

Quantifying The Impact Of Domestic Violence On Women's Physio-Psychological Health In District Lower Dir, Khyber Pakhtunkhwa

Dr. Umar Daraz¹, Dr. Muhammad Bial², Dr. Raza Ullah (Corresponding Author)³

¹Lecturer Department of Sociology, University of Malakand Chakdara
Email: dr.umar@uom.edu.pk

²Lecturer Department of Sociology, Abdul Wali Khan University Mardan
Email: bilal@awkum.edu.pk

³Assistant Professor, Department of Sociology Rawalpindi Women University Rawalpindi.
Email: raza.ullah@f.rwn.edu.pk

Abstract

Domestic violence against women and women's physio-psychological health are theoretical concerns and policy issues. This article quantifies the impact of domestic violence on women's physical and psychological health in District Lower Dir, Khyber Pakhtunkhwa (KP). Data were collected from 125 participants through a structured interview schedule. Empiricist epistemology guided the theoretical and methodological application of the study. Statistical tests, such as correlation and chi-square, helped analyze the association between domestic violence and women's physical and psychological health. The findings reveal that domestic violence affects women's physical health, causing injuries, body fractures, miscarriage, permanent disabilities, headaches, asthma, and gynecological problems. The findings further show the psychological impact of domestic violence, creating trauma, depression, tension, anxiety, stress and strain, phobia, and psychometric disorder in women.

Keywords: Domestic violence, women's physical health, injury, miscarriage, asthma, women's psychological health, trauma, anxiety, phobia.

Introduction

Domestic violence creates serious physical and psychological health issues among women (Modi & Armstrong, 2014). Physiologically, domestic violence causes permanent disabilities, headaches, asthma, miscarriage, and body injuries (Zainab, 2003). Domestic violence also affects women's psychological health, causing phobia, stress, anxiety, depression, trauma, and tension (Lutgendorf, 2019). This phenomenon has been getting scholarly attention and healthcare professionals'

recognition for one and a half decades (Irene, 2020). The issue of domestic violence and women's physio-psychological health has also been of academic interest in the past (Jones et al., 1999; Ratner, 1993). Domestic violence against women is also considered one of the global health issues causing physiological and psychological health issues among women, such as injury, diseases, unwanted pregnancy, trauma, depression, injuries, sexually transmitted diseases, and suicide (Fischbach & Herbert, 1997; Coker et al., 2000; Campbell et al., 2002). Studies

once recorded that the global health burden caused by domestic violence against women was 9.5 million (Gerbert et al., 1999; Guth & Pachter, 2000). At that time, domestic violence led to various health issues among women like depression and anxiety, eating and sleeping disorders, feelings of shame and guilt, phobias and panic disorders, physical inactivity, poor self-esteem, post-traumatic stress disorder, psychosomatic disorders, smoking, suicidal and sexual behavior (Maman et al., 2002; Memmott et al., 2001). Every third woman globally experienced domestic violence (Mertin & Mohr, 2000). Women have suffered physically and mentally from domestic violence, and even children are no exception (Molina & Basinait, 1998; Thompson et al., 2006). According to the World Health Organization multi-country study on violence against women in intimate relationships, the lifetime prevalence of physical or sexual violence ranges between 15% and 71%, and past-year prevalence also shows a wide variation (4%–54%), with the lowest rates found for Japan and the highest for Ethiopia, Peru, and Bangladesh (Parker & Lee, 2002a; 2002b). Every day, more than 4000 people, over 90% of them in low- and middle-income countries, die because of severe domestic violence against women, which burdens the health industry (Poole et al., 1996; Queensland Health, 2001). WHO's a multi-country study on women's health and domestic violence explicitly reflects the proportion of ever-partnered women who had experienced physical or sexual violence, or both, by an intimate partner in their lifetime ranged from 15% to 71%. The prevalence of violence in the past year ranges from 4% to 54% (Ramsden & Bonner, 2002; Rhodes & Levinson, 2003).

