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ANALYSIS ON WOMEN'S AUTONOMY, Their EXPERIENCE OF DOMESTIC VIOLENCE AND ITS EFFECT ON CHILD HEALTH OUTCOMES

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ABSTRACT

Domestic violence has a variety of hazardous physical and psychological health links, but there are so far little evidences on the relationship between domestic violence and child health outcomes. In order to examine this relationship, we analyzed a national survey data on 6270 currently married women of reproductive age aged 15–49 years who ever experienced domestic violence, and 4390 children of age 12–35 months obtained from the third round of Indian National Family Health Survey (NFHS-3). The analysis in the study was based on a secondary data which focused on information obtained from NFHS-3 on Uttar Pradesh State of India. Three key aspects that have importance to women were examined in this study; women's decision making autonomy in their households, their experience of domestic violence and child health outcomes. Household decision making autonomy was assessed by four indicators (decision on health care, daily HH purchase, major HH purchase & visits to family/relatives), domestic violence was self reported by women (whether they have ever experienced domestic violence or not). Two aspects of child health outcomes were examined in the study – child immunisation status and nutritional status. Nutritional status was measured by child underweight status, while immunisation status was measured by responses of whether they were fully immunized or not. Results obtained indicate a strong association exist between decision making autonomy & experience of domestic violence, and these have a strong impact on the two child health outcomes considered in the study. Even though, women's decision autonomy on health care, large and daily household purchases are statistically not significant with child's immunization and underweight status, however, some important findings in the study revealed that women's experience of domestic violence has a strong significant association with the two child's health outcomes. The odds ratio revealed that, women who experienced domestic violence were less likely to have fully immunized children {odds ratio (CI) = 0.50[0.42–0.60]} but more likely to have underweight children {odds ratio (CI) = 1.42***[1.21–1.66]}. This finding indicates that reducing domestic violence is important not only from a good and intrinsic point of view but also because of its health benefits likely to accrue on both women and children.***

Keywords: ***Autonomy, domestic violence, underweight, health status, decision making.***

INTRODUCTION

Domestic violence is globally described by various scholars, academicians and professionals in human development as a stern social problem, and to say the least, a serious human rights abuse and public health issue, Moreno et al., (2006). The United Nations defines violence against women as "any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life." While intimate partner violence refers to behaviour by an intimate partner or ex-partner that causes physical, sexual or psychological harm, including physical aggression, sexual coercion, psychological abuse and controlling behaviours. Research continues to prove that children are potential victims of domestic violence at home and these happens in different ways and forms, and that most of these children are living in ferocious households therefore, they are prone to menace of physical harm both during prenatal and postnatal Christian et al., (1997); Peedicayil et al., (2004).

Intimate partner violence, which describes physical, emotional or sexual assault, or both, of a spouse or sexual partner, is a common health-care issue, Campbell (2002). Violence against women by an intimate partner mostly affects women and children's health and subsequently affects their well-being. Empirical evidence suggests that growing up in an abusive home environment can critically jeopardize the health, developmental progress and personal ability of children Martin (2002); McIntosh (2002), hence the cumulative effect of which may be carried into adulthood and can contribute significantly to the cycle of adversity and violence Cunningham & Baker (2004); Levendosky & Graham-Bermann (1998); Levendosky et al., (2001)

Several research findings have shown that the prevalence of domestic violence is high in most developing countries particularly in India, Jejeebhoy & Cook (1997), Jejeebhoy (1998), Martin et al., (2001), Verma & Collumbien (2003), Koeing et al., (2006), Jeyaseelan et al., (2007), Ackerson & Subramanian (2008) and Rocca et al., (2009). According to NFHS-3, 40% of the representative sample of women interviewed for domestic violence during the survey had experienced physical, sexual, or emotional violence. Prevalence of intimate partner violence is considerably higher among socioeconomically disadvantaged women.

