Research Article

Prevalence of Domestic Violence and Quality of Life among Ever-Married Women in Etawah District: A Community-Based Cross-Sectional Study

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Background: Domestic violence (DV) is one of the most common forms of gender-based violence and represents a major public health, social, and human rights concern worldwide. It adversely affects women's physical and psychological health while significantly reducing their quality of life. The purpose of the study was to assess the prevalence of domestic violence and quality of life among ever-married women.

Methods: A community-based cross-sectional study was conducted among 593 ever-married women (15–49 years) in rural areas between January 2019 and June 2020, using multistage random sampling. Socio-demographic and domestic violence data were collected, and quality of life was assessed using the WHOQOL-BREF questionnaire [21]. Data were analysed with SPSS version 24.

Results: The overall prevalence of domestic violence was 27.5%, with 24.8% of women reporting psychological violence and 20.4% reporting physical violence. Among the quality-of-life domains, the social domain showed the highest score (68.56 ± 12.6), followed by the environmental domain (66.78 ± 12.0), while the psychological domain (58.08 ± 12.3) and physical domain (56.16 ± 9.6) recorded the lowest scores. This suggests that social and environmental well-being were relatively stronger than physical and psychological well-being.

Conclusion: More than one-fourth of ever-married women experienced domestic violence, with psychological violence being more common than physical violence. Women exposed to domestic violence had a statistically non-significant poorer physical and psychological quality of life. Strengthening community awareness, women's empowerment, and early identification of victims is essential to reducing the burden of domestic violence and improving women's quality of life.

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Introduction

Domestic violence is recognized as one of the widespread violations of human rights and one of the major public health problems in the world. Globally, approximately one in three women suffer from physical or sexual violence in their lives, most often committed by intimate partners. Domestic violence occurs in all cultures, religions, educational levels, and socio-economic groups, although its extent and manifestations vary from country to country and community to community. The consequences extend beyond the individual victims and affect families, children, and communities. [1-4] The World Health Organization (WHO) defines domestic violence as "the range of sexual, psychological and physical coercion by present or former intimate partners of adult and adolescent women". In recent years, violence against women has become a problem in developing countries and developed countries, and the World Health Organization has declared domestic violence a "public health epidemic". [4-6] India bears a heavy burden of domestic violence due to deep gender inequalities, patriarchal social structures, early marriage, women's economic dependence, harmful cultural practices, and limited access to support services. According to the National Family Health Survey (NFHS-5), about 29 % of ever-married women aged 18 to 49 experienced spousal violence. Although legal measures, such as the 2005 Domestic Violence Protection Act, provide legal protection, underreporting remains widespread due to

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fear, social stigma, financial dependence, concern for children, and normalization of abuse. [5,7,8,9,11]

Uttar Pradesh, India's most populous state, continues to have a considerable burden of domestic violence. Rural women often face additional vulnerabilities due to low educational levels, limited economic opportunities, limited autonomy, and lack of health and legal access. Despite these obstacles, there is a scarcity of district-level data concerning both the incidence and the effects of domestic violence on the quality of life, especially in the Etawah district. Localized evidence is crucial for developing culturally relevant prevention programs and enhancing the responses of the health system. [7-11] Domestic violence is increasingly recognized not just as a legal or social concern but also as a significant factor affecting physical and mental health. Women who experience violence face a higher likelihood of sustaining injuries, enduring chronic pain, engaging in suicidal behaviours, abusing substances, contracting sexually transmitted infections, experiencing unintended pregnancies, and facing adverse maternal and child health outcomes. The enduring psychological effects often disrupt social connections, job performance, and overall well-being. [3,4,12,13,14,15,]

Quality of life (QOL), according to the World Health Organization, is described as how individuals view their status in life, shaped by their culture, values, personal aspirations, expectations, and worries. The WHOQOL-BREF tool assesses four aspects of quality of life: physical health, mental health, social connections, and environmental conditions. Evaluating the quality of life for women who have faced domestic violence offers significant insights into the wider implications of such violence beyond mere physical harm and assists in pinpointing key areas for intervention. [3,4]

