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Family and community driven response to intimate partner violence in post-conflict settings

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Abstract

This study explores risk factors, individual and family consequences and community-driven responses to intimate partner violence (IPV) in post-conflict eastern Democratic Republic of Congo (DRC). This qualitative study was conducted in 3 rural villages in South Kivu Province of DRC, an area that has experienced prolonged conflict. Participants included 13 female survivors

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and 5 male perpetrators of IPV as reported during baseline data collection for the parent study, an impact evaluation of the Congolese-led livestock microfinance program, Pigs for Peace. Participants described social and behavioral circumstances that increase risk for IPV; social, health and economic consequences on women and their families; and resources to protect women and their families. Social and behavioral factors reported by survivors and perpetrators indicate that IPV was linked to husband's alcohol consumption, household economic instability, male desire to maintain his position as head of family and perceived disrespect of husband by wife. In addition to well-known health consequences of IPV, women reported negative social consequences, such as stigma, resulting in barriers for the well-being of the family. Survivors and perpetrators described the impact of IPV on their children, specifically the lack of proper parental guidance and lack of safety and stability that could result in the child(ren) misbehaving and using violence in their relationships resulting in further stigma towards the child and family. Strategies employed by survivors to protect themselves and family, include placating male behaviors (e.g. not responding to insults, trying to meet household demands). Perpetrators that tried to reduce the impact of IPV reported a preference for social and financial control of their partner rather than physical violence, believing this to be less severe. Participants described community and family based social support systems including couple's mediation, responsible partner and fatherhood programs and economic activities that can influence behavior, maintain confidentiality, address social stigma and other multi-level outcomes.

Keywords

Democratic Republic of Congo; intimate partner violence; post-conflict; family and community response

Introduction

Intimate partner violence (IPV) is the most pervasive form of violence against women (VAW) globally (L. Heise, Ellsberg, & Gottmoeller, 2002) and constitutes a violation of women's basic human rights. Results from a systematic review and synthesis of scientific research estimate that almost 30% of women globally that have ever been in an intimate relationship experienced physical and/or sexual IPV by their partner (World Health Organization, 2013). IPV is often indicative of a pattern of violence and abuse and involves the use physical, sexual or psychological harm and coercive control by a current or former partner or spouse (L. Heise et al., 2002). Data show that the impact of IPV on the survivor is both immediate and long lasting, with negative health, economic and social outcomes including difficulty working, depression and death (Campbell et al., 2002; Ellsberg et al., 2008). Financial costs to the individual, family and community are high; IPV negatively impacts paid and non-paid productive work by the survivor and other household members, increases the out-of-pocket expenditure for health care when accessed and increases costs to service providers (e.g., health, community-based mediation) to care for survivors (UNFPA & ICRW, 2009).

Risk factors and consequences of IPV have been studied in different countries and multiple settings including urban, rural and conflict settings; the results confirm that risk for IPV vary

across culture, geography and context, for example risk factors in one setting may be protective in another (L. L. Heise, 1998; Lawoko, 2008). Studies on the impact of violence in conflict and post-conflict settings have largely focused on the impact of conflict-related traumatic experiences on health, although the elevated risk for IPV and role of IPV in producing negative health and economic outcomes is increasingly recognized as important. With more than one and a half billion people living in areas affected by conflict, fragility or large scale violence (World Bank, 2011), a better understanding of the multilevel factors that increase risk for and outcomes related to IPV in these settings is critical for successful development post-conflict. In eastern DRC, rural populations have endured over 18 years of conflict including human rights violations, displacement, loss of economic opportunities and disruption to health and social services (Coghlan et al., 2007; Réseau des Femmes pour un Développement Associatif, Réseau des Femmes pour la Défense des Droits et la Paix, & International Alert, 2005). Men and women living in North and South Kivu provinces of eastern DRC have reported experiences of physical violations (17.2% women, 34.5% men); movement violations (7.8% women, 12.0% men) and property violations (23.6% women, 30.7% men) during conflict (Johnson et al., 2010). Nationally, in the past year, 57.4% of women reported physical, sexual and/or psychological IPV (Ministere du Plan et Suivi de la Mise en oeuvre de la Revolution de la Modernite, Ministere de la Sante Publique, & ICF International, 2014). In eastern DRC, 30.5% of women and 16.6% of men report physical and/or sexual IPV experience (Johnson et al., 2010). This study applies an ecological framework to understand IPV risk, consequences and family and community-driven responses in post-conflict eastern DRC.