The fact is palpable that domestic violence is a threat and menace to women's health

(Webster et al., 2001), where interpersonal and self-inflicted violence are heavy contributors to global death rates, particularly among people aged 15 to 44 years (Sethi, 2006). In fact, in these age groups, suicide and homicide are among the top ten causes of death, which further produces health complications for women (Robinson, 1999). Beyond fatalities, the damaging effects of violence on health include physical consequences such as brain injuries, bruises and scalds, chronic pain syndromes, and irritable bowel syndrome (Stenson et al., 2001). Violence against women can also be a risk factor for various sexual and reproductive health problems, such as infertility, pregnancy-related complications, unsafe abortion, pelvic inflammatory disorders, HIV and other sexually transmitted diseases, and unwanted pregnancy (Sutherland et al., 2002). It has also been linked with various chronic diseases, such as cancer, ischemic heart, and chronic lung disease (Taft, 2001; Webster et al., 1996). Similarly, World Health Organization (2008) estimated that sexual abuse during childhood accounts for serious health problems in the general population, including 27% of posttraumatic stress disorders, 10% of panic disorders, 8% of suicide attempts, 6% of cases of depression, alcohol misuse, and illicit drug abuse (Siemieniuk et al., 2010). As reported by the United States Department of Justice (2000) survey, that 16,000 Americans showed, 22.1% of women and 7.4% of men reported being physically assaulted by a current or former spouse, cohabiting partner, boyfriend or girlfriend, or date in their lifetime (Kevin et al., 2011). National Violence Survey against Women particularly stresses women's data concerning violence that shows 22% of women's physical assault by a partner or date during their lifetime, and nearly 5.3 million

partner victimizations occur each year among U.S. women ages 18 and older, resulting in 2 million injuries and 1,300 deaths (USDJ, 2001).

Intimate partner violence has long-term negative health consequences for women, even after the abuse has ended (Tollestrup et al., 1999). These effects can manifest as poor health status, poor quality of life, and high use of health services (Wisner et al., 1999). Battering is a significant direct and indirect risk factor for various physical health problems frequently seen in healthcare settings (Grisso et al., 1999). Battered women were more likely to have been injured in the head, face, neck, thorax, breasts, and abdomen than in other ways (Kyriacou et al., 1999). The Indian National Family Health Survey (2005-2006) found that 35% of 28,139 married women reported experiencing lifetime physical intimate partner violence (Bachman and Saltzman, 1995). From eastern India, a study of 1718 married women found that 16% were exposed to physical violence and 25% to sexual violence, while 52% suffered psychological abuse in their lifetime (Barron, 2004a). Similarly, a study from Iran of 2400 married women found that 15% had suffered physical abuse from their husbands in the previous year, 42% from sexual abuse, and 82% from various psychological abuse (Barron, 2004).

Domestic and intimate partner violence directly affect women's health during pregnancy and creates various health complications such as sexually-transmitted diseases, including HIV, urinary tract infections, substance abuse, depression, and other mental health symptoms (Mezey et al., 2001; Muhajarine & Ary, 1999). Depression and post-traumatic stress disorder are the most prevalent mental-health sequelae of intimate partner violence (Ratner, 1993).

Depression in battered women has also been associated with other life stressors that often accompany domestic violence, such as childhood abuse, daily stressors, changes in residence, forced sex with an intimate partner, marital separations, negative life events, and child behavior problems (Martin, 1998 and Parsons & Harper, 1999). Thus, the literature regarding domestic violence's physiological and psychological impacts is multi-dimensional.

Similarly, domestic violence against women is the cultural norm in Pakistan because of its men-dominant structure (Daraz, 2012). In the context of KP, Naz (2011) revealed that almost more than half of married women reported being kicked, slapped, beaten, or sexually abused when husbands were dissatisfied with their cooking or cleaning or when women had failed to bear a child or given birth to a girl instead of a boy. Due to domestic violence against women in Pakhtun society, women face serious health risks like miscarriage, pre-term labor, and injury to or death of the fetus (Humphreys and Thiara, 2003). This study investigates the impact of domestic violence against women on women's physical and psychological health in District Lower Dir, KP.