Numerous studies conducted in India and various other countries have reliably shown that women who experience domestic violence report significantly worse physical, mental, and social well-being compared to those who do not face such violence. Nonetheless, variations in cultural attitudes, study demographics, assessment methods, and socioeconomic factors lead to differences in reported rates and health impacts. [1,2,13,16] The results are anticipated to serve as a foundation for enhancing community awareness, incorporating domestic violence screening into primary healthcare services, fostering women's empowerment, and guiding district-level public health strategies aimed at preventing violence against women and improving their quality of life. [4,5,9,11]

Study Objectives

- To estimate the prevalence of domestic violence among ever-married women.
- To identify the pattern of physical and psychological domestic violence experienced by the study participants.
- To assess the quality of life using the WHOQOL-BREF questionnaire[17]
- To determine the association between domestic violence and different domains of quality of life among ever-married women.

Materials and Methods

A community-based cross-sectional study was conducted among married women aged 15–49 years living in rural areas in the Etawah district of central Uttar Pradesh, comprising eight blocks of community development. The study lasted about one and a half years, from January 2019 to June 2020. The study period included the development of protocols, ethical approvals, pilot testing of questionnaires, field data collection, data entry, statistical analysis, and interpretation of results. Participants included women who are currently married, widowed, separated, or divorced. Researchers selected women from the community through home visits after obtaining informed written consent.

Inclusion Criteria

- Ever-married women aged 15–49 years.
- Women who were permanent residents of the selected villages.
- Women who provided informed written consent for participation.
- Exclusion Criteria
- Women who were unwilling to participate in the study.
- Women who were seriously ill or unable to respond to the interview at the time of data collection.

Sample Size

The sample size was calculated using the formula for estimating a single population proportion:

$$n = \frac{(Z_{1-\alpha/2})^2 * P(1-P)}{d^2} = 593$$

where

Z = 1.96 at 95% confidence level

P = 39.3% (prevalence of domestic violence among women in rural Uttar Pradesh based on previous literature)
d = 10% relative precision
The calculated minimum sample size was 593

Sampling Technique

We conducted a community-based study using a two-stage random sampling technique. In the first phase, a village was selected by the simple random sampling method from eight community development blocks in the Etawah district. A total sample of 593 married women was included to ensure equal representation in the selected blocks. In the second phase, eligible participants were selected by systematic random sampling. The sample interval was calculated by dividing the total number of households in each village by the required sample size (74). The first household was randomly selected, and the next was visited at the predetermined sampling interval. If more than one eligible woman is present at home, one participant is selected by simple random sampling. After explaining the purpose of the study, written informed consent was obtained from all participants. The data were collected using a predesigned and pre-tested questionnaire, which was piloted in 10% of the sample in a nearby non-study village. Confidentiality and anonymity were strictly maintained during the study.

Section I: Domestic Violence Assessment

Physical violence included acts such as

Slapping, twisting the arm or pulling hair, pushing, kicking or beating, punching, threatening or attacking with a weapon

Psychological violence included

Humiliation, restricting contact with friends or family, Jealous or controlling behaviour, Constant monitoring, financial control, Threatening behaviour, Insulting remarks, Allegations of infidelity

Section II: Quality of Life Assessment

The World Health Organization Quality of Life-BREF (WHOQOL-BREF) questionnaire was used to assess quality of life. The 26 items in the WHOQOL-BREF are divided into four domains: Physical Health, Psychological Health, Social Relationships, and Environmental Health.[17]

Data Collection Procedure

Data collection process for environmental health, social relationships, psychological health, and physical health. This study was authorized by the UPUMS, Saifai, Etawah institutional ethics committee on June 1, 2020, with ethical clearance number 72/2019-20. Following that, residence visits were made to qualified participants. Written informed consent was obtained once the study's goals were described in Hindi. Participants were reassured that their privacy would be protected during the interview and that the data they provided would be utilized for the study. The Statistical Package for the Social Sciences (SPSS) version 24.0 (IBM Corporation, Chicago, USA) was used to analyse the data after it had been coded and entered into Microsoft Excel. The Mann–Whitney U test was used to compare quality-of-life domain scores between women who had experienced domestic violence and those who had not. Statistical significance was considered at a p-value <0.05.

