



Original Research Article

SOCIODEMOGRAPHIC AND CONTEXTUAL DETERMINANTS OF INTIMATE PARTNER VIOLENCE AMONG MARRIED MIGRANT SLUM WOMEN OF ALIGARH: A CROSS-SECTIONAL ANALYSIS

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ABSTRACT

Background: According to the WHO, 30% of women globally have experienced intimate partner violence (IPV). Migrant women are at heightened risk due to various barriers. This study was conducted among married women residing in slum areas of Aligarh with the aim of estimating the prevalence of different forms of IPV from their husbands and their associations with socio-demographic factors.

Materials and Methods: A cross-sectional study was conducted using simple random sampling with PPS from April to December 2024. The samples comprised 555 ever-married migrant women aged 18-49 from an urban slum area in Aligarh, who were administered the Revised Conflict Tactics Scale (CTS-2) to estimate the prevalence of IPV. Data were analysed using IBM SPSS, employing proportions, frequencies, and chi-square tests.

Results: Among the 555 married migrant women interviewed, 48.6% had experienced some form of intimate partner violence (IPV). Physical violence was reported by 44.3%, sexual violence by 35.7%, and emotional violence by 17.5%. The majority of women experiencing IPV were aged 18-39 years, Muslim (61.1%), and belonged to the OBC category (68.8%). Illiteracy was prevalent among both women (58.7%) and their husbands (49.4%). Most women were unemployed (92.1%), while their husbands were engaged in unskilled or semi-skilled occupations. Nearly half of the respondents were married before the age of 18, and 61.3% had more than three children. Nuclear families predominated (66.5%), and 80.5% had normal vaginal deliveries, with 25.6% reporting home deliveries. These sociodemographic and reproductive characteristics reflect multiple vulnerabilities that may contribute to the elevated risk of IPV in this population.

Conclusion: This study found a high prevalence of IPV among married migrant slum women, mainly physical, followed by sexual and emotional forms. Significant associations were observed with younger age, lower female education, Muslim religion, early marriage, higher parity, and employment. Other factors showed non-significant patterns. The use of CTS2 enhanced reporting, especially of sexual violence. Findings highlight the need for targeted interventions addressing early marriage, education, reproductive burden, and migrant vulnerabilities.

Keywords: Intimate partner violence; sociodemographic factors; prevalence; slums, migrants.

INTRODUCTION

Intimate partner violence is one of the most common forms of violence against women. IPV is a huge problem globally, with 1 in 3 women estimated to face it sometime in their lives. In India, besides, IPV is abundant, though often underreported. Various factors contribute to this problem, including cultural, socioeconomic, and educational influences. IPV is more prevalent in developing nations (Yonfa et al., 2021). Intimate Partner Violence (IPV) is a significant public health issue in India. 38.4% of married women between the ages of 18 and 49 reported having experienced partner violence at least once, according to the National Family Health Survey-5. While violence is a part of life in all social categories, it is more common and severe in lower socioeconomic groups in a variety of situations, including the USA, Nicaragua, and India (Martin et al., 1999). Economic disparities are a significant factor, as there is a correlation between higher income inequality and increased rates of IPV (Chaurasia et al., 2021). The national average is 32%, representing the percentage of spousal violence nationwide. Highest Rates: Karnataka (48%), Uttar Pradesh (39%), and other states have the highest rates of domestic violence. Compared to the national average, these rates are noticeably greater. Lowest Rates: With 2.1%, the lowest rate of domestic violence in India is seen in Lakshadweep, well below the national average. Intimate partner violence occurs in all settings and among all socioeconomic, religious, and cultural groups. IPV refers to any behaviour within an intimate relationship that causes physical, psychological, or sexual harm to those in the relationship. Migrant women may experience considerable multifaceted and interrelated barriers that place them at heightened risk for intimate partner violence (WHO RHR, 2019).

Intimate Partner Violence (IPV) is a significant public health concern among married women of reproductive age, with a national prevalence of 32.7% as reported in NFHS-5. IPV is associated with adverse outcomes, including psychological distress, reproductive health problems, and reduced utilization of healthcare services. Migrant women residing in urban slums are particularly vulnerable due to socio-economic hardships, migration-related stressors, and limited access to support systems. Despite the magnitude of the issue, IPV in this population remains insufficiently explored. This study aims to examine the prevalence of IPV among married migrant slum women of Aligarh and the association of IPV with socio-demographic factors and its determinants.

