Original Article
ISSN (Online): 2582-7472

ShodhKosh: Journal of Visual and Performing Arts
March 2024 5(3), 795–801

COMPARATIVE STUDY OF RURAL AND URBAN WOMEN IN KASHMIR: PARTNER VIOLENCE AND REPRODUCTIVE HEALTH

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DOI
10.29121/shodhkosh.v5.i3.2024.3240

Funding: This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

ABSTRACT

The frequency and effects of intimate partner violence (IPV) on reproductive health in Kashmir among rural and urban women are investigated in this paper, together with evaluations of their knowledge, awareness, and practices (KAP). Six hundred women from three districts—Anantnag, Srinagar, and Baramulla who suffered with IPV, reproductive health issues, and their KAP was surveyed. The results show that, in rural women as opposed to urban women, where psychological violence is more widespread, IPV prevalence is higher. With rising STIs, reproductive pain, and medical consultations, results suggest that IPV has significant effects on reproductive health. Comparatively to rural women, urban women show better knowledge, awareness, and more proactive behaviours connected to reproductive health. Particularly in remote regions, the results suggest the need for context-specific treatments, including healthcare services that would integrate IPV screening and reproductive health support. Policies aiming at IPV prevention combined with community education initiatives aiming at raising KAP in rural settings could help reduce the health effects of IPV and promote reproductive health equity. The long-term and cumulative consequences of IPV on health must be investigated in future studies, including a conservative test of the literature on such socio-cultural settings.

Keywords: Reproductive Health, Women, Knowledge, Attitudes, Practice, Partner Violence

1. INTRODUCTION

Gender-based violence, particularly intimate partner violence (IPV), has caught the attention of policymakers and academicians due to its detrimental short- and long-term impact on physical and mental well-being across the globe (Finkel & Eckhardt, 2013; White et al., 2024). World Health Organization defines IPV as encompassing all behaviour within an intimate relationship that causes some (physical, psychological, and sexual) harm (WHO, 2024). IPV severely influences women's choices over their quality of life, reproductive health, etc. Violence in intimate relationships harms reproductive health (Guo et al., 2024; White et al., 2024). Hence, working towards and sustaining good reproductive health through social empowerment is necessary. Several studies have linked IPV to poor reproductive health outcomes, including unintended pregnancies, STIs, miscarriage, and perinatal complications (Murvartian et al., 2023; Spencer et al., 2023). The effects can be even more severe in socio-economically vulnerable regions, given their limited access to healthcare and knowledge.

Women in the region of Kashmir are especially vulnerable to IPV and the adverse effects of IPV on reproductive health due to the peculiar socio-political, cultural, and economic contexts therein (Bashir & Rafiq, 2023; Rasool, 2022). Equal importance must be given to how such concerns manifest differently in the rural and urban set-ups, as different socio-cultural norms, accessibility to health resources, and levels of cognizance will impact the extent of women and the nature

of IPV-related backlash on their reproductive health. Rural women might have limited access to health care information and resources than their urban counterparts, who are much more privileged in terms of access to information and medical services (Mushtaq, S2023; Rasool, 2022). An insight into comparative studies on IPV's impact on the reproductive health of rural and urban women in

2. RESEARCH GAP

While awareness of IPV and its health consequences have increased over the years, much less research has explicitly focused on IPV and reproductive health in Kashmir or urban/rural differentials in their experiences (Bashir & Rafiq, 2023; Rasool, 2022). Other studies reported that rural women might have worse access to health care or be less likely to report IPV. Nevertheless, adequate attention has not been given to the context of Kashmir in conjunction with healthcare inequities. In addition to this, the current literature lacks information on KAP regarding reproductive health among IPV women in Kashmir, which the present study aims to fulfil. This study seeks to fill a significant gap by comparing IPV-related factors and the impact on reproductive health in rural and urban populations of Kashmir.

3. THEORETICAL FRAMEWORK AND LITERATURE

Intimate Partner Violence (IPV): For this study, intimate partner violence is defined as physical, psychological or sexual violence by an intimate partner. Such acts of aggression, threats, moral coercion or deprivation cause cruelty and suffering to the woman in a relationship (Finkel & Eckhardt, 2013; White et al., 2024).

