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The Hidden Epidemic: Alcohol and Domestic Violence in Rural Rajasthan

Roopali Nath Mathur[1], Himansu Tanwar[2], R.K. Manohar[3] Abid Manzoor[4] ,Yashika Gupta[5] Sachin Khandelwal[6] , Mohit Mathur[7]

[1]PhD Scholar, Associate Professor, Department of Community Medicine, NIMS&R, Jaipur
[2]Associate Professor, Department of Community Medicine, Index medical College and Research Centre, Indore
[3] Professor and Head , Department of Community Medicine, NIMS&R, Jaipur
[4]Tutor, Department of Physiology, SMVDIME, Kakryal, Katra
[5]PG Resident, Department of Psychiatry, NIMS&R, Jaipur
[6]PG Resident, Department of Physiology, NIMS&R, Jaipur
[7]Block Chief Medical Officer, Shahpur, Rajasthan

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Abstract; Background: Domestic violence remains a significant public health issue, particularly in rural areas, where its causes and effects are often influenced by socio-economic and cultural factors. In rural Jaipur, alcohol consumption has emerged as a primary contributor to domestic violence, affecting women's mental and physical well-being. **Aim**: To investigate the causes and effects of domestic violence against married women in rural Jaipur. **Materials and Methods**: This cross-sectional study was conducted in rural Achrol, Jaipur, with 332 married women aged 15-49. Data were collected through face-to-face interviews using a structured questionnaire covering demographics, socio-economic status, husband's profile, and details of domestic violence experienced. **Results**: Alcohol consumption was the leading cause of domestic violence (41%), followed by job dissatisfaction and family-related stress. The most common effects included anxiety, depression, sleep disturbances, and physical health issues, as reported by 12.1%, 8.4%, and 17.7% of respondents, respectively. **Conclusion**: The study highlights alcohol consumption as the predominant cause of domestic violence in rural Jaipur, with significant mental health repercussions. Addressing alcohol abuse and improving socio-economic conditions are crucial for reducing domestic violence and its impact on women's health.

Keywords: Domestic violence, alcohol, mental health, socio-economic factors, rural Jaipur, depression, anxiety, sleep disturbances.

INTRODUCTION

Domestic violence is a pervasive issue that deeply impacts the social fabric of communities, posing significant threats to the health, well-being, and autonomy of affected women. While strides have been made in women's empowerment globally, reports of violence against women remain alarmingly high, often rooted in societal norms that perpetuate gender inequality.[1] In India, the prevalence of domestic violence varies significantly across states, with Rajasthan being one of the regions where the issue remains critically underexplored despite its sociocultural uniqueness. Women subjected to domestic violence face an increased risk of mental health conditions such as anxiety, depression, and post-traumatic stress disorder, as well as physical health challenges including sleep disturbances, gastrointestinal issues, and miscarriages.[2,3] Socioeconomic and demographic factors such as lower education levels, economic dependence, and substance abuse by the spouse are widely acknowledged as contributors to domestic violence.[4–6] However, the intersectionality of these factors, particularly in rural settings, remains inadequately addressed. The National Family

Health Survey (NFHS-5) highlights the prevalence of domestic violence in Rajasthan but fails to delve into the specific causes, typologies, and associated health outcomes within rural communities.[7] Existing literature often focuses on urban areas or generalized state-wide data, leaving a critical gap in understanding the localized causes and health impacts of domestic violence in rural Jaipur. This study seeks to fill this gap by examining the specific causes of domestic violence and their associated health consequences in this underserved region. The findings underscore the need for tailored interventions that address the specific challenges faced by women in rural areas and highlight the critical role of healthcare providers, community leaders, and policymakers in creating a supportive and responsive environment for survivors of domestic violence.