MATERIALS AND METHODS

Study setting: A community-based cross-sectional study was performed in Aligarh from April 2024 to

December 2024. Aligarh, located in Uttar Pradesh, India, has an estimated population of 1,346,000 as of 2024. Occupants belong mostly to the migrant population below the poverty line. The main occupations are daily labourers, vendors, domestic help, and small businesses. Slums in Aligarh are mostly located along the roadside (43%), market areas (9%), railway lines (8%), and other areas (22%). District Aligarh is in Uttar Pradesh, 342km northwest of the state capital Lucknow and approximately 130 km southeast of INDIA's capital, New Delhi. The latitude is 27.88 North and 70.08o East. The district is fortunate to have a reputed central university named Aligarh Muslim University, established by Sir Syed Ahmed Khan in 1875-78, which offers more than 300 courses.

Sample size

The sample size was calculated by applying the formula $n = Z^2PQ/d^2$, where Z is 1.96 at a 95% confidence interval, P is 32.7%, Q = (100-p) = 67.3% and 'd' (absolute precision) is taken as 4%. The calculated sample size, by adding a 5% non-response rate, comes out to be 555.

Data collection

A comprehensive list of all registered slums and eligible couples within the Aligarh district, Uttar Pradesh, India, was obtained from the Municipal Corporation of Aligarh. Out of 57 slums, 4 slums were selected randomly. To enhance logistical feasibility and data collection efficiency, the sample was drawn from the four geographically closest slums. A sample of married women within the reproductive age group (18-49 years) was selected using simple random sampling with PPS. Any woman unwilling to participate was excluded and moved to the next household. All married women between 18 and 49 years old who were willing to give consent for participation in the study were included. If there were more than one married woman in a house, then one woman was randomly selected. Married women who were divorced, widowed, or unwilling to participate were excluded. Before collecting the data, the respondent was informed about the purpose of the interview, and her informed and written consent was obtained. Participants were assured of anonymity and confidentiality. Participants were also given the option to withdraw from the interview at any time they felt uncomfortable. Privacy was maintained throughout the interview. Data was collected via one-to-one interviews in a pre-validated and semi-structured questionnaire. The questionnaire was divided into two parts. Part I included all socio-demographic details of the eligible women. Part II included the types of intimate partner violence and personal behaviours. Ethical clearance was obtained from the Institution's Ethics Committee before proceeding with data collection.

Variable under study

Dependent variable - the dependent variable was considered as women who had ever experienced violence from their husbands. Women were asked

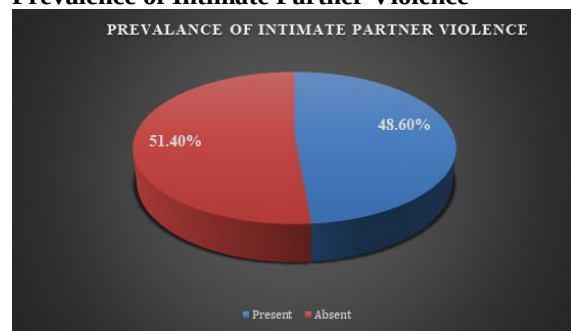
questions to measure the violence from husbands, related to physical, sexual, and emotional violence, as listed in Table I. A “yes” response to one or more of the above items was considered as having ever experienced violence by a husband. Independent variables - Information regarding socio-demographic, economic, reproductive, and marital characteristics.

Statistical Analysis

Data collected were entered in Microsoft Excel, and analysis was done using SPSS 20.0 software. The baseline characteristics of the socioeconomic variables, along with the prevalence of women experiencing IPV, were obtained. Then, the association between IPV and various factors was found using the Chi-square test. $P < 0.05$ was considered statistically significant.