However, recent debate on domestic violence explains the significant influence it has on children's health. Research over the years creates more awareness about the ordeal of children induced by family violence, McIntosh (2009). Nevertheless, the main problem identified in literature on domestic violence is how to connect the vulnerable young children with the probable inter-spousal trauma that disrupt their neurological and biochemical pathways in development Barnish (2004), Humphreys (2006). Furthermore, a literature also confirmed the existence of

relationship between exposure to domestic violence and children's development. For example, the British Psychological Society, BPS (2007) states that experiencing domestic violence at home will impact negatively on children's quality of life.

Moreover, domestic violence is gender oriented and it creates social and public health issues that cut across nations, cultures religion and class, McIntosh (2002), Dodd (2009), UNIFEM (2007), Mooney (2000) and is also associated with particular cultural cum tribal communities, or restricted to a group in the society, Khan et al., (2012). It has implication and influence on vulnerable young children, Hague & Mullender (2006); Hazen et al., (2006).

The study also reveals the different forms and patterns of the how the violence perpetuated against women relates to socio economic and demographic characteristics of women and children across two different areas and cultures, revealing the consequences of such violence against women on child's health status.

The study in this chapter is intended to assist the national authorities in the two study populations towards designing policies and programmes that will help to deal with the problem of domestic violence against women; examine the effect of domestic violence against women on child health outcomes. Furthermore, the study will also contributes to the clear understanding of the relationship that exists between women's status, domestic violence and child health outcome and its inter-relatedness with women's background characteristics. Challenging the social norms that condone and therefore perpetuate violence against women is everyone's responsibility.

Female empowerment seems to be protective or reduce the rate of violence against women. A cross-cultural study by Levinson (1989) has shown that societies with stronger ideologies of male dominance have more intimate partner violence. These ideologies usually have effects at many levels within a society for example women at the household and societal levels.

Violence is a major obstacle to development, particularly violence against women retards progress in achieving development targets, WHO (2005). However, despite the growing recognition of violence against women as a public health and human rights concern, and of the obstacle it poses for development, this type of violence continues to have an unjustifiably low priority on the international development agenda and in planning, programming and budgeting, WHO (2005). According to WHO's estimates, one out of every five women face some form of violence during their lifetime, in some cases leading to serious injury or death. Until recently, most governments have considered violence against women (particularly "domestic" violence by a husband or other

intimate partner) to be a relatively minor social problem. Today, due to the efforts of some women's organizations and the evidence provided by researchers, violence against women is recognized as a global concern, WHO (2005). Violence against women is a major threat to social and economic development in both the developed and developing nations. This was recognized in the Millennium Declaration of September 2000, in which the General Assembly of the United Nations resolved "to combat all forms of violence against women and to implement the Convention on the Elimination of All Forms of Discrimination against Women", UN report (2000).

Combating violence against women is central to MDG 3- promoting gender equality; at the same time, achieving gender equality and women's empowerment is central to the elimination of violence against women, WHO (2005). Since violence against women has such serious impacts on women's lives and their health, productivity and well-being, it must be addressed as a cross-cutting issue if this goal is to be achieved. Greater gender equality and empowerment will help many women to avoid violence, WHO (2005).

DOMESTIC VIOLENCE

The World Health Organization, WHO (1996) defines violence generally as "The intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, mal-development or deprivation. However, violence against women takes many forms, from the overt to the subtle. WHO has adopted the following definitions of physical and sexual violence to aid in research and programming, concentrating on identifiable acts, Krug et al., (2002).

However, Moore (1999) opined that domestic violence, dating violence, intimate partner violence, partner abuse, spousal abuse and battering are terms used to describe violence that occurs between partners in a current or previously intimate relationship. Violent acts between partners have been categorized as verbally abusing the partner, threatening violence, throwing an object at someone, pushing, slapping, kicking, hitting, beating up, threatening with a weapon and using a weapon. Definitions of intimate partner violence may also include sexual assault, stalking, psychological abuse, enforced social isolation, intimidation and the deprivation of key resources, such as food, clothing, money, transportation or health care. Intimate partner violence also include sexual assault, stalking, psychological abuse, enforced social isolation, intimidation and the deprivation of key resources, such as food, clothing, money, transportation or health care.