Methodology

This article is based on the data collected from Tehsil Adenzai, district lower Dir. As the study intended to investigate the impact of domestic violence on women's physical and psychological health, only women were selected for data collection. The study was conducted under the positivist paradigm. A structured interview schedule was designed for data collection. Part first of the interview schedule comprised some questions on the effect of domestic violence on women's physical health. However, the second part was composed of questions on the impact of

domestic violence on women's psychological health. Scales for the measurement of the effect of domestic violence on women's physio-psychological health were developed and tested for its validity through SPSS (a statistical package for the social sciences). It is pertinent to mention that the scales for the women's psychological effects of domestic violence were tested through the psychometric analysis technique. Data were collected from 125 respondents. SPSS was used for data management and extracting main contents. Descriptive and inferential statistics were used for the analysis of data. Descriptive statistics helped present the univariate analysis while discussing the frequency and percentage. Inferential statistics, such as chi-square and correlation, were used for bivariate analysis. The association and correlation between domestic

violence and women's physical and psychological health were analyzed through correlation and chi-square. How these statistical tests helped in the analysis of data is presented below.

Analysis and Results

The correlation between domestic violence and women's physical and psychological health was found through correlation presented in frequency and percentage. However, how domestic violence and women's physical and psychological health are associated are found through chi-square. These bivariate variables were associated with a 95% confidence interval (CI). The following table (table-1) presents the correlation between domestic violence and women's physical and psychological health.

Table-1 Effect of Domestic Violence on Women's Physical Health

Women's Physical Health	Frequency	Percentage
Injury (from a laceration to fractures and internal organ injury)	11	09%
Unwanted pregnancy	09	07%
Gynecological problem	08	06%
STDs (Sexually Transmitted Diseases)	17	14%
Miscarriage	10	08%
Pelvis inflammatory diseases	06	05%
Chronic pelvic pain	14	11%
Headaches	06	05%
Permanent disabilities	08	06%
Asthma	09	07%
Irritable bowel syndrome	12	10%
Self-injury	15	12%
Total	125	100%

The table expresses the physiological impacts of domestic violence against women, which directly or indirectly affect women's health. In this regard, 11(09%) respondents believed that domestic violence causes severe injury to women's health, ranging from lacerations to

fractures and internal organ injuries. In comparison, 9 (07%) respondents argue that domestic violence causes unwanted pregnancy, which further creates problems regarding women's health and pregnancy-related issues. In addition, 8 (06%)

respondents reflected that domestic violence produces gynecological problems. In comparison, a major portion of respondents, i.e., 17 (14%), strongly recommended that domestic violence causes STDs (Sexually Transmitted Diseases), which negatively impact women's health and can create futuristic problems.

The quantitative analysis further demonstrates that 10 and 06 (08%:05%) sequentially argue that domestic violence produces miserable impacts in the form of miscarriage and pelvic inflammatory diseases on victims. Women in rural Pakistan live miserable lives due to the frequent practice of domestic violence. Likewise, 14 (11%) and 06 (05%) respondents express that domestic violence produces chronic pelvic

pain and headaches among women and creates physiological disturbances regarding women's health. The data analyses expound that permanent disabilities and asthma are the major outcomes of domestic violence against women, as supported by 08 (06%) and 09 (06%) respondents systematically. Finally, the field data further demonstrate that domestic violence threatens women's health as supported by 12 (10%) and 15 (12%) respondents that domestic violence creates irritable bowel syndrome and self-injury to the physical health of victimized women among the target population. The tabulated data also has been verified through the following statistical test:

The Association between Domestic Violence and Women's Physical Health

Physiological Impacts	Domestic Violence		Total
	Mild	Severe	
Injury (from a laceration to fractures and internal organ injury)	02 (18%)	09 (82%)	11 (100%)
Unwanted pregnancy	01 (11%)	08 (89%)	09 (100%)
Gynecological problem	02 (25%)	06 (75%)	08 (100%)
STDs (Sexually Transmitted Diseases)	01 (06%)	16 (94%)	17 (100%)
Miscarriage	02 (20%)	08 (80%)	10 (100%)
Pelvic inflammatory diseases	02 (33%)	04 (67%)	06 (100%)
Chronic pelvic pain	03 (21%)	11 (79%)	14 (100%)
Headaches	02 (33%)	04 (67%)	06 (100%)
Permanent disabilities	01 (12%)	07 (88%)	08 (100%)
Asthma	01 (11%)	08 (89%)	09 (100%)
Irritable bowel syndrome	02 (17%)	10 (83%)	12 (100%)
Self-injury	03 (20%)	12 (80%)	15 (100%)
Total	22 (18%)	103 (82%)	125 (100%)
Chi-square = 2.456	Significance = 0.000**	Lambda = 0.12	Gamma = 0.025

($P=0.000^{**} < .05$ there is a highly significant relationship between physiological impacts and domestic violence ($\chi^2 = 2.456$, $D.f=6$)

The chi-square test, gamma, and lambda results show a highly significant relationship between the independent and dependent variables. The respondents' responses were

recorded in two-point categories (mild and severe impacts). The values of the chi-square test illustrate ($P=0.000^{**} < .05$ there is a highly significant relationship between

physiological impacts and domestic violence, $\chi^2 = 2.456$, D.f=6). The results further express that the dependent variable has a strong association and relationship with independent variables. Similarly, in association with the chi-square test, lambda, and gamma values further authenticate the

regressor variables' results with the regrets and variable, concluding that "Physiological impacts have a strong correlation with domestic violence" and thus verify the hypothetical discussion. The correlation of the two mentioned variables has been noted in the following correlation table:

Correlation

		Domestic Violence	Physiological Impacts
Domestic Violence	Pearson Correlation	1	0.925**
	Sig. (2-tailed)		.000
	N	125	125
Physiological Impacts	Pearson Correlation	.925**	1
	Sig. (2-tailed)	.000	
	N	125	125

(*Correlation is highly significant at the 0.05 level (2-tailed), $r(125) = 0.925^{**}$; $p < .01$. $r^2 = 0.86$)
(Since 86% of the variance is shared, the association is a strong one)

The correlation further validates the results in a manner that correlation is highly significant at the 0.05 level (2-tailed), $r(125) = 0.925^{**}$; $p < .01$. $r^2 = 0.86$; the association is strong since 86% of the variance is shared. It has

been concluded that there is a positive correlation between the independent variable, i.e., domestic violence, and the dependent variable, physiological impacts.

Table-2 Impact of Domestic Violence on Women's Psychological Health

Psychological Impacts	Frequency	Percentage
Trauma	09	07%
Depression	10	08%
Tension	11	09%
Anxiety	05	04%
Stress and strain	08	06%
Sleeping disorder	16	13%
Feeling shame and guilt	13	10%
Stress disorder	11	09%
Cognitive impairment	09	07%
Phobia	08	06%
Panic disorder	12	10%
Psychometric disorder	13	11%
Total	125	100%

The psychological impacts of domestic violence are also obvious and their impacts are apparent, as mentioned in the above table. The psychological and mental health of the victimized women has been observed from the field information, and the frequency concerning each ailment shows its particular ratio. In this regard, the psychological impacts of domestic violence, like trauma and depression, are supported by 9 (07%) and 10 (08%), the major concern of domestic violence in the community under study. Besides, 11 (09%) and 05 (04%) of the statistical information declare that domestic violence causes tension and anxiety among victimized women. In comparison, stress & strain, along with sleeping disorders as the psychological impacts of domestic violence, have been supported by 8 (06%) and 16 (13%) respondents simultaneously. Furthermore, the data reveals that domestic violence produces several psychological

consequences to women's health; likewise, 13 (10%) and 11 (09%) respondents supported feelings of shame and guilt and stress disorder as the consequences of domestic violence. In addition, 9 (07%) and 08 (06%) of the respondents were of the view that domestic violence creates cognitive impairment and phobia among victimized women, and 12 (10%) and 13 (11%) of the female expressed that domestic violence produces panic disorder and psychometric disorder that further produces health crises among such women. The information thus analyzes that domestic violence has multifarious psychological consequences that further strengthen the physiological ailment and reduces women's capacity in both physical and mental space and social and communal relations. The information has also been verified by applying the chi-square test in the following table.