MATERIALS AND METHODS

Study Design, Setting, and Participants

This field-based cross-sectional study was conducted to identify the causes and health consequences of domestic violence among married women in the rural area of Achrol, Tehsil Amber, Jaipur, Rajasthan. The study was carried out over a one-year period from 2022 to 2024 and targeted married women aged 15-49 years who had been residing in the study area for at least six months. The study utilized a multistage random sampling technique to select participants, ensuring representative coverage of the target population. A total of 322 participants were included in the study based on the calculated sample size using Cochran's formula. Inclusion criteria required participants to be married women aged 15-49 years, residing with their husbands during the study period, and free from serious medical illnesses. Women below 15 years of age or those who did not consent to participate were excluded.

Ethical Considerations

The study adhered to ethical standards for research involving human participants. Written informed consent was obtained from all participants after explaining the study's objectives and procedures. Participants were assured of confidentiality and their right to withdraw from the study at any time. Ethical approval was obtained from the institutional ethics committee before the commencement of the study.

Study Tools

Data were collected through structured, face-to-face interviews using a validated questionnaire. The questionnaire covered the following domains:

1. **Demographic and Socioeconomic Information**:
   - Participant's age, religion, caste, educational level, occupation, monthly income, and family structure (nuclear or joint).
   - Socio-economic status was determined using the modified B.G. Prasad Scale[8].
2. **Domestic Violence Profile**:
   - Causes of domestic violence, including physical, psychological, and social factors.
   - The questionnaire captured detailed information on the types and frequency of violence, its severity, and its impact on participants' mental and physical health.
   - Health consequences such as anxiety, depression, sleep disturbances, gastrointestinal issues, and other related conditions were documented.
3. **Awareness and Support Mechanisms**:
   - Awareness of legal protections under the *Protection of Women from Domestic Violence Act, 2005*[9].
   - Access to healthcare, legal assistance, and counseling services for survivors of domestic violence.

Data Collection Procedure

Data collection was conducted by trained female enumerators to create a comfortable and trustworthy environment for participants. Each interview was conducted privately to ensure confidentiality and encourage openness about sensitive topics. The data collection tool was pre-tested in a similar rural setting to assess clarity, reliability, and cultural relevance. Feedback from the pilot testing was incorporated to refine the questionnaire. Enumerators were trained in empathetic

interviewing techniques and equipped to handle sensitive discussions. The collected data were analyzed using statistical software. Descriptive statistics were applied to summarize demographic characteristics, prevalence, and types of domestic violence. The causes and health impacts were reported as frequencies and percentages, aligned with the study's objectives.

RESULT

Table 1: Main Causes of Domestic Violence

S.No	Main Cause of Domestic Violence	No. of cases	Percentage
1	Alcoholic nature of the husband	132	41.0
2	Alcoholic nature of the husband, Dowry	51	15.9%
3	Alcoholic nature of the husband, Extra-marital affair, Dowry, Mental disorders, Physical non-attractiveness	42	13%
4	Alcoholic nature of the husband, Extra-marital affair, Job dissatisfaction, Suspicion, Mental disorders	33	10.2%
5	Dowry, Job dissatisfaction	22	6.8%
6	Job dissatisfaction	7	2.2%
7	Not Known	22	6.8%
8	None of the above	132	41%
9	Total	322	100%

Table 2: Health Issues Associated with Domestic Violence

S.No	Main Cause of Domestic Violence	No. of cases	Percentage
1	Anxiety, Depression, Fainting, Headaches, Sleep disturbances, Miscarriage	39	12.1%
2	Gastrointestinal issues, Anxiety, Depression, Eating disorders, Sleep disturbances	18	5.6%
3	Headaches, Anxiety, Depression, Sleep disturbances, Eating disorders, Homelessness	27	8.4%
4	Headaches, Anxiety, Depression, Fainting, Miscarriage, Sleep disturbances	22	6.8%
5	Headaches, PTSD, Sleep disturbance	57	17.7%
6	Overburdening with work	2	0.6%
7	All of the above	7	2.2%
8	None of the above	137	42.5%

9	Total	322	100%

DISCUSSION

Domestic violence remains a significant public health and social issue in rural India, with profound implications for women's physical, mental, and social well-being. This study, conducted in the rural area of Achrol, Tehsil Amber, Jaipur, Rajasthan, explored the prevalence, causes, and health consequences of domestic violence among married women aged 15-49 years. The findings revealed a concerning prevalence of domestic violence, with diverse contributing factors and associated adverse health outcomes such as anxiety, depression, headaches, and sleep disturbances.

