asian women, Afghanistan, Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan, and Sri Lanka

A wide range of literature searches was carried out to identify the published literature. The search was extended to South-Asian countries since WHO assessed a significantly higher rate of IPV. [1] This also allows us to obtain all the applicable studies and safeguarding interventions available for review. References of relevant studies and applicable reviews were examined for further literature availability. Search terms and the Boolean operator 'AND' were used in the search technique for all four databases. Duplicate articles were pulled out before implementing inclusion and exclusion criteria to avoid duplicate bias. However, sufficient articles that discussed IPV and safeguarding principles were lesser in number.

A total of 163 research papers were identified through database searching and many of the articles were removed during the screening process for various reasons. Major reasons for exclusion were duplicate articles, lack of full-text availability, irrelevant to the main subject, or discussing more topics other than the inclusion criteria (Table 1). A few systematic reviews and meta-analyses were found during the search, where most of them analysed the relationship between IPV and any of the risk factors of IPV. Figure 1 shows the PRISMA chart, [12] which gives the number of articles at every stage. Finally, 14 articles were selected for the review.

Inclusion and exclusion criteria

Briefly, research papers were included if they investigated IPV, marital rape with a dowry system or substance abuse, or male dominance among South-Asian women. Articles were screened after applying the criteria mentioned in Table 1. The articles that did not meet the criteria or did not supply adequate information were excluded. Research papers between January 2018 and February 2023 were included in the review. After implementing the inclusion and exclusion criteria, 14 articles were chosen.

Table 1 : Inclusion and exclusion criteria

Inclusion criteria	Exclusion criteria
Research papers where the population of women who are married and belong to South-Asian countries was included	Research papers where the population of women who are not married and do not belong to South-Asian countries were excluded
Research papers that studied IPV or marital rape and dowry system/substance abuse/male dominance were only included	Research papers that discussed IPV or marital rape alone and IPV or marital rape with any other subjects were excluded
Experimental & Observational Research papers were included	Case studies, Case series, Conference abstracts, Animal studies, and Grey literature were excluded
Research papers published between January 2018 and February 2023 were included	Research papers published before January 2018 were excluded
Only full-text research papers were included	Abstracts, Analyses, and Reviews were excluded
Research papers only in the English language were included	Research papers in all other languages were excluded

Results

Data were extracted from eligible full-text papers. Data extracted included the study design, aim of the study, sample size, study setting, key findings & limitations. Characteristics of the relevant studies are shown in Table 2. Studies were published between 2018 and 2023. There were 12 Cross-Sectional Studies, one Qualitative study, and one Mixed Method study which included qualitative and quantitative data analysis.

Study characteristics

Among 14 studies, 12 were published in India, one from Pakistan, and one from Nepal. No relevant articles were identified from Afghanistan, Bangladesh, Bhutan, Maldives, and Sri Lanka. All the studies were based on married women between the reproductive ages (15 to 60 years). Of all the studies, six were conducted nationwide, four were conducted among communities and four were based in hospital settings. In India, four studies estimated the prevalence of IPV nationwide and in particular communities. Three studies investigated the utilisation of the healthcare system and whether electronic, economic, and media empowerment protect women. Two Studies investigated IPV among married women with mental health disabilities. One Study investigated the pregnancy outcome associated with IPV and another investigated the usage of contraceptives among IPV victims. One study explored the association between social status and IPV in India, and the other investigated the influence of dowry systems on IPV in Pakistan. The study conducted in Nepal evaluates the relationship between alcohol use and IPV.

As a result of the thematic analysis that was performed, the following main themes were generated:

1. Understand IPV among South-Asian women in modern marriages
2. Safeguarding of IPV among South-Asian women in modern marriages

1. Understand IPV among South-Asian women in modern marriages

I. Prevalence of IPV and outcomes among South-Asian women

Violence against women is a violation of human rights [1] and the prevalence of IPV in marriages in South Asia is higher. Four relevant studies discussed the prevalence of IPV and its outcomes whereas all studies mentioned a higher prevalence. In the fourth round of study where the NFHS dataset is used by Garg et al [13], it pointed to a decrease where physical violence was 29.2% making it the commonest, sexual violence was 6.7% pushing it to the least, emotional was 13.2% and all other forms was 32.8%. The fourth round showed a comparative decline in prevalence to the third round. Another study by Gupta and his coworkers [14] revealed 171 (56.6%) women out of 315 had encountered any form of violence. The psychological form was the most prevalent with 32.16%. 55.5% notified that they oppressed violence due to substance abuse. Pengpid and Peltzer [15] also studied the association between IPV and factors such as spousal violence victimization and physical health outcomes. 29.9% reported physical violence, and 7.1% reported sexual violence. Furthermore, malnourishment, elevated blood glucose levels, anaemia, and hypertension are the health outcomes depicted in the study. Ram et al [10] also studied the prevalence of IPV documented as 77.5% where 40% has undergone severe abuse.