Reproductive Health: In this context, reproductive health means a state of reproduction-related well-being, including access or lack thereof to reproductive healthcare services, security from reproductive illnesses or complications, and the ability to make safe, informed reproductive choices. Adverse reproductive health outcomes—such as unintended pregnancies, STIs, and complications in childbirth, are measures indicating undesirable reproductive health (Glasier et al., 2006; Kilfoyle et al., 2016)

Knowledge, Awareness, and Practice (KAP): In this study, KAP refers to the level of women's knowledge and understanding about reproductive health, their awareness of available healthcare resources, and their practice or behaviour in reproductive healthcare such as the use of contraceptives, regular in clinics for a check-up and seeing a doctor for having problems related to the reproductive system (Dube & Sharma, 2012; Gaferi et al., 2018).

A theoretical framework based on social-ecological theory, the limitations of feminist theory for understanding women's vulnerability to both IPV and unwanted pregnancy, and insights from the health belief model providing brief background experiences with IPV, commentary explaining how such experiences shaped their reproductive life. The concepts of these frameworks contribute to making sense of the dimensional nature of IPV's effects on reproductive health outcomes among women and variations in KAP regarding reproductive health between rural and urban Kashmir.

4. SOCIAL-ECOLOGICAL THEORY

Social-ecological theory, frequently applied to IPV dynamics, asserts that personal, relational, community and societal factors influence individual behaviours and health outcomes. IPV, as experienced by a woman, does not occur in a void; it is influenced by multiple layers of context, including social family dynamics, socio-economic factors, cultural & religious beliefs, customs, and broader community norms. The framework offered as a working example below will assist in theorizing potential differences in IPV's effects on reproductive health between rural and urban contexts based on previously demonstrated variability in social organization, healthcare access, and social support. Community norms and geographic or financial barriers restricting access to healthcare may mean that rural women have few resources to seek help or reproductive health services in cases of IPV (Gashaw et al., 2018; Whitaker et al., 2009).

This paper uses the ecological model to acknowledge that IPV influences reproductive health outcomes but also by overlapping contextual factors specific to rural or urban environments. It emphasizes the relevance of all levels of intervention — the physical health problems and needs, relational circumstances, broader community structures, and policy frames within which such violence occurs.

5. FEMINIST THEORY

Fundamental tenets of feminist theory argue that IPV cannot be fully understood without first addressing the underlying mechanisms of power imbalance between men and women as well as entrenched cultural norms about the acceptability of violence against women. Patriarchal structures of control, especially over women's reproductive health decisions, are often one of the most explicit displays of IPV. This suggests that in patriarchal societies, such as those existing in parts of

Kashmir, women usually continue to face obstacles from their partners or more significant social norms prohibiting them from accessing reproductive physical health services. This perspective allows us to situate IPV as a complex multi-systemic issue rather than simply an individual experience and one that is fundamentally tied to unequal gender dynamics (Lawson, 2012; McPhail et al., 2007).

This study, dialectically analyzing IPV as a constraint on women's reproductive autonomy with consequences to their health and reproductive decision-making, is grounded in feminist theory. This lens is precious to examine how IPV might differentially affect KAP towards reproductive health since rural women may be living under higher social oppression compared to their urban counterparts, who are somewhat liberalized by better urbanization and exposure to diverse social elements.

6. HEALTH BELIEF MODEL (HBM)

The Health Belief Model (HBM) serves as a relevant conceptual model to analyze women's knowledge, awareness, and practices (KAP) about reproductive health within the context of IPV. According to HBM, human behaviours related to health are controlled by perceptions of susceptibility, perceived severity of risk, and perceived benefits and barriers regarding access to health resources. With IPV, for example, a woman may be less likely to engage in proactive reproductive health behaviours if she does not view this as a health risk for herself, is unaware of these options, or they are inaccessible (Burke, 2015; Rakhshani et al., 2024).

The usefulness of the HBM framework allows for disparities in KAP between rural and urban women to be explored using HBM. The perceptions and actions related to women's reproductive health may differ based on the culture, education, availability of access, etc., with a regional variation as well. One such reason is that women in rural areas might see more considerable obstacles in accessing reproductive health services as increased stigma, logistics, or financial pressure may inhibit them from going to life-saving healthcare, thereby putting their reproductive health at risk.