The study identified domestic violence as a multifaceted problem influenced by socio-economic, psychological, and cultural factors. The findings align with studies conducted in other parts of India, South Asia Africa and other parts of the world that similarly highlight domestic violence as a pervasive issue. For example a study conducted in rural Maharashtra identified physical violence in 49% of cases and psychological violence in 38%, aligning with our findings on the predominance of these forms of abuse (Bhattacharya et al., 2019)[10]. Similarly, a study in Haryana reported that 41.7% of women experienced spousal violence, with economic dependence and lack of autonomy being major contributors (Kishor & Gupta, 2009)[11]. The National Family Health Survey (NFHS-5) corroborates the high prevalence of domestic violence in Rajasthan, reporting rates exceeding 25%, though underreporting remains a significant barrier. Comparative findings from South Asia indicate similar patterns, with a Nepalese study identifying 48% of married women experiencing violence, frequently linked to substance abuse and low educational attainment of spouses (Pandey et al., 2018)[12]. Globally, studies demonstrate parallels in the rural context. Research in Nigeria highlighted that 56% of women in rural areas experienced domestic violence, with economic dependence and cultural norms perpetuating abuse (Adebayo et al., 2020)[13]. A systematic review in Ethiopia revealed that up to 63% of rural women suffered physical or emotional violence, predominantly due to financial stress and lack of spousal communication (Tesfaye et al., 2021)[13]. The health impacts observed in our study, such as anxiety, depression, and sleep disturbances, are consistent with findings from a multi-country WHO study, which identified mental health issues as primary outcomes of domestic violence across diverse populations (Garcia-Moreno et al., 2006)[14]. A recent study in Bangladesh also linked domestic violence to adverse reproductive health outcomes, including miscarriages, reinforcing the need for integrated healthcare responses (Rahman et al., 2020)[15]. Outcome of the Study

Outcome of the Study

This study highlights the urgent need to address domestic violence as a multifactorial issue with far-reaching health and social consequences. It underscores the importance of community-level interventions, including legal awareness, counseling services, and healthcare support, to mitigate the impact of domestic violence on women. By identifying key contributing factors and their consequences, the study provides a foundation for developing targeted strategies to prevent and address domestic violence in rural Rajasthan. These findings can inform policymakers and healthcare providers, emphasizing the need for an integrated approach to improve the safety and well-being of women in similar settings.

CONCLUSION

The study identifies alcohol consumption as the primary cause of domestic violence in rural Jaipur, followed by factors like job dissatisfaction and family tensions. These causes contribute significantly to the prevalence of violence. The effects of this violence are primarily manifested in mental health issues such as anxiety, depression, sleep disturbances, and physical health problems. Addressing alcohol abuse, improving socio-economic conditions, and providing mental health support are essential steps in reducing domestic violence and its negative impact on victims in the region.

AUTHORS' CONTRIBUTIONS

All authors contributed significantly to the study's conception, design, and execution. Dr. Roopali Nath Mathur and Dr. Himansu Tanwar contributed to the study design and data collection. Dr. R.K. Manohar supervised the research and

provided critical insights into the methodology and analysis. Abid Manzoor and Sachin Khandelwal contributed to statistical analysis and data interpretation. Yashika Gupta and Mohit Mathur reviewed the manuscript and contributed to the discussion and conclusions. All authors reviewed and approved the final version of the manuscript for publication.

CONFLICT OF INTEREST

The authors declare no conflicts of interest concerning this study.

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