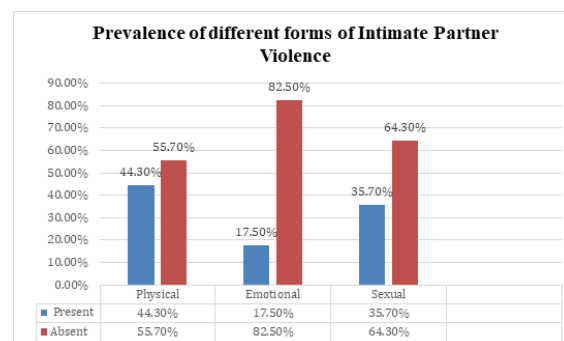
RESULTS

Prevalence of Intimate Partner Violence



This chart illustrates the prevalence of intimate partner violence (IPV) among married migrant women residing in urban slums of Aligarh, directly addressing the first objective of the study. Out of the

total 555 participants, 48.6% reported experiencing IPV, while 51.4% did not report any such experience. The nearly equal distribution highlights a high burden of IPV in this marginalized population.



The bar chart presents the distribution of different forms of intimate partner violence (IPV) reported by married migrant women residing in urban slums of Aligarh, in line with the first study objective: To estimate the prevalence of IPV in this population. Among the various types, physical violence was the most commonly reported, experienced by 44.3% of respondents. This was followed by sexual violence, reported by 35.7% of women, while emotional violence was the least reported, with a prevalence of 17.5%. This pattern highlights the predominance of overt forms of IPV—particularly physical abuse—in the study population, suggesting a high burden of direct bodily harm and coercion within intimate relationships. The relatively lower reporting of emotional violence

Table 1: Frequency of study participants having experienced various forms of violence by their husbands in the urban slum area of Aligarh

CHARACTERISTIC	FREQUENCY(N=555)	%
1. PHYSICAL IPV		
Pushing, shaking, or throwing an object		
Yes	100	18.0
No	455	82.0
Total	555	100.0
Slapping		
Yes	234	42.2
No	321	57.8
Total	555	100.0
Pulling hair or twisting an arm		
Yes	90	16.2
No	465	83.8
Total	555	100.0
Punching or hitting with a fist or something harmful		
Yes	21	3.8
No	534	96.2
Total	555	100.0
Kicking or dragging		
Yes	5	0.9
No	550	99.1
Total	555	100.0
Choking or burning		
Yes	5	0.9
No	550	99.1
Total	555	100.0

2. EMOTIONAL IPV		
Jealousy or anger if she talked to other men		
Yes	26	4.7
No	529	95.3
Total	555	100.0
Humiliated in front of others		
Yes	57	10.3
No	498	89.7
Total	555	100.0
Insulted and made to feel bad about herself		
Yes	26	8.3
No	509	91.7
Total	555	100.0
Asked to leave the home		
Yes	42	7.6
No	513	92.4
Total	555	100.0
3. SEXUAL IPV		
Forced to have sex		
Yes	198	35.7
No	357	63.4
Total	555	100.0

Table 2: Percentage of Study Population ever experienced violence by their husband in the urban slum, Aligarh

CHARACTERISTIC	IPV present		IPV absent		Total		P value
	No.	%	No.	%	No.	%	
1. WOMEN'S AGE (YEARS)							
18-29	131	48.5	128	44.9	259	46.7	0.56
30-39	119	44.1	130	45.6	249	44.9	
40-49	20	7.4	27	9.5	47	8.4	
Total	270	100.0	285	100.0	555	100.0	
2. RELIGION							
Hindu	123	45.6	93	32.6	216	38.9	0.002
Muslim	147	54.4	192	67.4	339	61.1	
others	00	00	00	00	00	00	
Total	270	100.0	285	100.0	555	100.0	
3. CASTE							
General	27	10.0	45	15.8	72	13.0	0.076
OBC	192	71.1	190	66.7	382	68.8	
SC/ST	46	17.0	49	17.2	95	17.1	
Do not know	5	1.9	1	0.4	06	1.1	
Total	270	100.0	285	100.0	555	100.0	
4. TYPE OF FAMILY							
Nuclear	190	70.4	179	62.8	369	66.5	0.059
Joint	80	29.6	106	37.2	186	33.5	
Total	270	100.0	285	100.0	555	100.0	
5. EDUCATION OF WOMEN							
Illiterate	161	49.4	165	50.6	326	58.7	0.022
Primary school	32	47.8	35	52.2	67	12.1	
Middle school	29	43.3	38	56.7	67	12.1	
High school	37	63.8	21	36.2	58	10.5	
Intermediate	10	35.7	18	64.3	28	5.0	
Graduate /postgraduate	1	11.1	8	88.9	9	1.6	
Total	270	100.0	285	100.0	555	100.0	
6. EDUCATION OF HUSBAND							
Illiterate	140	51.1	134	48.9	274	49.4	0.113
Primary school	22	55.0	18	45.0	40	7.2	
Middle school	55	43.7	71	56.3	126	22.7	
High school	33	40.2	49	59.8	82	14.8	
Intermediate	13	72.2	5	27.8	18	3.2	
Graduate /postgraduate	7	46.7	8	53.3	15	2.7	
Total	270	100.0	285	100.0	555	100.0	
7. OCCUPATION OF WIFE							
Unemployed	240	47.0	271	53.0	511	92.1	0.007
Employed	30	68.2	14	31.8	44	7.9	
Total	270	100.0	285	100.0	555	100.0	
8. OCCUPATION OF HUSBAND							
Unemployed	7	63.6	4	36.4	11	2.0	0.15
Unskilled worker	139	52.3	127	47.7	266	48.0	
Semi-Skilled/Skilled worker	119	43.6	154	56.4	273	49.1	
Professional	5	100.0	00	0.0	5	0.9	
Total	270	100.0	285	100.0	555	100.0	