Relationship between IPV, substance abuse, dowry system, pregnancy outcomes, and male dominance in modern married life.

The grounds for IPV among modern couples are diverse in South Asia and it results in physical, health, and mental complications. Akombi-Inyang et al[16] studied the relationship between IPV and substance abuse and its aftereffect on perinatal care in pregnant women. Out of 2,728 women, 47.6% have partners involved in substance abuse where 22.3% of women faced physical, 14.1% faced

emotional and 11.4% faced sexual violence. These women are less likely to utilise maternity health services and hence complicate the lives of their children too. Ali et al [17] scrutinize the perspectives of women on dowry practice and its influence on their marital life. Dowry system exists in Pakistan ranging between 87% - 97%. [19] 94.1 % of women conveyed that dowry was given while their marriage and more than 40% of male partners belong to the age group of 25-35 years. Although this practice is considered to nourish a marital life, still more than 50% of women face all forms of violence. Women may blame the dowry practices as a platform for their IPV experience since in this study, couples, where dowry trade is performed, have more favourable outcomes.[17] Poor reproductive and maternal health effects are also associated with IPV as per the study conducted by Dhar and his colleagues.[20] 45% of mothers face IPV and the complications increased with increasing age. Multivariable analysis revealed that IPV has an association with labour complications. Those women who have experienced violence are more prevalent to maternal complications, abortions, stillbirth, and miscarriage. The study also emphasizes the implication of the healthcare sector in supporting women. Indicators of wealth also decline the risk of IPV and perinatal health concerns.[20]

Male dominance through coercive control is more frequent than other forms of IPV and it restrains women from socializing, lowering self-respect and mental health crises. Kanougiya, Sivakami, and Rai [21] studied the association between spousal coercive control and IPV. Sociodemographic and socioeconomic predictors are assessed in this study. Physical or sexual IPV has spousal control as a critical factor and ultimately leads to partner dominance. 48% of women inform that they were victims of spousal control and were newly married. Risk factors such as alcohol abuse, employment status, and education also contribute to coercive control. 82% of women faced emotional, 72% faced physical, and 84% faced sexual forms of IPV. All of the cross-sectional studies also remark on the confounding factors of IPV such as the education of couples, employment status of women, the rural or urban area of residence, ethnicity, age, sex of children, and mass media. Surprisingly, mobile phones and bank accounts also acted as a risk factor for IPV in maternal health as per Dhar et al.[20]

Estimation of IPV among psychiatric patients

Psychiatric people is a high-risk group for being vulnerable to IPV. Aggression, grumpiness, lowered self-control, and lacking judgment capabilities put them for being perpetrators of IPV. [22] Out of 500 married people, 13% had psychosis and 41.2% had neurosis. 16% of the sample size experienced IPV and 6% were perpetrators of IPV. Victims of sexual IPV were the commonest. Poreddi et al [23] explored the IPV experience of women in a mental health care setting. Women described that they had experienced various forms of IPV from their partners as well as family members. Physical, sexual, and physiological forms were prevalent along with social and financial violence.[23] Many of the participants had a fear of disclosing their abusive experience to nurses due to several reasons such as their family may be shameful in society, worrying, poor support, or hopelessness. This study concluded that mentally-ill women are vulnerable to various forms of IPV.

2. Safeguarding of IPV among South-Asian women in modern marriages

I. Contraceptive use effectiveness in IPV

IPV is stated to be associated with contraceptive use specifically based on the type used. Of the 14 research papers, only one relevant paper studied the association between IPV and contraceptive uses among married women. IPV is said to be more prevalent among pill users and less prevalent among condom users. In the study by Chen et al[18],

among 1001 women, 10.9% reported physical and 2.7% reported sexual violence. 37.9% were using contemporary contraceptives, 8.4% were using pills, and 23.5% were using IUDs. IUD use was seen raised among women who undergo physical violence.