The Association between Domestic Violence and Women's Psychological Health

Women's Psychological Health	Domestic Violence		Total
	Mild	Sever	
Trauma	01 (11%)	08 (89%)	09 (100%)
Depression	02 (20%)	08 (80%)	10 (100%)
Tension	02 (18%)	09 (82%)	11 (100%)
Anxiety	01 (20%)	04 (80%)	05 (100%)
Stress and strain	02 (25%)	06 (75%)	08 (100%)
Sleeping disorder	02 (12%)	14 (88%)	16 (100%)
Feeling shame and guilt	02 (15%)	11 (85%)	13 (100%)
Stress disorder	01 (09%)	10 (91%)	11 (100%)
Cognitive impairment	02 (22%)	07 (78%)	09 (100%)
Phobia	01 (12%)	07 (88%)	08 (100%)
Panic disorder	02 (17%)	10 (83%)	12 (100%)
Psychometric disorder	01 (08%)	12 (92%)	13 (100%)
Total	19 (15%)	106 (85%)	125 (100%)
Chi-square = 1.987	Significance = 0.000**	Lambda = 0.08	Gamma = 0.015

($P=0.000^{**} < .05$ there is a highly significant relationship between psychological impacts and domestic violence ($\chi^2 = 1.987, D.f=6$))

The chi-square test analyzes the results as ($P=.000^{**} < .05$ there is a highly significant relationship between psychological impacts and domestic violence, $\chi^2 = 1.987$, D.f=6), and these results demonstrate that random variables have a strong relationship with non-

random variable. The chi-square test results and the gamma lambda's numerical value fall in the acceptance region, which validates the proposed hypothesis. The data has also been judged through correlation analysis in the following table:

Correlation

		Domestic Violence	Psychological Impacts
Domestic Violence	Pearson Correlation	1	0.946**
	Sig. (2-tailed)		.000
	N	125	125
Psychological Impacts	Pearson Correlation	.946**	1
	Sig. (2-tailed)	.000	
	N	125	125

(*Correlation is highly significant at the 0.05 level (2-tailed), $r(125) = 0.946^{**}$; $p < .01$. $r^2 = 0.89$)
(Since 89% of the variance is shared, the association is a strong one)

The correlation further certifies the results like (*Correlation is highly significant at the 0.05 level (2-tailed), $r(125) = 0.946^{**}$; $p < .01$. $r^2 = 0.89$); since 89% of the variance is shared, the association is a strong one), which shows that there is a positive and simple correlation between the dependent and independent variable.

Conclusion

The analysis presented in this article concludes that domestic violence influences women's physical and psychological health in the district of lower Dir, KP. Physiologically, domestic violence causes injury, unwanted pregnancy, gynecological problems, sexually transmitted diseases(STDs), miscarriages, pelvic inflammatory diseases, chronic pelvic pain, headaches, permanent disabilities, asthma, and irritable bowel syndrome. The analysis also found the psychological effect of domestic violence on women's health.

Domestic violence causes trauma, depression, tension, anxiety, stress and strain, sleeping disorder, shame and guilt, stress disorder, cognitive impairment, phobia, panic disorder, and psychometric disorder. To enhance theoretical and practical understanding of the effect of domestic violence on women's physio-psychological health, this study suggests further research to explore how women deal with those men (probably husbands) who are involved in domestic violence. This study suggests that the local community/government should launch an awareness campaign to sensitize the masses to stop domestic violence against women.