Ecological Framework

The social ecological model of human development was developed by Bronfenbrenner in the 1970's (Bronfenbrenner, 1979) and adapted by Heise to understand the multi-level risk for IPV (L. L. Heise, 1998). The ecological framework emphasizes two key concepts: (1) individuals are nested in a multi-level environment; and (2) these levels interact to produce outcomes (Bronfenbrenner, 1979). The four-level framework of factors that affect the individual include: (1) personal; (2) microsystem, which describes the immediate setting (e.g., family, home, peer groups) and interpersonal relationships; (3) exosystem, which includes institutions and social structures (e.g., work, neighborhood, social networks); and (4) macrosystem (i.e., the cultural, historical and political context). The model can be used to understand the multi-level risks and outcomes associated with IPV and the interaction between risk factors. It also facilitates identifying opportunities for multi-level prevention and response interventions. There is little research on risk factors for IPV in post-conflict eastern DRC. The ecological model presented below draws from global findings on IPV risk and protective factors with a specific focus on findings in post-conflict settings and countries in east Africa.

Risk factors that have shown association with increased IPV perpetration or victimization include individual level factors such as exposure to parental or caregiver violence, personal experience of violence and an absent or rejecting father (Abeya, Afework, & Yalew, 2011; Abramsky et al., 2011; L. L. Heise, 1998; Kiss et al., 2012). IPV in conflict-affected populations may be related to traumatic events experienced by the perpetrator or survivor,

displacement, disruption to traditional support systems and economic instability. In a cross-sectional study with male and female guardians of 2nd-grade students from communities exposed to conflict-related violence in northern Uganda, increased IPV was associated with women's exposure to conflict-related events, increased female re-experiencing symptoms related to the trauma of the events and male pattern drinking behavior (Saile, Neuner, Ertl, & Catani, 2013). A nationwide household survey conducted in Liberia examined the lasting impact of war experiences on use of physical IPV in relationships and mental health outcomes. Nationwide, 37.7% reported severe IPV (e.g., beatings, strangulation) during their lifetime. Male perpetrators and female survivors of severe physical IPV were more likely to have had direct exposure to traumatic events during the conflict (e.g., witnessed or experienced violence) and taken part in the conflict. Women who reported more security, better family relations and increased age were less likely to report experience of severe physical IPV (Vinck & Pham, 2013). Studies with Lebanese women (Usta, Farver, & Zein, 2008), South African men who have experienced human rights violations (Gupta, Reed, Kelly, Stein, & Williams, 2012), Eritreans living in refugee camps (Feseha, G/mariam, & Gerbaba, 2012), and men who have experienced political violence (Clark et al., 2010; Gupta et al., 2009) describe an association between exposure to traumatic events and increased IPV perpetration or victimization.

In DRC, microsystem risk factors for female experience of IPV include having a male partner that drinks alcohol and being in a polygamous relationship (Tlapek, 2014). In Goma, the capital of North Kivu province, a post-conflict area in eastern DRC, male perpetration of IPV is associated with childhood experience of IPV, binge drinking and increased age (Slegh, Barker, & Levtov, 2014). Slegh et al (2014) propose that male inability to support family and experiences of trauma may influence men's behavior including consuming alcohol frequently and use of violence. Globally, microsystem risk factors for IPV perpetration include male dominance in family decision-making, frequent marital conflict, polygamous partners and heavy alcohol consumption (Abeya et al., 2011; Deribe et al., 2012; L. Heise et al., 2002; Kiss et al., 2012; Koenig, Ahmed, Hossain, & Khorshed Alam Mozumder, 2003). Exosystem risk factors include female isolation, poor peer association, lower educational achievement, socio-economic status or unemployment although violence occurs across economic strata and the underlying factor may be stress, crowding, frustration or a sense of inadequacy rather than unemployment itself (L. Heise et al., 2002; Michelle J. Hindin & Adair, 2002). The association of masculinity with male toughness and honor, rigid gender roles and male and female acceptance of the use of violence are examples of macrosystem risk factors for IPV (Deribe et al., 2012; L. Heise et al., 2002; Koenig et al., 2003). In DRC, female acceptance of male use of violence is associated with increased risk for IPV (Tlapek, 2014).