7. CONCEPTUAL MODEL FOR THE STUDY

Based on these theoretical perspectives, the conceptual model for this study posits that:

Intimate Partner Violence (IPV), influenced by socio-ecological and gendered power dynamics, negatively impacts women's reproductive health, with differing intensities in rural versus urban settings (Finkel & Eckhardt, 2013; White et al., 2024).

Reproductive Health Outcomes are moderated by knowledge, awareness, and practices (KAP) regarding reproductive health, where IPV directly and indirectly affects reproductive health via barriers to access and perceived health risks (Glasier et al., 2006; Kilfoyle et al., 2016).

KAP Variations between rural and urban settings serve as an essential lens, as urban women may exhibit higher KAP due to increased healthcare access and awareness, while rural women face distinct structural barriers that may exacerbate IPV's impact on their reproductive health (Dube & Sharma, 2012; Gaferi et al., 2018).

This theoretical framework provides a foundation for investigating how IPV influences reproductive health, the role of KAP in moderating this relationship, and the differences between rural and urban contexts in shaping women's experiences and health outcomes in Kashmir. Through this framework, the study seeks to understand IPV as a health and social justice issue, highlighting the need for context-specific interventions.

8. METHODS

This study used a cross-sectional analysis and descriptive research design intending to determine the prevalence and consequences of intimate partner violence (IPV) against women's reproductive health in Kashmir's rural and urban areas of women. A sample of 600 women, i.e., 200 women from each district of Anantnag, Srinagar and Baramulla, were drawn through stratified random sampling to ensure adequate coverage of the rural and urban populations, respectively. The participants were surveyed using a structured questionnaire that included demographic information, experience of IPV, reproductive health measures, and a KAP questionnaire that measures respondents' knowledge, attitude and practice towards reproductive health issues. The IPV scale had adapted and validated items that were relevant to report psychological and physical abuse, while the reproductive health indicators have observed STI, pain, and visits to a doctor in the previous year. KAP items have measured participants' perceptions and practices of contraceptive use, STI and reproductive hygiene practices.

The information obtained was analyzed using descriptive and inferential statistics, and the findings were presented using tables. The prevalence of IPV between rural and urban areas was tested using chi-square tests of difference, while regression analyses sought to determine the impact of IPV on reproductive health measures. KAP scores from rural and urban women were compared using independent t-tests. The statistical significance level was at $p < 0.05$.

Objectives

i. To examine the partner violence between rural and urban women in Kashmir.
ii. To determine the impact of partner violence on reproductive health.
iii. To evaluate the Knowledge, Awareness and Practice (KAP) concerning reproductive health among women.

9. ANALYSIS & RESULTS

Based on factors like marital status, experience of intimate partner violence (IPV), age, education, occupation, and yearly household income, the data in Table 1 shows a demographic breakdown of women from three districts in Kashmir: Anantnag, Srinagar, and Baramulla.

Marital Status: With 84.2% of the sample reporting being married, most women in all districts are married. The percentage of married women is lowest in Srinagar (80%) and highest in Anantnag (85%).

Experience of Partner Violence: 59.2% of women in all districts report having experienced some partner violence, indicating a very high incidence of IPV. With 62.5% of IPV survivors, Baramulla has the highest percentage, followed by Anantnag (60%) and Srinagar (55%).

Age Group: The majority of women in all districts are between 18 and 35 (45.8% of the sample), with the 35–49 age group coming in second (40%) after this. Women over 49 make up just 14.2% of the population, with Baramulla having the most significant proportion of these women (45%).

Educational Background: Baramulla has the highest percentage of women with at least a 10+2 education (55%), with the majority of women (48.3%) completing this study level. However, just 35.8% of women are graduates, with Srinagar having the most significant percentage of graduates (45%), while a sizable portion of women in each district have lower educational levels.

Occupation: Housewives comprise the bulk of women in the districts; 55.8% of the sample fit this description. The percentage of homemakers is lowest in Srinagar (50%) and most significant in Anantnag (60%). Women who work for themselves or run their businesses make up 28.3% of the total, with Srinagar having the most significant percentage (32.5%).