II. Effectiveness of economic and electronic media empowerment to protect women

Electronic and economic empowerment has positive as well as negative impacts on population health. Dalal and his co-workers [8] studied the effectiveness of economic and electronic empowerment as a protective factor against IPV. This study also analysed based on the NFHS data set. Prevalence of physical, emotional, and sexual violence was 28%, 13%, and 7% respectively. Women residing in rural areas encountered more IPV than in urban areas. Hindu women experienced more physical (30%) as well as sexual violence (7%) than women from any other community. Women who are educated and wealthy show a lesser prevalence of IPV. Other factors, such as understanding business loans, using mobile phones, and operating bank accounts, were less exposed to IPV. Women often accept the misuse and violence imposed on them, quietly worrying about the stigma and family and treating male dominance as normal in society. However, improved economic status and electronic equipment support women to an extent.

III. Examination of help-seeking behaviour of sexual violence in marriage

Violence in marriage is not rare and is epitomized in various states including marital rape. IPV has serious consequences on women's health ranging from sexually transmitted diseases (STI) to reproductive tract infections and on their rights. Deosthali, Rege, and Arora[24] analysed the service records of women who are survivors of violence. Out of 1783, 1416 women were married and 58.5% reported experiencing sexual violence including forced intercourse. After the counseling, 41% of women were guided to seek support from the crisis intervention department. 91% also mentioned that they were facing forms of violence since marriage. Mental health issues were cited by 98%. An interesting fact is that nearly half of this population, that is 48% seek help from the police by filing a complaint. Out of 1664 marital rape survivors, 18 of them requested medico-legal support. Even though it was not the first attempt at rape, the fear of being attacked including their children or family forced them to seek help. [24] Regrettably, since the police aren't aware of how to act in situations of marital rape, outcomes were delayed. For a few of the cases, rather than filing a rape case, it was domestic violence. Health workers carried out the examinations for medico-legal support, however, this help cannot be expected in every hospital due to a lack of knowledge. The study also highlights that hospitals are the primary places where help can be initiated as they can apprehend the signs of rape and violence in women.[24]

IV. Utilisation of the healthcare system for safeguarding women from IPV

Paul and Mondal studied the association between the maternal healthcare system (MHS) and IPV exposure. Utilising MHSs is a crucial measure to lower the incidence of maternal death. Data used for this study was from the fourth round of NHFS. [25] 58% of the sample population was between 25 and 34. Physical, sexual, and emotional abuse was reported by 22%, 6%, and 10%, respectively. MHS included Antenatal care (ANC) visits, assisting delivery by a skilled health worker, and Perinatal care (PNC) in less than 2 days after delivery.[25] MHS was mostly used by women residing in urban areas along with forward caste groups. Lowered use of MHS was seen among women for whom decisions are made only by husbands or by family members, illiterate, and employed. One another significant inference is that women who have faced IPV are less likely to receive MHSs.

Table 2 : Data extraction table (Characteristics of 14 studies included in the review)