In addition to individual (e.g., willingness to report IPV, knowledge of IPV service) and microsystem (e.g., male acceptance of female accessing services, access to financial resources to pay for services) factors, social and cultural factors (i.e., exosystem and macrosystem factors) influence experience of IPV and decisions to seek help for IPV (Krishnan, Hilbert, VanLeeuwen, & Kolia, 1997; Pinn & Chunko, 1997). Where institutional facilities exist (e.g., health care, police), women may not be aware of or may choose not to access services due to cultural acceptability of the service, lack of non-

judgmental service provision, fear of stigma and fear of partner retribution (Horn, 2010; Hyder, Noor, & Tsui, 2007). In a study with Nigerian and Ghanian immigrants to Australia, women who experienced IPV described how displacement to Australia had severed access to family-based mediation resulting in IPV survivors reporting that they 'suffered in silence' rather than seek institutional based services (Ogunsiji, Wilkes, Jackson, & Peters, 2012). Similarly, preference for traditional family and community-based solutions to IPV have been expressed by Ethiopian refugees (Sullivan, Senturia, Negash, Shiu-Thornton, & Giday, 2005), African refugees living in refugee camps in Kenya (Horn, 2010), low-income mothers attending health clinics in Mumbai (Decker et al., 2013) and Cambodian immigrant women living in the US (Bhuyan, Mell, Senturia, Sullivan, & Shiu-Thornton, 2005).

Despite the noted elevated levels of IPV in post-conflict settings including DRC, there is limited research on the multi-level risk factors for IPV and effective interventions to prevent and respond to IPV in post-conflict settings. For example, in DRC, an analysis of 2007 Demographic and Health Survey provide evidence that female experience of sexual IPV is 1.8 times higher than female experience of rape by unknown persons (Peterman, Palermo, & Bredenkamp, 2011). Yet interventions and research focused on gender-based violence in the DRC have largely focused on the juridical and health system response to sexual violence associated with conflict and neglected IPV. A better understanding of traditional, culturally acceptable family and community based support structures to respond to IPV is essential for the development of effective prevention and response interventions (Bhuyan & Senturia, 2005; Carlson, 2005). Through in-depth interviews with rural men and women who have experienced conflict-related trauma and report perpetration or experience of IPV, this study has the following three research objectives: 1) to describe the social and behavioral risk factors for IPV perpetration and victimization; 2) to describe the multiple and interrelated social, health and economic consequences of IPV on women and their families; and 3) to describe family and community driven response to IPV in rural villages.

Methods

This qualitative study was conducted with adult male and female participants in the National Institute of Health/National Institute of Minority Health and Health Disparities (NIMHD) funded impact evaluation of a livestock microfinance intervention, Pigs for Peace (PFP). PFP is a Congolese-led microfinance intervention implemented in partnership between Programme d'Appui aux Initiatives Economiques (PAIDEK) and Johns Hopkins University School of Nursing. The parent study is testing the effectiveness of a village-based livestock microfinance program on health (physical health, depression, PTSD, anxiety, reduction of IPV and other forms of violence), economic (household food consumption, asset value) and social outcomes (visiting community members, having visitors in the participants home) with over 800 families in 10 rural, conflict-affected villages of eastern DRC.