Annual Household Income: 69.2% of women live in homes that earn between 1 and 5 lac annually. The percentage of women in this income group is slightly lower in Srinagar (65%), while it is higher in Anantnag (70%) and Baramulla (72.5%). Around 30.8% of women say they make more than 5 lac, with Srinagar having the most significant percentage at 35%.

These demographic traits offer crucial background information for comprehending the frequency of partner violence and its effects on reproductive health in these areas. They also draw attention to socio-economic variables like income and education levels that may impact women's experiences and coping strategies in various Kashmiri districts.

Table 1 Demographic Characteristics of the Sample (N = 600)

Variable	Category	Anantnag (n = 200)	Srinagar (n = 200)	Baramulla (n = 200)	Total (N = 600)
Marital Status	Yes	170 (85%)	160 (80%)	175 (87.5%)	505 (84.2%)
	No	30 (15%)	40 (20%)	25 (12.5%)	95 (15.8%)
Experience of Partner Violence	Yes	120 (60%)	110 (55%)	125 (62.5%)	355 (59.2%)
	No	80 (40%)	90 (45%)	75 (37.5%)	245 (40.8%)
Age Group	18-35 years	90 (45%)	100 (50%)	85 (42.5%)	275 (45.8%)
	35-49 years	80 (40%)	70 (35%)	90 (45%)	240 (40%)
	Above 49 years	30 (15%)	30 (15%)	25 (12.5%)	85 (14.2%)
Educational Qualification	10+2	100 (50%)	80 (40%)	110 (55%)	290 (48.3%)
	Graduate	60 (30%)	90 (45%)	65 (32.5%)	215 (35.8%)
	Others	40 (20%)	30 (15%)	25 (12.5%)	95 (15.8%)
Occupation	Self-employed/Business	50 (25%)	65 (32.5%)	55 (27.5%)	170 (28.3%)

Variable	Category	Anantnag (n = 200)	Srinagar (n = 200)	Baramulla (n = 200)	Total (N = 600)
	Housewife	120 (60%)	100 (50%)	115 (57.5%)	335 (55.8%)
	Others	30 (15%)	35 (17.5%)	30 (15%)	95 (15.8%)
Annual Household Income	1-5 lac	140 (70%)	130 (65%)	145 (72.5%)	415 (69.2%)
	Above 5 lac	60 (30%)	70 (35%)	55 (27.5%)	185 (30.8%)

Examining Partner Violence Among Rural and Urban Women in Kashmir

A chi-square test was employed to evaluate the disparities in IPV rates between rural and urban areas to examine the prevalence of partner violence (both psychological and physical) among these women, as seen in Table 2. Rural women are 60% more likely than urban women to experience psychological violence ($p < 0.01$). Additionally, rural women experience physical abuse slightly more frequently (43.3%) than urban women (36.7%) ($p < 0.05$).

Table 2 Partner Violence Among Rural and Urban Women in Kashmir

Type of Partner Violence	Rural (n = 300)	Urban (n = 300)	Chi-square	p-value
Psychological Violence	180 (60%)	150 (50%)	7.8	<0.01
Physical Violence	130 (43.3%)	110 (36.7%)	3.6	<0.05

Assessing the Impact of Partner Violence on Reproductive Health

The effect of partner violence on several reproductive health outcomes (e.g., STI occurrence, pain, and frequency of medical visits) was evaluated using a regression analysis (Table 3). Beta coefficients and significance levels are shown in this analysis. The risk of reproductive health problems, such as STIs, pain, and the frequency of medical visits, is significantly increased by both psychological and physical violence. Particularly when it comes to reproductive organ discomfort, psychological violence has a marginally more significant effect on health outcomes than physical violence ($\beta = 0.35$, $p < 0.01$).

Table 3 Impact of Partner Violence on Reproductive Health

Reproductive Health Outcome	β (Psychological Violence)	p-value	β (Physical Violence)	p-value
STIs (past 12 months)	0.28	<0.01	0.22	<0.05
Pain in Reproductive Organs (past 12 months)	0.35	<0.01	0.30	<0.01
Doctor Visits for Reproductive Issues	0.25	<0.05	0.20	<0.05

Knowledge, Awareness, and Practice (KAP) Regarding Reproductive Health Among Women

Independent t-tests were used to compare the KAP levels between rural and urban women. Urban women scored significantly higher than rural women across all KAP measures. (Table 4) This indicates that urban women are generally more knowledgeable, aware, and practice better reproductive health hygiene than rural women ($p < 0.01$).