TYPES OF DOMESTIC VIOLENCE

i. Physical Violence - means a woman has been slapped, or had something thrown at her, pushed, shoved, or had her hair pulled, hit with a fist or something else that could hurt, choked or burnt, threatened with or had a weapon used against her.

ii. Sexual Violence - means a woman has been: physically forced to have sexual intercourse; had sexual intercourse because she was afraid of what her partner might do; or forced to do something sexual she found degrading or humiliating.

iii. Emotional Violence - Though this type of violence is recognized as a serious and pervasive problem, does not yet have a widely accepted definition, but includes, for example, being humiliated or belittled; being scared or intimidated purposefully.

iv. Intimate-partner Violence (also called "domestic" violence) - means a woman has encountered any of the above types of violence, at the hands of an intimate partner or ex- partner; this is one of the most common and universal forms of violence experienced by women. It can also refer to any behaviour within an intimate relationship that causes physical, psychological or sexual harm to women.

CAUSES OF VIOLENCE AGAINST WOMEN

Generally speaking, violence cannot be attributed to a single factor because its causes are complex and occur at different levels, Lancet (2002). This study is limited to only one factor which is the biological and personal factor that influences how individuals behave and increase their likelihood of becoming a victim or perpetrator of violence-background characteristics.

NEED OF THE STUDY

Research shows that experiencing domestic violence affects both women and children's health and well-being and it influences their health seeking behaviours. This study analyzes the effect of women's decision making autonomy in relation to their individual experience of domestic violence to examine its effect on children's health status. Though, earlier report establishes that many children especially in developing countries are in danger of living in a domestic violence household, however, without proper and quick assessment and intervention, children are liable to suffer permanent adverse effects on their health and wellbeing. It is important that the further research work related to domestic violence and its link with child health status should re-focus and concentrate on ways of understanding and analyzing the complexity surrounding the effects on children's health status. This study therefore is intended to

broaden our understanding about the association between women's autonomy, experience of domestic violence and child health status.

OBJECTIVE OF THE STUDY

The objective of this chapter is to find out the effects of women's decision-making and domestic violence on child health outcomes in Northern India.

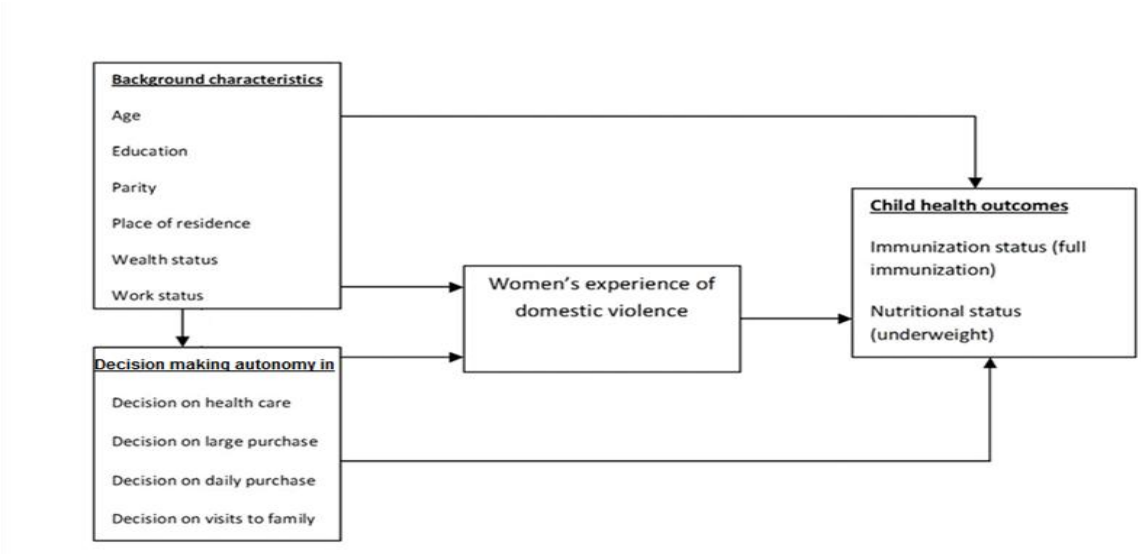
In other to achieve this objective, one seek to answer the question whether women's decision making autonomy in relation to their experience of domestic violence have any effect on child health outcomes. Hence the hypothesis here is that, women's decision autonomy and their experience of domestic violence has no effect on child health outcomes.