References

1. Bachman, R., and Saltzman, L.E. (1995). Violence against women: estimates from the redesigned survey. Washington, DC: Bureau of

- Justice Statistics, National Institute of Justice, 1995.
2. Barron, J. (2004a). *Health and Domestic Violence: Two Years on Survey 2002-2003* Bristol: Women's Aid.
 3. Barron, J. (2004b). *Struggle to Survive: Challenges for Delivery of Services on Mental Health, Substance Misuse and Domestic Violence. Report of Findings of Survey* Bristol: Women's Aid.
 4. Barron, J. (2005). *Domestic Violence, Mental Health and Substance Misuse Project - Good Practice Guidelines* Bristol: Women's Aid.
 5. Bradley, F., Smith, M., Long, J., and O'Dowd, T. (2002). 'Reported Frequency of Domestic Violence: Cross-Sectional Survey of Women Attending General Practice' *British Medical Journal* 324, 2 February 271-274.
 6. Campbell, J., Jones, A.S., Dienemann, J., Kub, J., Schollenberger, J., O'Campo, P., Gielen, A. C. and Wynne, C. (2002). 'Intimate partner violence and physical health consequences', *Archives of Internal Medicine*, vol. 162, no. 10, pp. 1157-1163.
 7. Coker, A. L., Sanderson, M., Fadden, M. K. and Pirisi, L. (2000). 'Intimate partner violence and cervical neoplasia', *Journal of Women's Health & Gender-based Medicine*, vol. 9, no. 9, pp. 1015-1023.
 8. Department of Health (2000). *Domestic Violence: A Resource Manual for Health Professionals* London: Department of Health.
 9. Fischbach, R.L. and Herbert, B. (1997). 'Domestic violence and mental health: correlates and conundrums within and across cultures', *Social Science and Medicine*, vol. 45, no. 8, pp. 1161-1176.
 10. Gerbert, B., Abercrombie, P., Caspers, N., Love, C. and Bronstone, A. (1999). 'How health care providers help battered women: the survivors' perspective', *Women and Health*, vol. 29, no. 3, pp. 115-135.
 11. Grisso, J.A., Schwarz, D.F., and Hirschinger, N. (1999). 'Violent injuries among women in an urban area. *N Engl J Med* ; 341: 1899-1905.
 12. Guth, A. A. and Pachter, L. H. (2000). 'Domestic violence and the trauma surgeon', *The American Journal of Surgery*, vol. 179, no. 2, pp. 134-140.
 13. Hagemann-White, C. (2006). *Combating violence against women. Stocktaking study on the measures and actions taken in Council of Europe Member States.* Strasbourg Directorate General of Human Rights, Council of Europe.
 14. Hanmer, J. (2000). *Domestic Violence and Gender Relations: Contexts and Connections* in Hanmer, J. and Itzin, op cit 9-23.
 15. Hollins, S. and Sinason, V. (2000). 'Psychotherapy, Learning Disabilities and Trauma: New Perspectives' *British Journal of Psychiatry* 176 pp 32-36.
 16. Humphreys, C. and Thiara, R. (2003). 'Mental Health and Domestic Violence: "I Call It Symptoms of Abuse"' *British Journal of Social Work* 33 209-226.