The sociodemographic characteristics of the 555 married migrant women residing in urban slums of Aligarh revealed several key patterns relevant to the study of intimate partner violence (IPV). Nearly half of the participants were aged 18–29 years (46.7%), followed closely by those aged 30–39 years (44.9%), with a smaller proportion aged 40–49 years (8.4%). The majority of respondents identified as Muslim (61.1%), while 38.9% were Hindu. Most women belonged to the Other Backwards Classes (OBC) category (68.8%), followed by the Scheduled Castes/Scheduled Tribes (17.1%) and General category (13%). Educational attainment among women was low, with 58.7% being illiterate and only 1.6% having completed graduation or higher

education. A similar trend was observed among their spouses, with 49.4% of husbands being illiterate and only 2.7% holding graduate or postgraduate degrees. Regarding occupational status, the vast majority of women were unemployed (92.1%), whereas their husbands were mostly engaged in unskilled (48.0%) or semi-/skilled labour (49.1%), with only a small fraction in professional roles (0.9%). Nuclear families were more prevalent (66.5%) than joint families (33.5%). These sociodemographic factors are essential in understanding the contextual vulnerabilities of the study population and may have significant associations with the risk and prevalence of IPV.

Table 3: Percentage of the Study population's marital status having ever experienced violence by their husband in the urban slum, Aligarh

Urban slum, Angam

CHARACTERISTIC	IPV present		IPV absent		Total		P value
	No.	%	No.	%	No.	%	
1. AGE AT MARRIAGE							
< 18yrs	149	55.2	119	41.8	268	48.3	0.002
18-24yrs	115	42.6	150	52.6	265	47.7	
>24yrs	6	2.2	16	5.6	22	4.0	
Total	270	100.0	285	100.0	555	100.0	
2. DURATION OF MARRIAGE(YEARS)							
<5	72	26.7	77	27.0	149	26.8	0.102
5-10	123	45.6	104	36.5	227	40.9	
11-15	36	13.3	53	18.6	89	16.1	
>15	39	14.4	51	17.9	90	16.2	
Total	270	100.0	285	100.0	555	100.0	
3. PARITY							
<3	83	38.6	132	61.4	215	38.7	0.001
>3	187	55.0	153	45.0	340	61.3	
Total	270	100.0	285	100.0	555	100.0	
4. PLACE OF DELIVERY							
Home delivery	90	63.4	52	36.6	142	25.6	0.001
Private	61	52.6	55	47.4	116	20.9	
Government	119	40.1	178	59.9	297	53.5	
Total	270	100.0	285	100.0	555	100.0	
5. MODE OF DELIVERY							
Normal delivery	213	47.7	234	52.3	447	80.5	0.339
Caesarean section	57	52.8	51	47.2	108	19.5	
Total	270	100.0	285	100.0	555	100.0	

The reproductive and marital profile of the 555 married migrant women included in the study provides crucial context for understanding the potential determinants of intimate partner violence (IPV). Nearly half of the women (48.3%) were married before the age of 18 years, and another 47.7% were married between 18–24 years, indicating that a vast majority had early or moderately early marriages. Only a small proportion (4.0%) married after 24 years of age. Early marriage is a well-established risk factor for IPV, often linked to reduced autonomy, dependency, and limited access to education or support systems.