PFP Intervention And Impact Evaluation

Briefly, PFP provides loans, in the form of a 2 to 4 month-old female pig, to consenting adult male and female head of households randomized to the intervention group. With the support of trained Microfinance and Research Agents (i.e., PFP Agents), members of PFP

complete a training program, construction of a pigpen and compost and care for their pig. When the pig gives birth, participants in the intervention group repay their loan in the form of two female piglets, which are then provided by PFP as new pig loans in the same village to delayed control group members. After repaying their loan, the participant and family own the remaining offspring and original loan pig (Glass, Ramazani, Tosha, Mpanano, & Cinyabuguma, 2012). The impact evaluation of PFP includes ten rural, post-conflict villages of eastern DRC that were selected based on operational feasibility, local commitment from village chief and administrators and village-level assessments. Interested and eligible rural village residents (i.e., responsible adults 16 years and older that were committed to microfinance principles and were permanent residents of the village), were randomly assigned to intervention or delayed control groups. Participation was limited to one member (male or female) head of household. Due to high level of interest in participating in PFP in the ten villages, a second delayed control group was formed. Baseline data collection was completed between May and November 2012.

Participant Selection

Male and female participants randomized to the second delayed control group in three (Cagombe, Izege, Kahembari) of ten parent study villages were purposively selected for this qualitative study based on female report of IPV victimization or male report of IPV perpetration on the baseline questionnaires. Three villages were included to restrict the geographic scope of the qualitative study, provide variation in responses and reach saturation related to study aims (Morse, 2000). The final study sample was determined through an iterative process of debriefing post-interview with the interviewers and assessing if new information was being gained from the interviews. At the time of this qualitative study, participants in the delayed control group had not yet participated in PFP training or received their pig loan.

Data Collection

The interview guide was developed, translated to French and local languages (Swahili or Mashi) and implemented in partnership with skilled Congolese team members working with the parent study. The interview guide included general questions on IPV perpetration and victimization in their village; risk factors for IPV, individual and family consequences of IPV perpetration and victimization; and community-driven response to IPV in rural villages. Participants were selected for their report in baseline interview of IPV experience or perpetration; they were not asked in qualitative interview whether they were victims or perpetrators of IPV. Participants that reported during qualitative interview a personal experience of IPV were asked follow-up questions about their experience of IPV; social and behavioral risk factors for IPV perpetration; social, health and economic consequences of IPV on women and their families; and family and community based responses to IPV and to reduce men’s use of IPV. This strategy was employed to protect information shared by the participant in previous interview and to ensure that rumors did not spread in the household or village that participants were selected for participation in qualitative interview due to their history of IPV. Four PFP agents were trained over a 2-day period by the lead author on qualitative research methods, research ethics and safety for survivors of IPV. Four pilot interviews were conducted with PFP members (3 women, 1 man) in villages not associated

with the parent study. After revisions, the qualitative fieldwork was conducted in February 2013. To ensure discretion, the study was conducted when PFP agents were in the villages to provide their regular follow-up visits for the parent study. Debriefing post interview was used to understand key themes, opportunities for follow-up questions in future interviews, challenges and whether the data was progressing towards saturation.

Research Ethics

The Institutional Review Board of the Johns Hopkins Medical Institute approved the parent study. As there is no local IRB in South Kivu province, a committee of respected educators at the Universite Catholique at Bukavu reviewed and approved of the parent study. Interviews were initiated after individuals provided oral, voluntary, informed consent. Participants could choose to end the interview at any time or not respond to particular questions. To ensure confidentiality, only parent study identification codes were recorded on the transcripts. As interviews were conducted during times when members would be earning their daily income, compensation for the time spent away from work was provided as per local rates, approximately 2.00 USD. All interviews took place in a private setting of the respondent's choice, most often in their home.

Data analysis

Analysis of this study was informed by grounded theory methods that were first developed by Glaser and Strauss and adapted by Charmaz (Charmaz, 2006). Grounded theory involves an iterative process of data collection and analysis. Initial analyses are used to inform future areas of inquiry to help fill gaps in understanding focused on the research aims and further develop the questionnaire (Charmaz, 2006). There were some adaptations of grounded theory to fit the study focus and logistical needs. For example, the sample of eligible individuals was limited to men and women in three villages who reported either IPV perpetration or victimization in the baseline data collection of the parent study. Debriefing was held separately with each interviewer at the end of each fieldwork day instead of after each interview. This facilitated the PFP agent the flexibility to plan interviews in different villages and helped ensure confidentiality because debriefing by the team was done in a separate site, away from the participating villages. Initial coding involved a careful reading of each transcript, focused on understanding the content of different interviews and coding related the three research aims. Categories of common themes related to the three research aims were developed. Memos described the depth of and variation between focused codes. Focused codes were grouped according to research aim to identify relationships within and between categories. Notes from debriefing, which included the PFP agent perspective on key themes from each interview and overall understanding of the data, facilitated interpretation.