17. Irene, L. (2020). Older Women's Experiences of Intimate Partner Violence: A Phenomenological Study.
18. Jones, A.S., Campbell, J.C., and Schollenberger, J. (1999). Women's Health Issues; Annual and lifetime prevalence of partner abuse in a sample of female HMO enrollees. *9: 6: 295–305.*
19. USDJ (2001). Intimate Partner Violence. U.S. Department of Justice. Bureau of Justice Statistics. Crime Data Brief.
20. Indian National Family Health Survey (2005-2006). The Impacts of IPV (Intimate Partner violence and their consequences).
21. Kevin, Smith., Kathryn, Coleman., Simon, Eder., and Philip, Hall. (2011). "Homicides, Firearm Offences and Intimate Violence 2009/10". Home Office. <http://webarchive.nationalarchives.gov.uk/20110218135832/http://rds.homeoffice.gov.uk/rds/pdfs11/hosb0111.pdf>. Retrieved December 1, 2011.
22. Kyriacou, D.N., Anglin, D., and Taliaferro, E. (1999). Risk factors for injury to women from domestic violence against women. *N Engl J Med ; 341: 1892–98.*
23. Lutgendorf, M. A. (2019). Intimate partner violence and women's health. *Obstetrics & Gynecology, 134(3), 470-480.*
24. Martin, S.L., Kilgallen, B., Dee, D.L., Dawson, S., and Campbell, J.C. (1998). Women in a prenatal care/substance abuse treatment program: links between domestic violence and mental health. *Matern Child Health J 1998; 2: 85–94.*
25. Maman, S., Mbwambo, J., Hogan, N. and Kilonzo, G. (2002). 'HIV-positive women report more lifetime partner violence: findings from a voluntary counseling and testing clinic in Dares Salaam, Tanzania', *American Journal of Public Health, vol. 92, no. 8, pp. 1331-1337.*
26. Memmott, P., Stacy, R., Chambers, C. and Keys, C. (2001). Violence in Indigenous Communities, National Crime Prevention, Commonwealth Attorney-General's Department, Canberra.
27. Mertin, P. and Mohr, P. (2000). 'Incidence and correlates of posttraumatic stress disorder in Australian victims of domestic violence', *Journal of Family Violence, vol. 15, no. 4, pp. 411-422.*
28. Mezey, G.C., Bacchus, L, Bewley, S., and Haworth, A. (2001). An exploration of the prevalence, nature and effects of domestic violence in pregnancy. Surrey: Violence Research Program, University of London.
29. Molina, L, D. and Basinait-Smith, C. (1998). 'Revisiting the intersection between domestic abuse and HIV risk', *American Journal of Public Health, vol. 88, no. 8, pp. 1267-1268.*
30. Modi, M. N., Palmer, S., & Armstrong, A. (2014). The role of Violence Against Women Act in addressing intimate partner violence: A public health issue. *Journal of women's health, 23(3), 253-259.*

31. Muhajarine, N. D. and Ary, C. (1999). Physical abuse during pregnancy: prevalence and risk factors. *Can Med Assoc J* 1999; 160: 1007–11.
32. Naz, A. (2011). Socio-cultural and political constraints to women empowerment in Pakhtun society. PhD, Dissertation Department of Anthropology; Quaid-e-Azam University Islamabad.
33. Naz, A. and Rehman, H. (2011). Socio-economic and Political Obstacles in women's empowerment in Pakhtun society of District Dir Lower Khyber Pakhtunkhwa Pakistan. *FWU Journal of Social Science. Frontier Women University Peshwar. Vol-5 (1) PP.51-72, ISSN: 1995-1272.*
34. Parker, B., McFarlane, J., Soeken, K., Torres, S., and Campbell, D. (1993). Physical and emotional abuse in pregnancy: a comparison of adult and teenage women. *Nurs Res*; 42: 173–78.
35. Parker, G. and Lee, C. (2002a). 'Violence and abuse: an assessment of mid-aged Australian women's experiences', *Australian Psychologist*, vol. 37, no. 2, pp. 142-148.
36. Parker, G. and Lee, C. (2002b). 'Predictors of physical and emotional health in a sample of abused Australian women', *Journal of Interpersonal Violence*, vol. 17, no. 9, pp. 987-1001.
37. Parsons, L.H and Harper, M.A. (1999). Violent maternal deaths in North Carolina. *Obstet Gynecol*; 94: 990–93.
38. Poole, G. V., Martin, J. N., Perry, K. G., Griswold, J. A., Lambert, C. J. and Rhodes, R. S. (1996). Trauma in pregnancy: the role of interpersonal violence, *American Journal of Obstetrics and Gynecology*, vol. 174, no. 6, pp. 1873- 1876.
39. Queensland Health (2001). Initiative to Combat the Health Impact of Domestic Violence Against Women: Stage 2 Report, Queensland Government
[<http://www.health.qld.gov.au/violence/domestic/dvpubs/Stage2tmcol.PDF>].
40. Ramsden, M. & Bonner, M. (2002). 'A realistic view of domestic violence screening in an emergency department', *Accident and Emergency Nursing*, vol. 10, no. 1, pp. 31- 39.
41. Rutherford, A., A. B. Zwi, N.J. Grove, and A. Butchart (2007). "Violence: a priority for public health? (part 2)." *J Epidemiol Community Health* 61(9): 764-770.
42. Ratner, P.A. (1993). The incidence of wife abuse and mental health status in abused wives in Edmonton, Alberta. *Can J Public Health* 1993; 84: 246–49.
43. Rhodes, K. V. and Levinson, W. (2003). 'Interventions for intimate partner violence against women', *JAMA*, vol. 289, no. 5, pp. 601-605.
44. Roberts, G., Lawrence, J., O'Toole, B. and Raphael, B. (1997). 'Domestic violence in the emergency department 1: two case-control studies of victims', *General Hospital Psychiatry*, vol. 19, no. 1, pp. 5-11.

