Partner violence is increasingly being recognized as a serious public health concern in developing countries. Recent studies in India for instance, have shown that a significant number of Indian women experience physical abuse and violence. One study indicated that between 22 to 60 percent of women in India had experienced physical violence (Visaria et al., 1999). With a substantial rise in the efforts of women's groups and a concurrent availability of data from qualitative and quantitative surveys, the problem of domestic violence in general and partner violence in particular is gradually being recognized as a serious impediment to development.

Partner violence stemming from such gender-based power struggles can have a multitude of negative effects on women's health. Apart from the immediate physical injury, long-term mental agony, and unwanted pregnancies, partner violence may increase the risk of sexually transmitted infections including HIV. It is widely being recognized that women's vulnerability to HIV/AIDS is only partly a matter of biology. Gender inequalities in the socioeconomic and cultural realms increase women's risk of HIV/AIDS and other sexually transmitted diseases disproportionately. Experiences of abuse by an intimate partner may not only render women powerless, but also make it difficult for them to negotiate safe sex within their sexual relationship (Zierler & Krieger, 1997; Maman et al., 2000).

Yet, research on partner violence is sparse, comprising largely of qualitative studies and small sample sizes. Also, research on domestic/partner violence is largely limited to the factors associated with such violence and very little has been done on addressing the consequences of such violence. Our study focuses on ever-married women in India and their experience of partner violence. In an attempt to address some

of these gaps in current research on this topic, this paper attempts to answer three research questions: (1) What is the association between partner violence and identified risk factors of HIV/AIDS and other STIs? (2) What is the association between partner violence and contraceptive use? (3.) What is the association between partner violence and STIs?

Data

We use a large nationally representative sample of over 84000 women from the National Family Health Survey conducted in India in 1998/99. Nearly 85 percent of this group of women indicates some experience of spousal violence. Among those who have experienced violence, a quarter has experienced it a few times, while nearly 13 percent have experienced violence many times.

In the absence of direct measures that can be used to estimate the risk of HIV and other STIs, our risk factors of HIV/AIDS include the use of condoms and knowledge of HIV/AIDS. Spousal discussion about contraception not only provides a measure of wives' participation in marital decision-making, but is also a proxy for the ability to negotiate condom use. We assume that when there is spousal discussion about contraception, the opinion of the wife is considered important in making life choices and under these circumstances, a wife is likely to have more negotiating power. Common symptoms of STIs like burning sensation, fever, bleeding are used as indirect indicators of STIs.

Multivariate logistic regression is used to model the association between partner violence and our 3 sets of outcome variables. Based on theoretical considerations, our regression models control for a host of socio-demographic factors that are considered in

the literature to have a confounding effect in the relation between spousal violence and risk of STIs.

Preliminary results show that women who have experienced spousal violence are significantly less likely to have discussed contraceptive use with their husbands. Although knowledge of HIV/AIDS does not vary significantly with the experience of spousal violence, women who have experienced partner violence are more likely to present symptoms of STIs.

Limitations

Our cross-sectional data does not allow for causal links between spousal violence and the risk of HIV/AIDS. Also, our measures of STI risks are indirect measures that can only be used as proxies for more direct measures. Yet, this analysis is an example of creative use of data when direct measures are unavailable. Also, when HIV/AIDS among other STIs is increasingly becoming a health concern in India, and when Indian women are subjected to cultural constraints and possible spousal abuse, it is pertinent that a link between them be studied. This analysis is a stepping-stone in that direction.