Regarding the duration of marriage, most women (40.9%) had been married for 5–10 years, followed by 26.8% married for less than 5 years. Women married for 11–15 years and those with over 15 years of marital duration constituted 16.1% and 16.2%, respectively. These distributions reflect a broad range of marital exposure, potentially

affecting IPV dynamics through varying levels of marital adjustment and accumulated stressors.

Parity was also skewed toward higher reproductive burden, with 61.3% of women having more than three children. High parity may contribute to increased household strain, caregiving responsibilities, and economic challenges, which are known to exacerbate the risk of IPV in vulnerable populations.

The place of delivery showed that more than half of the women (53.5%) delivered in government health facilities, while 25.6% had home deliveries and 20.9% delivered in private facilities. The relatively high proportion of home deliveries may reflect barriers in access to institutional healthcare, which can be intertwined with poor maternal health outcomes and heightened exposure to IPV.

Lastly, the mode of delivery data indicated that 80.5% of the women had undergone normal vaginal delivery, whereas 19.5% had caesarean sections. Although the mode of delivery alone may not be a

direct determinant of IPV, it can serve as an indicator of maternal healthcare access and outcomes, which are often shaped by broader gender and social inequities.

Together, these reproductive and marital characteristics not only contextualise the lived experiences of the study population but also provide essential variables for examining associations with IPV.

DISCUSSION

In the present study, among married migrant slum women, the overall prevalence of intimate partner violence (IPV) was found to be 48.6%. Physical violence was the most common form (44.3%), followed by sexual (35.7%) and emotional violence (17.5%), with 8.1% of women experiencing all three forms. Slapping was the most frequently reported physical act (42.2%), while severe forms like choking or kicking were rare. Emotional abuse primarily included humiliation (10.3%) and insults (8.3%). The Revised Conflict Tactics Scale (CTS2) was used for IPV assessment due to its detailed, behaviour-specific structure, which likely enhanced disclosure, particularly of sensitive issues like sexual violence. This tool, validated in earlier studies by Delkhosh et al., Pearson et al., Zakar et al., Surjeet et al., and Dasgupta et al., provided more precise estimates compared to general IPV tools used in NFHS or WHO surveys. When compared to other studies, our IPV prevalence lies in the mid to higher range. Jyotirmay et al. (2022) reported a higher prevalence (70.3%) in a rural tribal setting using IFVCS, while Jungari et al. (2022) reported a much lower rate (15.6%) in urban slums of Pune, possibly due to underreporting or tool sensitivity. Parvin et al. (2016) found 60% IPV among slum women, with slapping as the most common act (56%), similar to our findings. Donta et al. (2015) and Manna et al. (2024) reported lower IPV prevalence (21.2% and 26.21%, respectively), with Manna noting a higher rate of physical violence (60%) but low sexual (2.15%) and emotional (9.54%) IPV. Shrivastava and Shrivastava (2013) reported 36.9% IPV, predominantly verbal abuse (86.1%). Overall, our findings reflect a high burden of IPV among migrant slum women, particularly in physical and sexual domains, and emphasise that variations across studies likely result from differences in population characteristics, sociocultural context, and the specificity of tools used for IPV assessment.

In our study, the prevalence of intimate partner violence (IPV) was found to be highest among women aged 18–29 years (48.5%), followed by 30–39 years (44.1%), and lowest among those aged 40–49 years (7.4%). This pattern shows that younger women were more affected by IPV compared to older age groups. A similar age distribution was observed in the study by Jungari et al. (2022),