45. Robinson, K. (1999). "It's no life, this fear": women's experiences of services when in situations of family violence', *Australian Journal of Primary Health*, vol. 5, no. 1, pp. 53-59.
46. Ratner, P.A. (1993). The incidence of wife abuse and mental health status in abused wives in Edmonton, Alberta. *Can J Public Health*; 84: 246-49.
47. Sethi, D. (2006). Injuries and violence in Europe: why they matter and what can be done. WHO Regional Office Europe.
48. Siemieniuk, R.A.C., Krentz, H.B., Gish, J.A., and Gill, M.J. (2010). "Domestic Violence Screening: Prevalence and Outcomes in a Canadian HIV Population". *AIDS Patient Care and STDs* 24 (12): 763-770. doi:10.1089/apc.2010.0235. PMID 21138382.
49. Stenson, K., Saarinen, H., Heimer, G. and Sidenvall, B. (2001). 'Women's attitudes to being asked about exposure to violence', *Midwifery*, vol. 17, no. 1, pp. 2- 10.
50. Sutherland, C. A., Bybee, D. I. and Sullivan, C. M. (2002). 'Beyond bruises and broken bones: the joint effects of stress and injuries on battered women's health', *American Journal of Community Psychology*, vol. 30, no. 5, pp. 609- 636.
51. Taft, A. (2001). 'Intimate partner abuse in pregnancy', *O & G*, vol. 3, no. 4, pp. 250-253.
52. Tjaden, Patricia., and Thoennes, Nancy. (2000). "Full Report of the Prevalence, Incidence, and Consequences of Violence Against Women". National Institute of Justice, United States Department of Justice. <http://www.nij.gov/pubs-sum/183781.htm>.
53. Tollestrup, K., Sklar, D., and Frost, F.J.(1999). Health indicators and intimate partner violence among women who are members of a managed care organization. *Prev Med* 1999; 29: 431-40.
54. Webster, J., Chandler, J. and Battistutta, D. (1996). 'Pregnancy outcomes and health care use: effects of abuse', *American Journal of Obstetrics and Gynecology*, vol. 174, no. 2, pp. 760-767.
55. Webster, J., Stratigos, S. M. and Grimes, K. M. (2001). 'Women's responses to screening for domestic violence in a healthcare setting', *Midwifery*, vol. 17, no. 4, pp. 289- 294.
56. WHO (2008). Domestic violence against women and their implication.
57. Widding, L., Grimstad, H., Moller, A., Schei, B., and Janson, P.O. (1999). Prevalence of physical and sexual abuse before and during pregnancy among Swedish couples. *ACTA Obstet Gynecol Scand* , 78: 310-15.
58. Wisner, C.L., Gilmer, T.P., Saltzman, L.E., Zink, T.M. (1999). Intimate partner violence against women: do victims cost health plans more? *J Fam Pract* ; 48: 439-43.
59. Zainab, D. (2003). The effects of domestic violence to the status of women in kisenyi ii parish-Kampala, central division.