



Balance of Power, Domestic Violence, and Health Injuries: Evidence from Demographic and Health Survey of Nepal



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SUMMARY

A large literature has documented a complex and interdependent relationship between domestic violence, women empowerment, domestic risk factors, and violence-related health injuries. In this paper, we evaluate this relationship using data drawn from the Nepal Demographic and Health Survey, 2011. We simultaneously estimate the impact of women empowerment and domestic risk factors on domestic violence, and the impact of domestic violence on health consequences. Specifically, an IV ordered probit regression strategy is used, which addresses both the endogenous nature of domestic violence and the ordinal nature of health outcome variables. Our study finds evidence that it is not the autonomous power of women, but a cooperative decision-making environment in a marital relationship that reduces violence. Additionally, education decreases domestic violence and domestic risk factors, including alcohol and multiple unions exacerbate domestic violence. Finally, in terms of adverse health outcomes, we find that domestic violence has a non-linear impact on health injuries. At low levels of violence, the likelihood of injuries is low and injuries are generally not threatening, and as the level of violence increases, it considerably increases the probability of multiple and more serious health injuries.

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1. Introduction

Domestic violence (DV) is a substantial problem, especially in the developing world. For instance, a World Health Organization (WHO) study found violence rates to be 71% in Ethiopia, 62% in Bangladesh, and 69% in Peru (Garcia-Moreno, Jansen AFM, Ellsberg, Heise, & Watts, 2005). DV can take many forms and lead to a multitude of negative outcomes including physical injuries, permanent disability, reproductive health issues, mental health problems, and even death (Campbell, 2002). However, in spite of the widespread prevalence and significant negative consequences, many times social constructs do not acknowledge it as a problem. Historically, gender-based DV was accepted to be “normal” in many societies, but this is starting to change. In part due to the World Conference on Human Rights, held in Vienna in 1993, and the Declaration on Elimination of Violence against Women in the same year, civil society and governments in developing countries have begun to realize the magnitude of violence against women and emphasize it as a public policy and human rights concern.

Country-specific studies have explored the physical health consequences of intimate partner violence (Ackerson & Subramanian, 2008; Gage, 2005; Hindin & Adair, 2002; Kramer, Lorenzon, & Mueller, 2004; Rocca, Rathod, Falle, Pande, & Krishnan, 2009).

Campbell (2002) found that in comparison to non-abused women, abused women sustain two to three times more injuries that require surgery. Also, abused women have an increased probability of suicide (Rosenberg, Ocarroll, & Powell, 1992). Beyond immediate repercussions, DV can also have an impact on long-term health outcomes such as reproductive health, anemia, neurological disorder, and other chronic health issues (Ackerson & Subramanian, 2008; Campbell, Garcia-Moreno, & Sharps, 2004).

Obviously, there is a greater need to combat the negative consequences of DV. In the last 15 years, a number of mechanisms have been proposed to combat DV which includes public discourse and protests, empowerment of women, community participation, and government policies (Htun & Weldon, 2012; Krishnan, Subbiah, Khanum, Chandra, & Padian, 2012). However, while significant progress has been made mitigating DV, it continues to be a substantial problem. To that end, the root causes of DV must be identified and better strategies need to be developed to combat it. One mechanism that has been shown to reduce DV is the empowerment of women (Deborah & Williams, 1995). Yet, while empowerment has been documented to be effective in reducing DV in a number of contexts, the issue of empowerment itself is complicated and involves the interaction of various individual, household, and marriage-specific characteristics. Further, to be able to identify the impact of risk factors, consequences (health injuries), and

mitigating strategies (empowerment) on DV a simultaneity approach is required (Campbell, 2002; Gupta et al., 2013).

In this study we build upon prior literature by examining the relationship between empowerment and domestic risk factors on DV, and the associated health impacts of DV using the Nepal Demographic Health Survey (NDHS) data in 2011. While previous studies in this area of research have applied reduced-form models to dichotomous DV variables (Bhattacharyya, Bedi, & Chhachhi, 2011; Panda & Agarwal, 2005), we estimate the relationship using a two-stage simultaneous ordinal model. This model is an improvement over traditional models because it allows us to jointly estimate the impact of empowerment and domestic risk factors on DV and the role of DV on self-reported health injuries.

2. Background on Empowerment, balance of power, and domestic violence

Historically, DV has been a substantial problem in both the developed and developing world. A growing area of research has addressed the global prevalence of violence, but there is a dearth in literature on the mitigation, or intervention strategies that can guide policies against violence, especially in the developing countries (Krishnan et al., 2012).

DV is thought to be impacted by a number of variables such as economic empowerment, education, decision-making, and community participation, among other things. For instance, studies have found evidence that women who participate in economic activities and have substantial control over household assets are less vulnerable to violence (Bhattacharyya et al., 2011). Also, education can help transform gender relations (Dhakal, Berg-Beckhoff, & Aro, 2014) and a supportive community may provide a safety net to women in less conservative societies (Koenig, Ahmed, Hossain, & Mozumder, 2003). There are also domestic characteristics (or risk factors) related to DV such as unemployment, alcohol, or drug use, and estranged husbands (Kyriacou et al., 1999). Additionally, women who have been separated or divorced from a prior union tend to face more violence due to the stigma attached to the concept of divorce (Krishnan, 2005).