conducted in the urban slums of Pune, where 46.6% of the participants were below 24 years, and 44.4% were between 25–30 years. While their study did not directly report IPV prevalence by age group, the younger age structure of the sample suggests similar risk patterns. Ler p et al. (2020) also reported that IPV was most common among women aged 15–24 years (29.1%), followed by 25–34 years (28.2%), and declined to 21.3% among women aged 35–49 years. This age-wise decline in IPV prevalence is consistent with our findings and supports the understanding that younger women may face greater vulnerability. Likewise, Jyotirmay et al. (2022) reported that over half (51.1%) of their participants were aged 15–29 years, which aligns with the age group in our study with the highest IPV prevalence. Although their study was based in a tribal population and ours in an urban slum, both point to a similar trend where IPV is more common in early reproductive years. The consistent pattern across these studies suggests that younger age is an important factor associated with IPV. This may be due to the early years of marriage, being newly married, hesitating to speak up, having less experience in handling relationships, and greater dependency on partners, all of which may increase vulnerability to violence. In our study, the majority of women who reported experiencing IPV belonged to the OBC category (71.1%), followed by SC/ST (17.0%) and General caste (10.0%). However, the association between caste and IPV was not statistically significant ($p = 0.07$). In contrast, Manna et al. (2024) observed a different pattern, where IPV was more commonly reported among SC women (31.31%), followed by ST (28.58%), OBC (27.67%), and others (20.17%). Similarly, NFHS-5 (2019–21) reported a higher prevalence of IPV among ST (39.3%) and SC (34.6%) women compared to OBC (29.5%) and General category women (22.0%). These findings highlight a consistently higher burden of IPV among socially disadvantaged caste groups. Although our study did not show a statistically significant association, the higher proportion of IPV among OBC women reflects their dominance in the study population and may point to underlying vulnerabilities. Differences could influence the variation across studies in regional caste compositions, sample sizes, and study settings. In the present study, among 555 married women residing in an urban slum area, the Prevalence of IPV was higher among Muslims (54.4%) compared to Hindus (45.6%), and a statistically significant association (p value = 0.002) was observed between religion and IPV. This pattern is supported by Dasgupta et al. (2019), who also found higher IPV among Muslim women (58.9%) in Mumbai slums. The similarity in findings may reflect shared challenges in low-income urban Muslim communities, such as limited access to education, social support, and formal services. In contrast, Jungari et al. (2022) reported more IPV among Hindu women, but this likely

reflects the religious composition of their sample, not a direct association. Overall, our findings suggest that the higher prevalence among Muslim women in our study may be influenced not by religion alone, but by broader social and economic challenges often faced by migrant Muslim communities, such as poverty, limited access to education and services, weaker support networks due to migration, and greater social restrictions may increase their vulnerability to IPV. In our study, intimate partner violence was most common among illiterate women (49.4%) and decreased with higher levels of education. Only 11.1% of women who were graduates or postgraduates reported IPV. The association between education level and IPV was statistically significant ($p = 0.022$), showing that lower educational status increases the risk of experiencing IPV. This finding is supported by Chaurasia et al. (2021), who reported that women with no education were more likely to experience IPV, highlighting education as a protective factor. Similarly, Izugbara et al. (2020) found that women without formal education were 4.5 times more likely to report lifetime IPV and 5.6 times more likely to report recent IPV than those with more than 12 years of schooling. Their study also showed that almost half the women had no education, while only 5% had studied beyond 12 years. Roy et al. (2014) also found that 63.6% of their participants were illiterate or had only primary-level education, and there was a significant link between lower education and IPV ($p < 0.001$). While Jungari et al. (2022) reported a different distribution, with most women (85%) having secondary or higher education and only 5.8% being illiterate, this likely reflects the educational profile of their specific urban slum population. Despite this difference, the overall evidence supports our finding that women with lower education face a higher risk of IPV. This may be due to reduced awareness, lower self-confidence, and limited ability to seek help among less-educated women. In our study, we observed the distribution of IPV and husband's education level, and there was no significant association (p value = 0.113) found between husband's education and IPV. However, IPV was slightly more prevalent among wives of illiterate husbands (51.1%) and primary school-educated husbands (55%). Similarly, Garg et al. (2022) reported higher sexual IPV among women whose husbands were uneducated (10.8%). Kalokhe et al. (2017) also found that a large proportion of husbands had low educational attainment, with 53% not studying beyond the 10th standard. These findings suggest that although not always statistically significant, lower education in husbands may still increase the risk of IPV through limited awareness, communication gaps, and poor conflict resolution skills. In our study, a statistically significant association was observed between a woman's occupation and the experience of IPV ($p = 0.007$). The prevalence of IPV was higher among employed women (68.2%) compared to unemployed

women (47.0%). This suggests that employment may not always offer protection against IPV and, in some cases, could increase the risk due to factors such as partner insecurity or tension related to changing gender roles. Donta et al. (2015) reported a similar finding, where working women were 1.61 times more likely to experience IPV than non-working women. In contrast, Jungari et al. (2022) found that among women who experienced IPV (15.3% of their respondents), the majority (84.6%) were not working, suggesting different social or cultural dynamics in their study population. Additionally, Mary, Jacob, and Shetty (2025) reported very low female employment (0.7%) in their sample, similar to the pattern seen in our study population. Differences in findings across studies may reflect the nature of women's work, family dynamics, and how society views female employment. Our study shows that employment alone does not protect against IPV and may sometimes contribute to it, depending on the surrounding social and family context.