Results

Thirteen women survivors of IPV and 5 male perpetrators of IPV participated in this study. In baseline interview, all selected participants reported experience or perpetration of physical IPV and 13 participants reported experience (11 women) or perpetration (2 men) of sexual IPV.

Findings are presented according to three themes identified from the analysis: (1) Social and behavioral circumstances that increase risk for IPV; (2) Social, health and economic consequences of IPV on women and their families; and (3) Family and community driven response to IPV.

Social and behavioral circumstances that increase risk for IPV

Almost all participants described male alcohol consumption as a "cause" of IPV directly through use of physical, psychological and sexual IPV and indirectly through increased marital conflict. Wives expressed humiliation with regard to their husband's drunken behavior and fear of his return home because of the potential for violence. One female participant explained that, while drinking alcohol, men "can speak about anything without remembering including his wife's body and household secrets". Financial stress and male unemployment also led to increased tension, marital conflict and IPV. In post-conflict eastern DRC, lack of employment opportunities and financial difficulty have been exacerbated by ongoing insecurity and limited infrastructure thus increasing financial stress within the family. One female participant explained the major reason for IPV is the "lack of financial means…an unemployed man is a turbulent man." Another woman explained, "When a man lacks money, he becomes violent and depressed".

Women described men humiliating and insulting their wives in public and private settings. There were a variety of behaviors that were considered disobedient by the husband justifying the use of violence in the home, including wife arriving home late, not preparing food at the time the husband was ready to eat, and not completing household duties as determined by the husband. One man explained that his wife's language and actions affected his self-confidence and challenged his authority, "it destroys me. She doesn't respect my dignity". He further noted that his use of IPV against his wife restored his place as head of the family, and therefore, his self-confidence. Participants discussed issues of trust in the relationship related to fidelity as another reason for IPV. Wives are expected to limit their social interaction, especially with men in the community. Female participants suggested that husbands insulted and abused their wives in public to demonstrate to the community that his wife was not capable of meeting her household and social obligations and therefore he was justified in the marriage of a second wife.

Men and women described the wife's marital duties to include sexual intercourse with a husband regardless of the wife's circumstance (illness, pregnancy, fatigue) or desire. Further, women reported having sexual relations with a husband to maintain a peaceful relationship, avoid the husband's use of physical violence to force sex, reduce possibility of or justification for male infidelity or accusation of the wife's infidelity; and fear of negative judgment of the wife by her husband's family and her own family, if her husband informs them that she is refusing sex.

Health, economic and social consequences of IPV on women and their families

Women reported multiple physical and mental health symptoms such as increased fatigue, reduced capacity for work due to weakness, persistent fear, having bad thoughts (e.g., feeling worried, lacking peace) and injury due to IPV experience. Women noted that living

in fear of her husband impacted her ability to care for her family. The ongoing stress makes her too weak to properly care for her children, cultivate her fields to bring food and complete her other household duties. Participants considered IPV as limiting the couple's ability to plan and build for the future of their family because of the distrust and fear in the relationship, often resulting in extreme poverty, household instability and neglect of children. One male participant explained, "when a man is violent towards his wife, it is difficult for things to advance for the family because there is no peace".

Women and men participants worried about how children from abusive homes suffered from lack of safety and stability in the home, reporting that the IPV increased risk for child misbehavior in the community and use of violence to resolve conflict. Parents described children in violent homes as living with high stress and fear, "lacking in education and good health, parental affection and role models of adult behavior all of which are important for creating a good future for children" (male participant). One woman explained that children, especially girls, from violent homes experience stigma in the community, for example, "they are not taken for marriage because people are scared of the family". While men and women participants described IPV as leading to negative outcomes for the entire family, they also reported that men were entitled to be violent, due to their gender and importance of maintaining their position as head of household.