Sl No	Author & Year	Study Design	Aim of the Study	Sample Size & Study Setting	Key Findings	Limitations
1.	Dalal et al, 2022 [8]	Cross-sectional study	To determine if economic and electronic empowerment safeguards Indian women from IPV by conducting NFHS from 29 states and 7 union territories. The study also explores if media exposure can protect women from IPV.	An NFHS between 2015 - 2016 where the sample size was 66,013 ever-married Indian women.	The prevalence rate of emotional, physical, and sexual violence was 13%, 28%, and 7%, respectively. IPV was highly experienced by women in rural households from the Hindu religion and SC. Higher socio-economic class as well as education are reported to be the preventive factors from IPV. Media exposure also reduced IPV prevalence. Working women, women who took advantage of mobile phones, SMS services, and business loans have experienced higher forms of IPV.	A cross-sectional study makes it challenging to determine causality. This study only assesses the IPV from IP or husbands. But Indian women are likely to be abused by other family members, relatives, and even political figures or police which can also be included. This can result in information bias. Longitudinal and qualitative studies which examine the causality as well as the use of mobile phones or SMS to prevent IPV may guide in further policy development.
2.	Ram et al, 2019 [10]	Community-based cross-sectional study	This study evaluates the domestic violence prevalence and the three components - emotional, physical, and sexual violence in women from 15 to 49 years aged.	120 permanent resident women (15 - 49 years) from six villages of Tamil Nadu - Edayansathu, Pennathur, Munjurpet, Adukkamparai, A. Kattupadi, and Mettu-Edayampatti from Kaniyambadi block, Vellore, Tamil Nadu, South India	77.5% of women were prevalent to all forms of domestic violence and 40% experienced severe forms of violence. Prevalence of physical, emotional, and sexual violence was 65.8%, 54.2%, and 17.5% respectively. Alcohol consumption by husbands is a remarkable factor contributing to IPV. In addition, the controlling nature of family members as well as the employment status of women also plays a crucial role. Dowry and IPV also correlate with each other as per this study (OR 2.29; 0.92, 5.65).	Sample bias is noted here since the sample size is smaller. A larger sample size may enhance this study by identifying more correlations. As there was no sound way to estimate domestic violence, this study had to exclude the severe violence faced by women. The study could be more generalised if the sample setting was extended to urban and tribal areas.
3.	Garg, et al, 2021 [13]	Cross-sectional ecological study design	The aim of this study is to evaluate the IPV prevalence in India along with the changes above a decade from Round 3 & 4 of NFHS.	64,607 ever-married women from Round 3 and 62,716 ever-married women from Round 4 of NFHS.	Prevalence of IPV as per NFHS -4: Physical=29.2%, Sexual=6.7%, Emotional=13.2%, Other forms=32.8%. These components had a relative change when compared to NFHS -3 and they are Physical= -14.9%, Sexual= -30.2%, Emotional= -11%, Other forms= -15.7%. Remarkable changes in prevalence were seen state-wise. Multivariate binary logistic regression analysis underlined the predictors of IPV as education of women and partners, socio-economic class, women empowerment, rural or urban residential areas, and controlling behaviour.	Only predetermined variables were considered to estimate the prevalence of IPV in this analysis which was the major limitation since there were many other variables that can affect IPV. These variables were not comprised in NFHS. Also, the self-reporting nature may result in information bias. This can miscalculate the overall IPV prevalence which contributes to fear, dependence, embarrassment, and detention faced by women.

4.	Gupta, et al, 2019 [14]	Community-based cross-sectional study	To estimate the domestic violence prevalence and risk factors in rural regions of Jammu district.	301 newly wedded women in Miran Sahib health zone of R.S Pura block which is a rural health training center of a tertiary care hospital in Jammu, J&K state, India.	171 (56.6%) of 301 respondents revealed forms of domestic violence. Prevalence rates of physical violence is 9.9%, psychological violence is 32.16%, and sexual violence is 2.33%. A statistically significant relation was found with variables such as literacy, type of family, income, sex of children, etc.	Since the research was performed in a small geographic area, findings cannot be generalised. Fear of Stigma is an addition to the limitation.
5.	Pengpid and Peltzer, 2018 [15]	Cross-sectional Study	This study aims to evaluate the relation between victimization of lifetime spousal violence, spousal violence perpetration, physical health outcomes and women's behaviour in India.	66,013 women who answered the domestic violence model from Round 4 of NFHS between 2015 and 2016.	This study shows that victimization of lifetime spousal violence was disclosed by 29.9% of women as a physical form, and 7.1% of women as a sexual form. 3.5% of women disclosed lifetime spousal physical violence perpetration. Lifetime spousal violence victimization and perpetration are substantially associated with STIs, asthma, genital discharge, genital sores or ulcers, tobacco use, alcohol use, and termination of pregnancy, whereas, adversely associated with dark vegetable consumption on a daily basis. Moreover, lifetime spousal violence victimization is also correlated with being undernourished, having high random blood glucose levels, anaemia and negatively correlated with being obese. Lifetime spousal violence perpetration was marginally significantly associated with hypertension.	Cross-sectional design makes it difficult to determine the causative relations. Need for further research on assessing victimization of spousal violence, spousal violence perpetration, mental health outcomes, and including Indian men is required.