One important aspect of empowerment is the power relation in a marital relationship. While this is clearly a significant aspect of empowerment the definition of power is still debated and the conceptualization of empowerment is not necessarily clear (Malhotra & Schuler, 2005). There is a rich literature measuring intra-household decision-making power and consequences in household outcomes. As Anderson, Reynolds, and Gugerty (2017) highlighted, the concept of women's status in the society has seen a transition over the years from sole possession of socio-economic resources, to women's access and control over resources, and finally to empowerment. In early conceptualizations, empowerment and women autonomy were used interchangeably (Dyson & Moore, 1983). Empowerment was defined as the ability of a woman to make decisions and choices independently, thus exerting control of their own lives and that of the family, community, and society. Generally, these studies have found that the more autonomous power a female has in the household, the better the household well-being (Acharya, Bell, Simkhada, van Teijlingen, & Regmi, 2010; Handa, 1999; Hoddinott & Haddad, 1995; Hopkins, Levin, & Haddad, 1994; Jejeebhoy & Sathar, 2001). However, this is not always the case. For instance, Govindasamy and Malhotra (1996) found that autonomy does not reflect cooperation or interdependence between partners, rather it symbolizes independence.

In terms of the early framework of unitary models, the dynamics of intra-household decision making was typically assumed away (Bobonis, 2009), but due to both qualitative and quantitative evidence against the unitary frameworks, cooperative and collec-

tive bargaining models arose. These models suggest that all household members may not have homogeneous preferences and intra-bargaining processes should be analyzed (Alderman, Chiappori, Haddad, Hoddinott, & Kanbur, 1995; Anderson et al., 2017; Doss, 2013; Duflo, 2003, 2012; Duflo & Udry, 2004; Heckert & Fabric, 2013; Kebede, Tarazona, Munro, & Verschoor, 2014; Richards et al., 2013; Sraboni, Malapit, Quisumbing, & Ahmed, 2014). Further, Felkey (2013) showed both theoretically and empirically that female autonomous decision-making power has a concave relationship with household outcomes and may actually have a negative effect on household public goods.

Overall, the ambiguity in literature about empowerment raises a fundamental methodological question of how to exactly capture the act of household decision-making. The debate remains about whether empowerment is a final say in decisions or a joint participation in household decisions. Recently, attempts have been made to associate the bargaining power of women with household outcomes such as family planning and contraceptive use (Belay, Mengesha, Woldegebriel, & Gelaw, 2016; Bogale, Wondafrash, Tilahun, & Girma, 2011; Hindin, 2000a), child and individual health outcomes (Hindin, 2000a, 2000b; Pokhrel & Sauerborn, 2004), household purchases and dietary diversity (Amugsi, Lartey, Kimani, & Mberu, 2016; Gage, 2005; Sraboni et al., 2014), and domestic violence (Antai, 2011; Donta, Nair, Begum, & Prakasam, 2016; Gage, 2005; Hindin & Adair, 2002).

3. Background of domestic violence in Nepal

Potentially surprising to the rest of the world, Nepal has a substantial level of DV that went largely unrecognized until 2008, when the Domestic Violence (Crime and Punishment) Act was passed. This act was aimed at punishing criminals of violence and offered immediate relief to the victims of violence by providing medical and temporary accommodations. Following this parliamentary move, the Government of Nepal declared 2010 as the year to combat gender-based violence by developing a National Gender-Based Violence Plan of Action. Unfortunately, poor implementation and unaccountability of government authorities in enforcing these laws ultimately increased violence-related incidents against women in Nepal. Previously, a survey collected by Centre for Research on Environment Health and Population Activities (CREHPA) was used to explore the determinants of DV in four districts of Nepal (Lamichhane, Puri, Tamang, & Dulal, 2011). The authors found that half of the married women (51.9%) reported experiencing physical and/or sexual violence.

In 2011, the Nepal Demographic Health Survey was implemented, for the first time providing a nationally representative sample of DV in Nepal. In part through these primary and secondary data sources, we now have a better understanding of the root causes of DV in Nepal. Notably, it has been found that the cultural, social, and religious patterns of Nepal impose a disadvantage for women, which may possibly lead to violence (Atteraya, Gnawali, & Song, 2015). For instance, alcohol consumption has led to negative social consequences and disruptions in marriage and family relations (Lamichhane et al., 2011). Puri, Frost, Tamang, Lamichhane, and Shah (2012) undertook a study on women with disabilities and found that disabled women who require permission from husbands or their families to go to health center or participate in community organizations are at a higher risk of facing violence.

Other studies have used Demographic Health Survey data to analyze long-term health outcomes of victims of violence. It is found that women who do not experience any violence have a 70% higher probability of making the required four antenatal care visits and a 34% lower probability of having anemic children

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