In our study, the prevalence of IPV was higher among women whose husbands were unskilled workers (52.3%) and unemployed (63.6%), while it was lower among those whose husbands were semi-skilled or skilled workers (43.6%). Although 100% of women whose husbands were professionals reported IPV, this group included only five participants and is too small to draw reliable conclusions. Overall, there was no statistically significant association between husband's occupation and IPV ($p = 0.15$).

This finding is similar to that of Dasgupta et al. (2019), who reported no clear link between partner's occupation and IPV, as 99% of husbands in their study were employed and only 1% were unemployed. Similarly, Shrivastava and Shrivastava (2013), in a study conducted in an urban slum in Mumbai, found no significant association ($p > 0.05$) between husband's employment status and IPV. In their sample, both unemployed (37.8%) and employed (36.4%) men were reported as perpetrators.

These results suggest that while certain occupational categories, like unskilled or unemployed, may show higher IPV prevalence, a husband's occupation alone may not be a consistent or significant predictor of IPV across different settings. Other factors, such as financial stress, household environment, or individual behaviour, may also play an important role.

CONCLUSION

This study highlights a high prevalence (48.6%) of intimate partner violence (IPV) among married migrant slum women, with physical violence being most common, followed by sexual and emotional forms. Significant associations were found between IPV and several socioeconomic and demographic

factors, including younger age, lower female education, Muslim religion, early age at marriage, higher parity, and female employment. While factors such as caste, husband's education and occupation, type of family, duration of marriage, and socioeconomic status showed varying IPV patterns, not all were statistically significant. The use of the Revised Conflict Tactics Scale (CTS2) facilitated more specific reporting, particularly of sexual violence. Overall, the findings underscore the need for targeted interventions addressing early marriage, women's education, reproductive burden, and the social vulnerabilities faced by migrant urban poor populations to reduce IPV and its consequences effectively.

Limitation

The study limits the generalizability as conducted in urban slum settings, and recall bias may exist, despite efforts such as careful interviewing and rapport-building. Despite these limitations, the study's methodological strengths enhance the credibility of its findings for this underserved population.