6.	1 Akombi-0Inyang et al, . 2021 [16]	Cross-sectional Study	This study estimates the correlation between IPV and alcohol use by husband/partner and the receipt of PNC in Nepal.	2728 women from Nepal	Prevalence of IPV experienced by women is as follows: Physical=22%, Sexual=11%, Emotional=14%. The study reports that women with alcoholic partners are less likely to engage in at least 4 skilled ANC visits and use institutional delivery or qualified delivery assistance services. This study points out the requirement of formulating community-based interventions and incorporating IPV support services with other healthcare services to address the negative relationship between IPV and PNC.	Since the study was a cross-sectional design, establishing causality was a challenge. Additionally, other factors that can influence PNC were not taken into consideration.
7.	Ali et al, 2021 [17]	Cross-sectional Study	Goal of this study is to investigate the perceptions that women have about the impact of the dowry system in their married life and IPV.	759 married women from two towns of Karachi between 2008 - 2010. Women belonged to the reproductive age group (25 - 60 years).	Overall IPV prevalence was 87.1% (661). The prevalence of the components is as follows: Physical= 57.6% (437), Sexual= 54.5% (414), Psychological= 83.5% (634). However, this study summarizes that contributing dowry to the husband does not necessarily prevent women from any forms of physical (adjusted OR: 3.7), sexual (adjusted OR: 3.7), or psychological (adjusted OR: 8.9) forms of IPV.	The key limitation of this study is that the study setting was restricted to two towns of Karachi. The study also didn't consider women below 25 years of age who were married. In addition, females whose spousal commitments were connected to the endowment as a rule detailed a more flourishing marital life. This finding, in any case, comes with a caveat as there were significantly differing qualities among the detailed results, as illustrated by the significant confidence intervals.

8.	Chen et al, 2020 [18]	Cross-sectional study	To determine the relationship between self-reported IPV and self-reported birth control usage, by type, among married women who are not pregnant and live in rural India who is more likely to use IUDs.	In rural Maharashtra, 1001 women were enrolled between September 2018 and May 2019.	In the preceding 12 months, 109 (10%) and 27 (2%) of 1001 included women reported having physical and sexual IPV, respectively. In comparison to women who did not experience violence, women who experienced physical IPV were considerably less likely to use condoms (adjusted relative risk ratio [RRR]: 054, 95% confidence interval [CI]: 030-098, p = 0042). When compared to women who were not suffering physical IPV, there was a tendency towards higher IUD usage (adjusted RRR: 178; 95% CI: 091-341; p = 0.091), but this did not achieve statistical significance.	The study's cross-sectional methodology makes it impossible to pinpoint the timing of connections. The research also depends on women's self-reported replies to questions concerning IPV and contraception usage when utilising baseline survey data. In addition to recollection bias, these reports are vulnerable to social desirability bias and may have underreported contraceptive usage owing to social stigma or overreported it because of the respondent's awareness that the survey was conducted as part of a family planning effort in the case of contraceptive use. Both the overall incidence of sexual IPV and the use of tablets were quite low in this investigation, thus null results should be seen in the light of the study's low power.
9.	Dhar, et al, 2018 [20]	Cross-sectional analysis	To determine if IPV is connected to poor fertility and maternal health, as well as whether poverty contributes to any observed connections, among women who delivered a child in the preceding period of 23 months in Bihar, India	13,803 moms of infants under the age of three reside in Bihar, India.	In the sample, 45% of the women reported using IPV. 8.7, 4.6, and 1.3% of the sample, respectively, reported having experienced a miscarriage, stillbirth, or abortion. 10.7% of women said that labour problems occurred during their most recent pregnancy, while 16.3% said that additional issues occurred either during pregnancy or birth. AOR = 1.35, 95% CI = 1.11-1.65) and stillbirth (AOR = 1.36, 95% CI = 1.02-1.82) ever, as well as with labour complications (AOR = 1.27, 95% CI = 1.04-1.54) and other pregnancy/delivery complications (AOR = 1.68, 95% CI = 1.42-1.99). These associations were significant according to adjusted regressions. While women in the greater wealth quartile (Quartile 3) observed correlations between IPV and pregnancy loss (Quartile 3 AOR = 1.55, 95% CI = 1.07, 2.25) and stillbirth (Quartile 3 AOR = 1.79, 95% CI = 1.04, 3.08), women in the lowest income quartile (Quartile 1) observed no relationship between IPV and miscarriage (Quartile 1 AOR = 0.98, 95% CI = 0.	In this study, survey data were cross-sectionally analysed. Although it is impossible to determine causation, using a representative sample of moms who recently gave birth in the state (while omitting stillbirths) does make the results more state-specific. In order to address the confounding effect of therapy, it was additionally adjusted for the intervention group. This study only examined self-reported instances of physical and sexual abuse; it did not examine other manifestations of IPV, such as emotional or financial abuse. These statistics also rely on individual self-reports of IPV experiences and reproductive outcomes, which may be biassed by social desirability and recollection. For sensitive topics like sexual IPV and abortion, social desirability bias may be more pronounced, which might result in underreporting of these occurrences.