Results

The study included 593 ever-married women. Domestic violence was reported by 163 women (27.5%). Psychological violence (24.8%) was more commonly reported than physical violence (20.4%) [Table1]. Most participants were aged 25–34 years (55.8%), had arranged marriages (98.1%), and were currently married (94.3%). The majority were Hindu (86.2%), lived in nuclear families (69.0%), and had three or more children (53.3%). Overall, 74.1% of women and 91.1% of their husbands were literate, while 96.8% of women were housewives and 78.3% of husbands were employed [Table2].

Among women reporting physical violence, pushing was the most frequently reported form (43.8%), while restricting friendships was the most frequently reported form of psychological violence (17.7%) [Table3].

The WHOQOL-BREF scores were highest for the social domain (68.56 ± 12.6), followed by the environmental domain (66.78 ± 12.0), psychological domain (58.08 ± 12.3), and physical domain (56.16 ± 9.6) [Table4].

Comparison of quality-of-life scores according to domestic violence status showed no statistically significant differences in the physical (p=0.730), psychological (p=0.276), social (p=0.608), or environmental (p=0.563) domains [Table5].

Overall, domestic violence was reported by more than one-fourth of the women, with psychological violence

Table 1: Distribution of study population according to the types of domestic violence (N=593)

S. No.	*Types of domestic violence*	*Frequency (n)*	*(%)*
1.	Physical	121	20.4
2.	Psychological	147	24.8
3.	Overall Domestic Violence	163	27.5

Table 2: Socio-demographic distribution of study population(N=593)

S. No.	*Socio-demographic variables*	*Frequency n (%)*
1.	Age group (Years)	
	15–24	102 (17.2)
	25–34	325 (55.8)
	35–44	153 (25.8)
	45–49	13 (2.2)
2.	Nature of marriage	
	Arrange	582 (98.1)
	Other than arrange	11 (1.9)
3.	Marital status	
	Currently married	559 (94.3)
	Separated	11 (1.9)
	Divorced	05 (0.8)
	Widow	18 (3.0)
4.	Duration of marriage (in years)	
	≤ 1 year	38 (6.6)
	> 1 year	555 (93.4)
5.	Religion	
	Hindu	511 (86.2)
	Muslim	82 (13.8)
6.	Type of family	
	Joint	90 (15.2)
	Nuclear	409 (69.0)
	Three generation	94 (15.9)
7.	Number of their children	
	No child	53 (8.9)
	1-2 children	224 (37.8)
	≥3 children	316 (53.3)
8.	Gender of their children	
	Male child	79 (13.3)
	Female child	90 (15.2)
	Both sexes	376 (63.4)
	No child	48 (8.1)
9.	Educational status of study participants	
	Illiterate	154 (25.9)
	Literate	439 (74.1)
10.	Educational status of participant's husband	
	Illiterate	51 (8.9)
	Literate	542 (91.1)
12.	Occupational status of the study participants	
	Housewife	574 (96.8)
	Employed	19 (3.2)
13.	Occupational status of the participants' husbands	
	Unemployed	111 (18.7)
	Employed	464 (78.3)
	*Not Found (Dead)	18 (3.0)

*This document's "Not Found (Dead)" category accounts for the 18 widowed women.