Participants explained that any type of IPV occurring outside the home or in front of family and/or community members (including insulting the woman) has a negative impact on the family's status in the community. One woman explained that "men who respect their wives will humiliate her at home and not outside of the house to ensure that no one else finds out about the violence". Although participants noted that family and community members provided support and assistance to families with IPV, other community members used these families as models of poor behavior when teaching children about respectful behavior. Further, participants reported that families with IPV were socially isolated; for example, they received limited visits in their home or were not invited to social events. The social impact of IPV was a serious concern for both men and women in the study and magnified the already negative effects of IPV on the woman and her family. One woman described that when a husband is violent, "it is a serious problem, when a woman is scared of her husband because they can never build a future together. She will always suffer from internal (emotional) injuries and even if she is well fed or clothed, when her husband is mean, nothing can move forward. She is always in bad health. The whole family is affected. They become the topic of gossip in the community".

Family and community driven response to IPV

Many of the individual strategies that women described using within the household to prevent or reduce IPV involved the woman's use of placating behaviors including changing her own behavior, abiding by her husbands needs and orders (e.g., serving food at the correct time), remaining quiet and calm with children in home, demonstrating submission, and ignoring concerns about her own and/or family well-being. One woman explained that to keep a man calm, a woman "cannot speak in just any manner to her husband. The husband is like a child and we have to care for him at every moment, otherwise his temper

will flare". Another participant stressed that women should "place water in their mouths" as a way of describing the need to remain quiet when their husband's are angry and abusive. For physical protection, some women would leave or send their children out of the house during the violence. Male participants described engaging in different strategies to reduce the negative impact of physical violence to maintain family health including limiting themselves to psychological abuse (e.g., humiliation, insults) and controlling behaviors (e.g., limiting access to money, isolating his wife in front of others). One man, who stated that his use of physical IPV was linked with alcohol consumption, explained that he would go to bed, without talking to anyone, after drinking to avoid becoming angry and using violence. Another man reported that he left the house each time he felt upset so as not to physically abuse his wife.

Men and women participants looked to the husband's parents, his siblings, and the couples marital advisors to provide advice on overcoming conflict in the relationship and planning for a violence free future together. Participants noted that improved communication between the couple about household decisions and problem solving as essential to reducing IPV including applying the counsel that they received from family and community members. If the advice and support of these close advisors did not prevent or reduce IPV, community and other family members (e.g., wife's family, religious leaders, traditional chief, respected members of the community and friends) could be asked for advice and support. The support provided by these counselors included working with the couple in understanding the source of the couple's problems while simultaneously explaining that IPV creates instability and insecurity for family members and could destroy the household. Advisor's provided counsel both individually and to the couple with a focus 1) rediscover of love and commitment, 2) respectful couple communication, 3) well-being and needs of the children and the entire family. Women were often held responsible and advised to be patient and to meet their husbands' demands. One woman explained the limits of counseling, as it required men to change their behavior "otherwise the violent spirit will always remain with him". A man who participated in counseling with his wife and subsequently reported he tried to reduce his use of IPV against his wife described his struggle to control his temper, "when I see my wife make a mistake, I scold her strongly and then I calm down. I cannot keep it in my heart". Women reported being able to escape the IPV briefly by staying with their in-laws or parents home. Returning to the parental home was not preferred by women as she risked losing her children to her husband's family or returning to a home to find her husband has remarried. In couples where IPV remained unresolved, women and men could seek a separation or men could seek a second wife. Women in the study reported fearing either outcome; they wanted the violence, not their marriage, to end.