10.	Kanougiya, Sivakami, and Rai, 2021 [21]	Cross-sectional Study	The goal of this study is to look at sociodemographic and economic factors that predict obsessive marital control and its link to IPV during the previous 12 months.	Between 20 January 2015 and 4 December 2016, there were 66,013 ever-married women in India's urban and rural areas, aged 15 to 49.	Spousal coercive control is often disclosed by 48% of women more frequently than IPV, which is only disclosed by 25% of women (emotional 11%, physical 22%, and sexual 5%) in the last year. With more instances of coercive control, more women reported experiencing IPV. In comparison to husbands without these traits, women with these attributes have demonstrated greater coercive control. The likelihood of coercive control increases with the presence of the markers three or more children per woman, employment status for women, higher level of education for the husband, and alcohol use by the husband.	Since this study is cross-sectional, no causal connection was established. In multivariate logistic regression models, potential risk variables such the mental health of participants, spouses, and family members were not taken into account.
11.	Gupta, et al, 2023 [22]	A questionnaire-based, cross-sectional study using systematic random sampling	To calculate the prevalence and correlation of IPV in mental patients, both as offenders and victims.	At a tertiary care hospital in Haryana, India, the psychiatric outpatient department's 500 participants diagnosed with a mental illness.	The lifetime prevalence of IPV victimisation was 26% and the past year's prevalence was 16%. During the first 10 years of marriage and the first 10 years of the disease, IPV victimisation was shown to be substantially more common among females (particularly sexual), young, and jobless participants. Most IPV was sexual in nature. The subjects' lifetime IPV prevalence was 10.6% and their annual IPV prevalence was 6%. Males between the ages of 40 and 50 who were jobless, had lower incomes, came from joint families, and lived in rural regions were more likely to commit crimes. The likelihood of perpetuation increases with a psychiatric disease diagnosis, especially psychosis. The frequency of IPV abuse rose as disease duration increased.	Due to the sensitive nature of the study, the study's limitations include the potential for recollection bias and participant reporting inaccuracies. Additionally, the examination of the complete IPV spectrum was constrained by the absence of drug use disorder (which is by itself a substantial cause of IPV).

12.	Poreddi, et al, 2021 [23]	Qualitative narrative research design	To examine women's experiences with violence and their views on routine domestic violence screening by nurses in mental health care facilities.	20 mentally ill women who are asymptomatic in a tertiary care facility in Bangalore, India.	Most of the participants agreed that frequent screening by nursing experts would help prevent the several forms of violence experienced by women with mental illness. In mental health care settings, nurses are crucial in recognising and helping abused women.	The present study may have several limitations, such as sample bias because participants were chosen deliberately and from a particular environment. Women with acute symptoms were also not included in this study. The women in question might very well be victims of serious instances of domestic violence (including sexual and physical abuse). So, these results might not apply to all women with mental disorders.
13.	Deosthali, Rege, and Arora, 2022 [24]	Mixed Method (Qualitative and Quantitative Study)	This essay tries to depict the experiences of married women who experience sexual assault, how these women interact with the healthcare system, and how the police and healthcare system responds to them.	Between 2008 and 2017, 1783 women enrolled in total. Data from the crisis intervention section of a public hospital and the medico-legal documents of three general hospitals in Mumbai.	The research shows that many victims of domestic violence who talk to crisis intervention counsellors about their experiences with physical, financial, and emotional abuse reveal that their husbands have pushed them into having sex. However, a limited percentage of women do disclose marital rape to authorities, including the police and hospitals.	The analysis used in this study is not based on population data, but rather on service documentation of women who could access the public hospital, which poses a major restriction on generalising the findings. Rape and other forms of sexual violence inside marriage may perhaps be more widespread than what has been documented in this study because the information provided is based on women's self-reports.