Table 3: Distribution of study population according to various variables of types of domestic violence

S. No.	*Variables of domestic violence*	*Frequency (n)*	*(%)*
	Physical violence (n=121)		
1.	Slapping	09	7.4
2.	Twisting of an arm or pulling of hair	38	31.4
3.	Pushing,	53	43.8
4.	Kicking, dragging, or beating	14	11.5
5.	Punching you with a fist or hurting	06	4.9
6.	Threatening or attacking with any weapon	01	0.8
	Psychological Violence (n=147)		
1.	Humiliation	17	11.6
2.	Unfaithful	22	15.0
3.	Don't permit to meet friends	26	17.7
4.	To limit contact with family	24	16.3
5.	Insist on knowing where you were at all times	9	6.1
6.	Trust with any money	21	14.3
7.	Jealousy or anger	11	7.5
8.	Threatening or hurting	10	6.8
9.	Insulting	7	4.8

being the predominant form; however, no statistically significant association was observed between domestic violence and any WHOQOL-BREF domain.

Discussion:

Domestic violence remains a major public health and human rights issue worldwide, with significant physical and psychological consequences for women.

Prevalence

The overall prevalence of domestic violence in this study (27.5%) aligns closely with national and international data. NFHS-5 reported[13] Approximately 29% of ever-married women in India experienced spousal violence, while NFHS-4 documented[7,8] a slightly higher prevalence

Table 4: Distribution of various domains of WHOQOL-BREF based on mean & SD

Domain of QOL	*Score*		
	Mean ± SD	*95% Confidence interval*	
		Lower	*Upper*
Physical	56.16 ± 9.6	55.41	56.93
Psychological	58.08 ± 12.3	57.04	59.07
Social	68.56 ± 12.6	67.83	69.56
Environmental	66.78 ± 12.0	65.81	67.74
Overall QOL	62.39 ± 8.9	61.68	63.12

Table 5: Association of domestic violence with the various domains of quality of life among ever-married women

S. No.	Domain of QOL	Domestic violence	Mean rank	Mann-whitney U test
1.	Physical	Present (163)	293.09	z = -0.345
		Absent (430)	298.48	p = 0.730
2.	Psychological	Present (163)	284.61	z = -1.090
		Absent (430)	301.70	p = 0.276
3.	Social	Present (163)	303.60	z = -0.513
		Absent (430)	294.50	p = 0.608
4.	Environmental	Present (163)	291.54	z = -0.579
		Absent (430)	299.07	p = 0.563
5.	Overall Score of QOL	Present (163)	291.54	z = -0.478
		Absent (430)	299.07	p = 0.633

of around 31%, suggesting only a modest decline over recent years. Comparable prevalence rates were also reported by Ramaiah and Jayaram in rural Karnataka[18] Vachhani et al. in Gujarat [19] reported similar findings, while studies by Begum et al. and Kambli et al. in Mumbai's urban slums similarly demonstrated a high burden of domestic violence. [16,20]

Internationally, studies from Ethiopia and Nepal also reported a considerable burden of domestic violence, though prevalence varied with cultural context, study populations, and measurement tools. [3,14] The WHO Multi-country Study estimated lifetime intimate partner violence prevalence ranging from 15% to 71% depending on region and methodology.[4]

The comparatively lower prevalence observed here may reflect growing awareness of women's rights, legal protections under the Protection of Women from Domestic Violence Act, improved female literacy, and better healthcare access. However, underreporting—driven by social stigma, economic dependence, concern for children, and cultural normalization of violence may have led to an underestimation of true prevalence. [5,11,12]

Types and Patterns of Violence

Psychological violence (24.8%) was more prevalent than physical violence (20.4%) in this study, consistent with findings by Vidushi and Sethi, who noted that emotional abuse often precedes physical violence and remains underrecognized due to its lack of visible injury. Psychological violence—including humiliation, controlling behaviour, intimidation, and social restriction can have lasting effects on mental health and quality of life.