DATA AND METHODOLOGY

The study made use of secondary data obtained from the third round of NFHS which was conducted in 2005-06 to uncover the relationship that exists between women's status, domestic violence and some important child health outcomes in the study areas.

CONCEPTUAL FRAMEWORK

In this study, women's decision autonomy, experience of violence, background characteristics and child health outcomes were linked to examine the effect of women experience of domestic violence on child health status and the conceptual framework of these inter-relationships is given in the chart below.



VARIABLES USED

Outcome variable

Two child health outcomes were used as the outcome variables in the study, these are; child's immunization status (full immunization) and child's nutritional status (underweight). The reason for using these two variables to determine child health status is because both immunization and nutrition are very important determinants of children's health which is a necessity for their growth and development.

Child's immunization status was assessed by asking the respondents (who have children under the age of five) the immunization history of their children, whether they received all the immunizations or not. Responses were given in binary form as 'Yes' or fully immunized (if a child has received BCG, 3 doses of DPT, 3 doses of Polio and measles vaccines) and 'No' (if the child has not received any or all the vaccines).

Child's nutritional status was assessed by whether a child is under-weight or normal. A child is considered underweight if the child's weight-for-age measurement is less than two standard deviations (<-2sd) from the globally accepted reference cut-off point, or three standard deviations in the case of severe underweight. Responses were presented in binary form 'Yes' (if a child is underweight) and 'No' (if child is normal).

Explanatory variable

Three sets of independent variables (autonomy indicators, domestic violence and background characteristics) are used here

Women's Autonomy Indicators

Women's autonomy was assessed by four questions regarding household decision making ability on women's health care, large household purchase, daily household purchase and visits to family or relatives. Responses were recorded in each case as 'Yes' (if she participate in making decision either independently or jointly with her partner) and 'No' if otherwise.

Domestic Violence

Domestic violence variable was assessed by asking the respondent whether they have ever experienced any kind of violence (physical, emotional or sexual) from their husbands in the past one year preceding the survey. Responses are 'Yes' (if she has experienced any violence) and 'No' (if she has never experience any of such violence).

Background Characteristics

The background characteristics used are; age of women (15-24, 25-34, 35-49) years, age of child (0-11, 12-35, 36-49), education level (no education, primary, secondary/higher), parity (0-2, 3-5, 5^{+}), residence (urban/rural), wealth status (poor, middle, rich), and work status (working/ not working).

ANALYSIS

The data used in the analysis part of this study consist of information on currently married women of reproductive age that were selected and interviewed for domestic violence in the third round of NFHS survey. A sample of 6270 currently married women were analysed.

in which both bivariate and multivariate analysis were performed on the selected sample of women. Bivariate analysis was run in order to examine the association between the dependent and independent variables. In addition, chi-square test was performed to examine the association between each of the explanatory variables and the immunization and nutritional status of children under age five in the two populations. In this study, we consider p-values less than 0.001, 0.01 and 0.05 as significant, while p-value less than 0.1 is considered not significant.

Multivariate analysis allow the separate and combine effects of the explanatory variable to be examined, hence it was performed in order to examine the association between women's autonomy (decision making and background variables), domestic violence and child health status (immunization and nutritional status).

Since chi-square bivariate analysis does not consider confounding effects; therefore, the net effects of each explanatory variables are estimated, controlling other factors using the Logistic regression analysis**.** Logistic regressions were performed to measure the relationship between each of the categorical outcome variables and each of the explanatory variables. In this study, three separate adjusted logistic regression models were computed for each of the two outcome variables so as to examine whether the explanatory variables (i.e. decision making, experience of domestic violence and background characteristics) has influence on each of the outcome variables (i.e. immunization and nutritional status) and to what extend it affects. The models are; Model I which takes into

account only women's decision making variables, Model II, domestic violence was controlled for, while in Model III, background character was controlled.