14.	Paul and Mondal, 2021 [25]	Cross-sectional study design	The study uses the latest large-scale population survey to examine the link between women's experience with IPV and the use of maternity medical facilities among women who are now married in India.	24,882 Indian women who are currently married and who had at least one live kid in the previous five years	In the previous year, 26% of the sample's married women reported engaging in any type of IPV. According to bivariate studies, women who encountered emotional, sexual, or physical abuse from their spouse used all three aspects of maternal medical care less frequently than women who did not experience any such violence. Even after adjusting for socio-demographic factors, multivariate analysis shows that women's exposure to IPV was substantially related to a decreased chance of appropriate ANC use (Adjusted Odds Ratio [OR]: 0.90, 95% CI 0.84-0.97). In the adjusted analysis, IPV exhibited an unanticipated favourable link with PNC use but did not correlate significantly with expert delivery assistance.	Because of the cross-sectional nature of the research design, a causal relationship between women's experiences with IPV and maternity care could not be established. Additionally, the data are retrospective and self-reported. Therefore, it is impossible to overlook the study's potential recollection bias. The women frequently don't speak out about their violent encounters. As a result, there's a chance that violence may not be reported as much as it should be because of shame, fear, and sensitivity. The variables were finally chosen based on prior research and in accordance with the data included in the dataset. As a result, our current study did not account for all possible factors that can have an impact on how often women use healthcare.

IPV: Intimate partner violence, ANC: Antenatal care, PNC: Perinatal care, FSW: Female Sex Workers, OR: Odds ratio, IUD: Intra -uterine device, NFHS: National Family Health Surveys, CI: Confidence Interval, SC: Scheduled Caste

Discussion

A total of 163 research papers were identified through database searching, and 14 papers were selected as relevant for the review. Among 14 studies, 12 were published in India, one from Pakistan, and one from Nepal. No relevant articles were identified from Afghanistan, Bangladesh, Bhutan, Maldives, and Sri Lanka. Studies focused on the association of IPV, substance abuse, dowry system, pregnancy outcomes, psychiatric patients, and male dominance, along with the effectiveness of contraceptive use, electronic empowerment, maternal healthcare, and help-seeking behaviour.

All of the studies repeated IPV as a major public health problem not only in South Asia but also worldwide. All 14 research papers discussed the prevalence of IPV as high together with the risk factors, including education of couples, employment status of women, the rural or urban area of residence, ethnicity, age, sex of children, and mass media. In addition, women using a mobile phone and handling bank accounts are said to have less exposure to IPV compared to those who do not use it.[18] Substance abuse,[16] spousal coercive control, [21] and the dowry system [17] are serious concerns that make IPV and marital rape more prevalent among married women and insist on the need to establish safeguarding interventions. IPV is noticed in diverse age groups, sexual orientations, gender, cultural, and economic statuses in all parts of the world. WHO assessed that one-third of women in a partnership had faced any form of IPV. [26] Many researchers preferred an ecological model to learn more about IPV and relations at the individual and community levels. [26] Severe mental health issues such as neurosis and psychosis,[22] physical injuries, and health intricacies are a result of forms of violence ranging from malnourishment, elevated blood glucose levels, anaemia, hypertension, [15] STIs, and reproductive tract infections. [24]

In a study by Akombi-Inyang et al,[16] the association between IPV and substance abuse and its aftereffect on perinatal care in pregnant women is studied. 47.6% of women have spouses who are involved in substance abuse. Substance abuse by males is stated as a substantial causal factor of IPV. [2] WHO study also reported that alcohol consumption at dangerous levels is a causal factor of IPV. [27] Non-attendance of ANC visits 4 or more times is related to the substance abuse behaviour of the spouse.[16] The negative relation between IPV and PNC indicates that developing community-based interventions incorporating health services is necessary for promoting ANC and PNC among pregnant women. [16] Further studies by Paul and Mondal [25] and Garg et al [13] also discussed the support by the healthcare system in safeguarding women from IPV. Garg et al mentioned the routine screening program in health settings for detecting IPV, however, limited knowledge of constructed intervention is not appreciated. [28] According to Paul and Mondal,[25] lack of usage of ANC, assistance by a skilled health worker during delivery, and PNC is strongly associated with all forms of IPV among pregnant women. They also emphasize providing urgent MHS to women who were exposed to IPV. Likewise, violence is also correlated with the liberation of decision-making power of women unfavourably but favourably with male dominance and coercion. With the increase in the age of females, literacy level, and wealth, the risk of spousal control is subsided, but working women are more prevalent to IPV based on male dominance. Men's age is also associated where younger men display more control.[21] Yet, studies from Nigeria [29] and Myanmar [30] show that a husband's education is not related to coercive control. The literature proposes that empowering women jeopardizes the status of male partners, making women riskier to IPV and controlling behaviour.[31] Another study in India also highlighted the relationship

between physical violence and PNC [32] and is similar to the studies conducted in other countries such as Bangladesh[33], Nigeria [34], and Ethiopia [35]. Although the study by Garg et al[13] found a lesser proportion of sexual violence, they still regard it as an area of research that needs more attention. Data available is scarce since women seeking the help of medical services is less in number. IPV is alike associated with poor pregnancy outcomes as concluded by Dhar et al.[20] IPV was prevalent in 45% of women and a history of abortion, miscarriage, and stillbirth was also noted. They are more vulnerable to maternal health complications compared to women who had not faced IPV.[20] Further results from multi-country research boosted these findings by concluding that there is a strong association between IPV and stillbirth. [36] This is contradicted by another study from India suggesting that IPV reduces with pregnancy, but other forms of abuse such as refusal of appropriate food or rest exist. [37]