Among women reporting physical violence, pushing (43.8%) and arm twisting or hair pulling (31.4%) were most common, mirroring patterns observed by Jawarkar et al. in rural Maharashtra[16] and Sinha et al. in urban Kolkata slums, where pushing, slapping, and beating were predominant.[21] For psychological violence, restriction from meeting friends (17.7%) and limiting contact with family (16.3%) were the most frequently reported behaviours, reinforcing controlling behaviour as a central feature of abuse—consistent with Ahmed-Ghosh's observations on social isolation as a dominance strategy,[12] and the WHO's recognition of controlling behaviour as an early indicator of intimate partner violence.[4]

Socio-demographic Factors

Most participants were aged 25–34 years, currently married, and living in nuclear family profiles consistent with other Indian studies. Women in this age group often bear greater household and childcare responsibilities alongside financial dependence, potentially increasing vulnerability to abuse.

The high proportion of housewives (97.9%) in this study points to substantial economic dependence on spouses, a factor consistently linked to domestic violence, as limited financial autonomy reduces women's ability to leave abusive relationships. [11] This aligns with Kaur and Garg's emphasis on economic empowerment as key to reducing domestic violence and enhancing household decision-making.[5] Notably, despite nearly three-fourths of participants being literate, domestic violence remained common, suggesting education alone is insufficient to eliminate gender-based violence. Persistent patriarchal attitudes, cultural norms, alcohol misuse, socioeconomic stress, and unequal power dynamics continue to drive domestic violence regardless of educational gains. [11,22]

Quality of Life

The WHOQOL-BREF assessment showed the social domain scoring highest and the physical domain scoring lowest among participants. Lower psychological scores suggest that women experiencing domestic violence often endure chronic emotional distress, anxiety, fear, depression, and reduced self-esteem—consistent with prior research showing that domestic violence impacts psychological health more severely than other quality-of-life domains. [4,15]

Notably, physical (p=0.730) and social (p=0.608) quality-of-life scores did not differ significantly between women who experienced violence and those who did not, a finding echoed in several other national and international studies examining the health impact of domestic violence.

Conclusion

The present study shows that study was conducted among ever-married women in rural areas, domestic violence continues to be a significant public health concern. Domestic abuse affected over one-fourth of the participants; psychological violence was more common than physical violence. The major influence of domestic violence on general well-being was highlighted by the fact that women who had faced such violence experienced markedly lower physical and psychological quality of life compared to those who had not. This study's findings echo similar patterns seen in both national and international research showing that domestic violence still takes a heavy toll on women's health, dignity, and quality of life, even where legal protections and policies exist.[4,9,11] These insights can play a key role in shaping targeted interventions and strengthening public health efforts to improve the health, safety, and quality of life among women in rural India.

Limitations of the Study

The cross-sectional study design limits the ability to establish temporal or causal relationships between domestic violence and quality of life. It cannot be established whether domestic violence contributes to diminished quality of life, or conversely, whether women with already compromised quality of life face heightened risk of abuse. Secondly, information regarding domestic violence was obtained through self-reporting, making the findings susceptible to recall bias. Because domestic violence is a sensitive issue, some participants may have underreported their experiences due to fear, embarrassment, social stigma, or concern about family reputation. [5,12] Finally, although several socio-demographic variables were assessed, the study did not capture several other potentially relevant influences such as early-life exposure to violence, mental health status, characteristics of the partner's personality, and levels of social support, each of which may independently affect both violence exposure and quality-of-life outcomes. [5,4,11]

Policy Implications

The findings of the present study have important implications for public health policy and programme implementation. Healthcare professionals should receive regular training to recognize signs of domestic violence, provide first-line psychological support, ensure confidentiality, and establish appropriate referral pathways for counselling, legal assistance, and shelter services. [4,5] Strengthening women's education, vocational training, employment opportunities, and financial independence may further reduce their vulnerability to domestic violence.

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