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REFERENCES

1. Census 2011 India. Aligarh district population census 2011–2021–2025, Uttar Pradesh literacy, sex ratio and density [Internet]. [place unknown]: Census2011.co.in; [date unknown] [cited 2025 Jun 27]. Available from: <https://www.census2011.co.in/census/district/514-aligarh.html>
2. Chaurasia H, Debnath P, Srivastava S, Purkayastha N. Is socioeconomic inequality boosting intimate partner violence in India? An overview of the National Family Health Survey, 2005–2006 and 2015–2016. *Glob Soc Welf*. 2021 Sep;8(3):263–77.
3. Dasgupta A, Raj A, Nair S, Naik D, Saggurti N, Donta B, et al. Assessing the relationship between intimate partner violence, externally-decided pregnancy and unintended pregnancies among women in slum communities in Mumbai, India. *BMJ Sex Reprod Health*. 2019 Jan;45(1):10–6.
4. Delkhosh M, Ardan A, Rahimiforoushani A, Salehpoor-Emran M, Merghati-Khoei E. Association between partner violence and the appearance of symptoms of sexually transmitted infections and reproductive tract infections among Afghan refugee women in Iran: a cross-sectional study. *BMC Public Health*. 2025 May 16;25(1):1803.
5. Donta B, Nair S, Prakasam C, Begum S. Socio-demographic factors associated with domestic violence in urban slums, Mumbai, Maharashtra, India. *Indian J Med Res*. 2015;141(6):783.
6. Garg P, Verma M, Sharma P, Coll CVN, Das M. Sexual violence as a predictor of unintended pregnancy among married women of India: evidence from the fourth round of the National Family Health Survey (2015–16). *BMC Pregnancy Childbirth*. 2022 Dec;22(1):347.
7. International Institute for Population Sciences (IIPS). National Family Health Survey (NFHS-5) 2019–21: compendium of fact sheets – key indicators, India and 14 States/UTs (Phase-II) [Internet]. Mumbai: IIPS; 2021 [cited 2023 Apr 19]. Available from: <https://ruralindiaonline.org/en/library/resource/national-family-health-survey-nfhs-5-2019-21-compendium-of-fact-sheets-key-indicators---india-and-14-statesuts-phase-ii/>
8. Izugbara C, Wekesah FM, Sebany M, Echoka E, Amo-Adjei J, Muga W. Availability, accessibility and utilization of post-abortion care in Sub-Saharan Africa: a systematic review. *Health Care Women Int*. 2020 Jul 2;41(7):732–60.
9. Jungari S, Chinchore S. Perception, Prevalence, and Determinants of Intimate Partner Violence During Pregnancy in Urban Slums of Pune, Maharashtra, India. *J Interpers Violence*. 2022 Jan;37(1–2):NP239–63.
10. Jyotirmay A, Bhattacharjee S, Tirkey L, Dalui A. Study on intimate partner violence against rural tribal women of reproductive age group in Siliguri subdivision of Darjeeling district, West Bengal. *Indian J Public Health*. 2022;66(4):410.
11. Kalokhe A, Del Rio C, Dunkle K, Stephenson R, Metheny N, Paranjape A, et al. Domestic violence against women in India: a systematic review of a decade of quantitative studies. *Glob Public Health*. 2017 Apr 3;12(4):498–513.
12. Ler P, Sivakami M, Monárrez-Espino J. Prevalence and factors associated with intimate partner violence among young women aged 15 to 24 years in India: a social-ecological approach. *J Interpers Violence*. 2020 Oct;35(19–20):4083–116.
13. Manna S, Singh D, Barik M, Rehman T, Ghosal S, Kanungo S, et al. Prevalence of intimate partner violence among Indian women and their determinants: a cross-sectional study from national family health survey – 5. *BMC Women's Health*. 2024 Jun 22;24(1):363.
14. Martin SL, Kilgallen B, Tsui AO, Maitra K, Singh KK, Kupper LL. Sexual behaviors and reproductive health outcomes: associations with wife abuse in India. *JAMA*. 1999 Nov 24;282(20):1967–72.
15. Mary P M, Jacob AM, Shetty AK. Physical violence and its associations: Insights from nationally representative data in India. *Womens Health (Lond Engl)*. 2025 Jan;21:17455057241310632.
16. Pearson E, Andersen KL, Biswas K, Chowdhury R, Sherman SG, Decker MR. Intimate partner violence and constraints to reproductive autonomy and reproductive health among women seeking abortion services in Bangladesh. *Int J Gynecol & Obstet*. 2017 Mar;136(3):290–7.
17. Roy D, Lees MH, Palavalli B, Pfeffer K, Sloot MAP. The emergence of slums: a contemporary view on simulation models. *Environ Model Softw*. 2014 Sep;59:76–90.
18. Shrivastava PS, Shrivastava SR. A study of spousal domestic violence in an urban slum of Mumbai. *Int J Prev Med*. 2013 Jan;4(1):27–32.
19. Surjeet S, Maji I, Khan Y, Chaudhuri SD, Punia J, Ruhil R, et al. Gender-based violence in an Indian resettlement colony threatened with re-eviction. *Med J DY Patil Vidyapeeth*. 2024 Jul;17(4):824–32.
20. World Health Organization. Understanding and addressing violence against women: intimate partner violence [Internet]. Geneva: WHO; 2012 [cited 2023 Apr 19]. Available from: https://iris.who.int/bitstream/handle/10665/77433/WHO_RHR_12.35_eng.pdf
21. Yonfa EDA, Fasol M, Cueva CM, Zavgorodniaya AC. Intimate partner violence: A literature review. *Open Psychol J*. 2021;14(1):11–16.
22. Zakar R, Zakar MZ, Mikolajczyk R, Krämer A. Intimate partner violence and its association with women's reproductive health in Pakistan. *Int J Gynaecol Obstet*. 2012 Apr;117(1):10–4.