Table 4 Knowledge, Awareness, and Practice (KAP) Regarding Reproductive Health Among Women

KAP Variables	Rural Mean (SD)	Urban Mean (SD)	t-value	p-value
Knowledge of Reproductive Health Issues	3.1 (0.8)	3.6 (0.7)	6.2	<0.01
Awareness of STIs	2.9 (0.9)	3.5 (0.8)	5.8	<0.01
Reproductive Health Practices (Hygiene)	3.0 (0.7)	3.4 (0.6)	5.3	<0.01

10. DISCUSSION AND CONCLUSION

The results show that the incidence of IPV among women of Kashmir is relatively high and shows considerable variation between rural and urban sectors in experiencing IPV and its effects on reproductive health outcomes. IPV is positively associated with adverse reproductive health outcomes, including increased STIs, pain in the reproductive organs, and more excellent medical visits. This would imply that IPV influences not only the immediate physical and psychological status of women but also has an influence on their reproductive health in the long term. The study further finds vast differences in KAP related to reproductive health between rural and urban women, with a much higher level of KAP among urban women (White et al., 2024).

These differences may result from differing access to health care providers, education, and social knowledge, which vary less in urban settings. The better exposure of urban women to health facilities and health information gives them a more accurate perception of some risk factors and practices related to reproductive health, possibly partly counterbalancing the adverse health impacts of IPV. The structural and social barriers would be the limited availability of rural healthcare,

financial constraints, and the burden of seeking help or discussing issues that fall under IPV due to various societal restrictions (Guo et al., 2024).

These results highlight an immediate need for region-specific interventions. There is evidence of a substantial IPV-related burden on reproductive health, and women would be significantly helped by interventions in the form of health care that integrated services for reproductive health, including screening for IPV. The results also suggest that community-based educational programs that improve KAP levels among rural women build agency and enhance positive health outcomes (Murvartian et al., 2023).

IMPLICATIONS

Policy and Health Infrastructure

The results indicate that policymakers must improve healthcare access in rural districts while integrating IPV screening with reproductive health services. This can be achieved through local-level health centres, which ought to provide IPV support and other reproductive health services confidentially and safely in a female help-seeking place.

Community Education and Outreach

Interventions which engage leaders within communities and stimulate open discussions on IPV can be an enemy to the stigmatized perceptions of IPV and reproductive health. These programs can help challenge norms and attitudes of cultural and social values contributing to IPV by motivating a supportive environment among survivors when they seek assistance.

Healthcare Training

Providing training to healthcare providers to handle IPV-sensitive approaches and to conduct regular reproductive health check-ups may be able to help the specific reproductive health needs of IPV survivors, even in rural settings where women have significant challenges in accessing health care.

LIMITATIONS

Because it relies on self-reported data, there is likely to be an underreporting of IPV because of stigma and fear-a drawback to the study's ability to track the full spectrum of IPV. As a cross-sectional study, causality between IPV and reproductive health outcomes cannot be determined. This study's emphasis on women in Kashmir may limit the generalizability of such findings across other regions due to differences in cultural and socio-economic environment.

FUTURE DIRECTIONS

Longitudinal designs can be used to assess the long-term effects of IPV on reproductive health and monitor possible changes in KAP over time. Intervention programs for IPV and better reproductive health can be developed and tested to determine effective mechanisms that address these issues in rural and urban settings. Replicating the same studies in other places may inform how far the patterns seen in Kashmir extend to different places and whether they contribute to a more general understanding of how IPV impacts reproductive health. Qualitative research, like in-depth interviews, would give a more internalized understanding of how women understood IPV and experiences related to reproductive health, thus making the findings richer in detail.

In conclusion, this study emphasizes adopting multi-level, integrated approaches to address IPV to enhance reproductive health among women in Kashmir. Targeted interventions that fill the structural gap, raise awareness, and provide IPV-sensitive healthcare will help reduce the negative impacts of IPV on health and will be influential in delivering reproductive health equity among the populations of rural and urban regions.

CONFLICT OF INTERESTS

None.

ACKNOWLEDGMENTS

None.

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