- Model I consist of four decision making variables given in binary form.
- Model II contains decision making variables and domestic violence (binary form)
- Model III is a full model comprising four decision making variables, domestic violence and the selected background characteristics (binary and categorical).

In this section, three logistic regression models were run and the results are given as odds ratio values and 95% confidence interval as presented in Table 2 and Table 3. The idea behind this analysis is to examine whether women's decision making autonomy and their experience of domestic violence influences child's immunization and nutritional status, and to what extent is the effect in the study population.

RESULTS

Results obtained from the analysis in this study were based on a sample of currently married women who were interviewed for domestic violence during the NFHS-3 survey in Uttar Pradesh state of Northern part of India.

Women's Autonomy, Domestic Violence, Child Health Outcomes and Background Characteristics

It can be observed from the result of bivariate analysis in Table 1 revealed that women's decision on health care, daily household purchase, work status are non-significant determinants of child's immunization and underweight status in the context of this study, however, variables such as domestic violence, women's age, age of child, education, parity, residence and wealth status were found to be highly significant with the two child health indicators. The result further shows that child's immunization status increases and underweight status decrease with increasing level of education and wealth status of both women and their husbands. An interesting trend was observed on women's working status, in whereby the tendency of children being underweight tends high among the working class women who reported ever experiencing domestic violence. The abnormality in this result may obviously be due to the fact that working class women rarely have time to feed and take care of their children well due to their work demands.

Association between Child Health Outcomes, Domestic Violence and Women's Background Characteristics

Multivariate analysis was conducted in this section which focused on the association between three variables - women's background characteristics, domestic violence and child health indicators. The result as presented in Table

2 revealed an inter relationship between some selected women's socio-economic and demographic variables, their experience of domestic violence and its effect on two child health indicators. A contradicting result was obtained here, that higher proportion 27% of the under five year children who were fully immunized are from middle aged women (25-34 years) who have ever experienced domestic violence, while higher proportion 27% of the immunized children are from women who has not experienced domestic violence. Furthermore, results on child's underweight status shows that high proportion 50% of underweight children among the same women's age group (25-34 years) who experienced domestic violence.

It was revealed that the proportion of child immunization status increases and underweight status decreases among women who experience or do not experience violence respectively with increase in the education of both spouses, hence revealing the important role of education in relation to violence plays in child health outcomes. Immunization and underweight also exhibit respectively an increasing and decreasing trend with wealth status among women who experience or do not experience domestic violence respectively. In addition, child's immunization was found to be more among the non-working women who do not experience domestic violence and children underweight is more among working women who experience violence.

Women's Autonomy, Domestic Violence and Child Immunization and Nutritional Status

Results in Table 3 present the odds ratios and confidence interval from a logistic regression analysis where the interaction between women's autonomy, experience of domestic violence and full immunization status is clearly seen. Three different models were presented in the result, model I was computed based on four women's decision autonomy variables and the result revealed that the four autonomy variables considered in this study were statistically not significant with the two child health outcomes except for autonomy on visit to family and relatives which is significant with child's immunization status. The result given by model II was controlled for domestic violence, and revealed a strong statistical significance existing between women's experience of domestic violence and the two child health outcomes. The odds ratio says that women who experience domestic violence were 50% less likely to have fully immunized children and 42% more likely to have underweight children as revealed by model II. Furthermore, model III was controlled for background characteristics, and age of child, education and wealth status significantly determine children immunization and nutritional status in Uttar Pradesh. Hence the odds ratio revealed that women with higher level of education were more likely to have immunized children and less likely to have underweight children than the less educated. The results further revealed that children whose mothers are in the rich wealth status are two times more likely immunized and 49% less like underweight compared to those in the poor wealth status.