The Dowry system is practiced for ages in many countries including India and Pakistan where it is believed to give a positive marital impact on females, however, is contradictory. Proofs urge that females are at risk of violence from husbands or family members oftentimes due to the failure of giving promised dowry at the time of marriage. [17] Ali et al [17] concluded that the dowry system ultimately does not protect women from IPV and only a quarter of women have positive impacts.[38] Deosthali, Rege, and Arora [24] assessed the service records of violence survivors where help-seeking behaviour is also recorded. 91% mentioned that they were facing forms of violence since marriage. Marital rape was another key element of this study. The Criminal Law Amendment Act of 2013 protected against rape and sexual violence but sadly, marital rape was left out making most police officers not know what steps have to be taken when a women report a case of marital rape causing delays.[24] 18 women out of 1664 marital rape survivors have requested medico-legal support. Doctors, nurses, and crisis center workers act an integral role in helping women to protect themselves from violence.[39] Nevertheless, this is not applicable in every hospital as health workers are not properly trained to perform rape case activities sensitively.[24] Electronic and economic empowerment are powerful tools to protect women against IPV. Women living in rural areas, employed women, and belonging to the Hindu community were more vulnerable to IPV as per the study by Dalal et al [8] whereas women who used mobile phones, bank accounts and have access to mass media were less threatened. Babu and Kar[40] in their research found that rural women are less exposed to sexual violence which is not true as per Dalal et al.[8] Another study from Bangladesh summarized that Muslim pregnant women face more violence than the Hindu community.[41] This difference is basically due to the existence of various socio-economic backgrounds. Dalal and his coworkers conclude that policymakers may utilise mobile phone services and media for creating awareness about IPV.[8] The effectiveness of contraceptives in IPV was analysed by Chen et al [18] who concluded that women facing IPV are more likely to use IUDs than condoms and pills. Dasgupta and his co-workers find similar results in their analysis. [42] Using condoms requires the participation of husbands and females facing violence are less likely to use condoms. This situation is confounded by IUDs where women have access to control their reproductive health safely and confidentially without the interference of husbands. [18]

This review aims to draw a few insights into understanding and safeguarding women facing IPV in modern marriages. Only peer-reviewed studies were taken into consideration such that to reduce the chances of bias. There were no relevant research papers within the short duration of 5 years, however, the context

of modern marriages was satisfied as the research papers were from the recent time frame. No relevant articles were identified from Afghanistan, Bangladesh, Bhutan, Maldives, and Sri Lanka, making it difficult to analyse the situation from these countries. Most of the research papers also noted the lack of studies conducted due to the lack of proper data from women survivors. This review also realized the need for more studies on physical, psychological, sexual, and social forms of violence against women.

Conclusion

This review aimed to identify IPV among South-Asian women, grounds, understandings, and safeguards in the context of modern marriages. Violence against women is a violation of human rights and the prevalence of IPV in marriages in South Asia is higher. Various reasons contribute to IPV and we found that IPV has a close association with substance abuse, dowry system, male dominance, and spousal coercion leading to severe health disparities. All of these factors contribute to IPV being more prevalent among female partners. After analysing the research papers, the main themes generated were understanding and safeguarding of IPV among South-Asian women in modern marriages. Utilising IUDs as contraceptives, economic and electronic media empowerment, help-seeking behaviour such as requesting medico-legal support and filing complaint, as well as using the healthcare system allows protecting women from forms of violence.

Abbreviations

IPV - Intimate Partner Violence
UN - United Nations
WHO - World Health Organization
PRISMA - Preferred Reporting Items for Systematic Reviews and Meta-Analyses
NFHS - National Family Health Surveys
IUD - Intra-uterine devices
MHS - Maternal Healthcare System
ANC - Antenatal care
PNC - Perinatal care
STI - Sexually Transmitted Infections

Acknowledgment: None

Conflict of interest: None

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