CONCLUSION

Domestic violence has impact on health and well being of women and children both in the immediate and long time, hence affecting future generation and development. The study examined the impact of women's decision making autonomy in relation to their experience of domestic violence on children's health outcomes, where a national survey data was used for the analysis. An inter-relatedness of women's autonomy variables, domestic violence, background variables with children's immunization and nutritional status, and how each influences child health practices using both bivariate and multivariate analysis was examined. Findings from the study revealed that there is strong and significant link between the variables used in the study (women's autonomy, domestic violence and child health status). Bivariate analysis gave us the empirical relationship between the outcome and explanatory variables and the result indicates a highly significant relationship exists between all the variables and child's full immunization and nutritional status.

Similarly, multivariate analysis revealed that domestic violence is influenced by some socio-economic and demographic characteristics of women and hence have effect on child health outcomes. Results from logistic regression model used to predict child health status using women's autonomy and their experience of domestic violence revealed that women's decision autonomy on health care, large and daily household purchases are statistically not significant with child's health outcomes (immunization and underweight).

Consequently, some important findings in the context of this study revealed that women's experience of domestic violence showed a strong significant association with the two child's health outcomes. Furthermore, a highly significant association between domestic violence and child health status was observed though, women who experience domestic violence were less likely to have fully immunized children but more likely to have underweight children. Finally, background variables such as age of child, parent's education and wealth status were found to be the most important determinants of child's immunization and nutritional status in the study areas.

Nevertheless, further studies can be done using more or other child health indicators as well as women's autonomy indicators to obtain more complex findings.

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TABLES

Table 1 Bivariate distribution of child health indicators with selected characteristics of women

Characteristics	Full Immunization		Nutritional Status (underweight)	
Autonomy variables	**Percent**	**X^2 (p value)**	**Percent**	**X^2 (p value)**
Own health care	18.2	1.2 (0.149)	44.3	0.1 (0.423)
Large household purchases	19.3	9.8 (0.001)	44.8	0.01 (0.476)
Household purchases for daily needs	17.8	2.4 (0.650)	45.9	1.1 (0.161)
Visits to family or relatives	19.2	18.3 (0.001)	47	1.8 (0.098)
Domestic violence				
		61.8		
No	22.9	(0.000)	40.3	19.1 (0.000)
Yes	13.3		47.6	
Age of women				
		17.6		
15 - 24 Years	15.8	(0.000)	40.1	4.0 (0.133)
25 - 34 Years	20.1		45.6	
23 - 49 Years	16.1		47.1	
Couple's age gap				
≤ 5 years	19.2	8.3(0.004)	44.6	0.124(0.379)
Above 5 years	16		42.6	
Age of child				
		240.9		
0 -11 months	2.9.0	(0.000)	33.3	42.4 (0.000)
12 - 35 months	21.5		48.7	
36 - 49 months	28.7		45.8	
Women's education				
No education	11.5	346.7	49.9	96.5 (0.000)

		(0.000)		
Primary	19.5		32.5	
Secondary/higher	36.5		32.4	
Partner's education				
		146.2		
No education	10.2	(0.000)	50.6	67.5 (0.000)
Primary	14.9		54	
Secondary/higher	24		37.6	
Parity				
0 – 2	19.5	33.4 (0.000)	45.3	5.6 (0.060)
3 – 5	11.5		36.9	
5+	30		74.2	
Residence				
		122.9		
Urban	28.5	(0.000)	35.9	51.9 (0.000)
Rural	15.3		45.9	
Wealth status				
		264.6		
Poor	11.9	(0.000)	51.1	125.9 (0.000)
Middle	16.7		41	
Rich	34.6		28.9	
Working status				
		1.5		
Not Working	18.4	(0.123)	41.6	18.6 (0.000)
Working	17.1		50.9	

Table 2 Distribution of Child Health indicators, Domestic violence with selected characteristics of women in Uttar Pradesh

Women's Background Characteristics	**Full immunization**		**Nutritional status (underweight)**	
Women's age (years)	**Violence**	**No violence**	**Violence**	**No violence**
15 - 24	12.9	18.0	42.8	38.1
25 - 34	13.6	26.9	49.6	41.2
35 - 49	13.1	20.4	49.0	43.8
Women's education				
No education	10.5	12.8	50.8	48.7
Primary	16.5	22.5	37.6	27.1
Secondary/Higher	25	42.1	39.3	28.8
Parity				
0 - 2	14.o	24.9	49.7	40.9
3 – 5	9.3	13.6	36.8	36.9

5+	50.1	16.6	74.3	74.2
Residence				
Urban	14.8	37.3	41.5	32.1
Rural	13.0	17.8	48.7	42.8
Wealth status				
Poor	11.2	12.8	51.4	51.6
Middle	12.8	20.1	42.2	51.4
Rich	23.6	39.6	37.0	40.0
Work status				
Not working	13.3	23.1	45.1	38.4
Working	13.3	22.0	53.7	47.1

Table 3 Logistic regression presenting the odds ratio and 95% confidence interval for Women's Autonomy Indicators, Domestic Violence and some Background Characteristics on Child's Immunization and Nutritional Status in Uttar Pradesh

Characteristics	Full Immunization (Odds ratio and 95% CI)			Nutritional status (underweight)		
Respondent Health Care	**Model I**	**Model II**	**Model III**	**Model I**	**Model II**	**Model III**
No®						
Yes	0.91 (0.73-1.13)	0.91 (0.73-1.14)	0.95 (0.74-1.22)	0.90 (0.74-1.10)	0.90 (0.74-1.09)	0.84 (0.68-1.03)
Large Household Purchase						
No®						
Yes	1.22 (0.97-1.53)	1.22 (0.97-1.54)	1.14 (0.88-1.49)	0.89 (0.72-1.09)	0.88 (0.72-1.09)	0.86 (0.70-1.07)
Daily Household Purchase						
No®						
Yes	0.89 (0.71-1.14)	0.93 (0.73-1.17)	0.86 (0.66-1.13)	1.15 (0.93-1.42)	1.13 (0.91-1.39)	1.12 (0.89-1.40)
Visits to Family or Relatives						
No®						
Yes	1.44***(1.17-1.78)	1.41***(1.14-1.75)	1.27 (0.10-1.61)	1.16 (0.96-1.40)	1.18 (0.97-1.43)	1.28*(1.05-1.56)
Domestic Violence						
No®						
Yes		0.50***(0.42	0.72***(0.58-		1.42***(1.21	1.13 (0.95-

	-0.60)	0.88)	-1.66)	1.33)
Age of Women				
15-24 Years®				
25-34 Years		1.06 (0.84-1.34)		0.98 (0.81-1.19)
23-49 Years		0.95 (0.67-1.34)		0.84 (0.63-1.12)
Couple's age gap				
≤ 5 years®				
Above 5 years		0.782*(0.63-0.97)		0.85 (0.71-1.02)
Age of Child				
0 - 11 months®				
12 - 35 months		10.66***(7.40-15.37)		1.79***(1.46-2.19)
36 - 59 months		13.53***(9.14-20.02)		1.75***(1.37-2.25)
Women's Education				
No education®				
Primary		1.82***(1.31-2.52)		0.58***(0.44-0.78)
Secondary/higher		3.37***(2.61-4.35)		0.74*(0.59-0.94)
Partner's Education				
No education®				
Primary		1.23 (0.85-1.71)		1.17 (0.89-1.52)
Secondary/higher		1.61***(1.23-2.09)		0.75**(0.61-0.92)
Parity				
0 - 2®				
3 – 5		0.756 (0.55-1.04)		0.84 (0.66-1.05)
5+		1.71 (0.42-6.96)		2.23 (0.60-8.25)
Residence				
Urban®				
Rural		0.84 (0.65-1.08)		1.14 (0.91-1.43)

Wealth Status		
Poor®		
Middle	1.20 (0.89-1.62)	0.79 (0.63 - 1.00)
Rich	2.15***(1.67-2.76)	0.51***(0.39 -0.67)
Working Status		
Not Working ®		
Working	1.02 (0.809-1.29)	1.14 (0.94 - 1.38)

*Model I = Autonomy variables; Model II = Autonomy and violence; Model III = Full model (Autonomy, violence and background characteristics); ® = reference category (has value 1), ***P ≤. 0.001, **P ≤ 0.01, *P ≤.0.05 significant levels, CI =95% confidence interval*