By sharing their family problems with community members, men and women noted that not all the advice is helpful. Some participants explained that traditional community resources for marital problems (e.g., counseling by traditional chief, respected community members, close friends) had deteriorated over the years of prolonged conflict due to increases in male alcohol consumption, lack of strong local leadership and lack of trust within families and between community members. One woman described this loss of community resources, "the community should advise the man, but here, curiously, the community doesn't do anything. They are only there to aggravate the situation and drink". In addition to lacking community

support to end IPV, interaction with certain community members may negatively impact the household. For example, participants expressed concern about male drinking patterns in the village and the advice they receive from male friends while drinking that support male's use of violence in the relationships to control his wife and secure his role as head of household. In spite of their descriptions of family and community resources to prevent and respond to IPV, most participants did not believe that IPV could be prevented in their household or community. As a result, one woman described the IPV-related social humiliation she felt and experienced, describing herself as a "slave" without options to end IPV. Women participants described the need for interventions in their community to teach men to be responsible husbands and fathers, resolve problems through dialogue and take part in activities that were productive for the family rather than harmful (e.g., reduce alcohol consumption). Participants thought that interventions should mobilize communities to respond to IPV and to engage families and communities to provide advice and counseling to end IPV. Economic interventions were suggested as necessary for improvement of the family and reduction in household stress that is associated with IPV. Women did suggest that female employment outside the home could improve her position in the household, although research has also demonstrated that an increase in women's status in the household may increase conflict in the relationship, as a husband can become concerned about the changing roles and responsibilities of the wife (Jewkes, 2002). Few women thought legal-based punishment (e.g., imprisonment) for the abusive partner was a desirable or an available outcome, because of the impact this has on the entire family such as potential loss of economic resources, lack of father figure for children and social isolation due to judgment associated with male imprisonment. Yet, two men described fear of imprisonment or wife's hospitalization as a result of physical violence as a reason for their preference for using controlling behaviors and psychological abuse over physical IPV.

Discussion

This study, conducted among adult men and women who had perpetrated or experienced IPV in their current relationship, described the social and behavioral risk factors; multiple health, economic and social consequences associated with IPV; with suggested family and community-driven responses to IPV. The authors did not identify in analysis differences between male perpetrator and female survivor responses on risk factors for violence, consequences of violence and response to IPV. Participants reported perpetration of and victimization using multiple types of IPV, including forced sex, occurring with physical force, psychological abuse (e.g. threats of violence, fear of justification for male infidelity) and controlling behaviors (e.g., limited women's access to household finances to feed and care for family). Women and men in the study, as in many global settings, noted that wives must accept sex with their husband as one of her duties in marriage. As reported elsewhere (L. Heise et al., 2002), women considered all types of IPV including psychological abuse to have long-term negative individual outcomes affecting their ability to be a good parent, to work effectively and to interact with others in the family and community. Psychological abuse by the husband can occur in front of his/her family and with community members even when she is not present. Some women described IPV occurring in public, including humiliation of wife when she was not present, as magnifying the negative impact of IPV on

herself and family through increased isolation, social judgment, and public knowledge of private family problems. As a result, women feared judgment, isolation and stigma associated with the IPV by family and community members. For example, she would be considered to be a bad wife and family or community members may counsel the husband to find another wife, as polygamy is accepted in participating rural villages.

IPV risk factors (i.e., research objective one) in this and other studies include husband's alcohol consumption, male fear of female partner infidelity, male infidelity/fear of male infidelity, economic instability in the household, male desire to maintain his position as head of the family, perceived disrespect of wife by husband, and wife not successfully completing household duties as perceived by husband (Abramsky et al., 2011; Jewkes, 2002; Karamagi, Tumwine, Tylleskar, & Heggenhougen, 2006; Saile et al., 2013). All participants in this study highlighted the importance of male alcohol consumption, including excessive consumption, lack of employment, household financial stress, male infidelity and fear of female infidelity as a consequence of instability in rural communities and conflict and directly related to male use of physical and psychological violence. Among conflict-affected populations, elevated alcohol consumption to deal with the prolonged stress and trauma (Roberts, Ocaka, Browne, Oyok, & Sondorp, 2011; Weaver & Roberts, 2010) and economic instability (male unemployment, lack of female economic opportunities) have been associated with IPV (Ezard et al., 2011). Behavioral and economic factors created by environment of deprivation, violence and trauma may contribute to the elevated risk for IPV among conflict-affected populations (Clark et al., 2010; Vinck & Pham, 2013). For example, a few female participants described some male peer influence in the post-conflict environment as increasing conflict in family by encouraging alcohol consumption, judging female behavior as disobedient and demonstrating need to recover male authority in the household. Social and behavioral risk factors for IPV in this study confirm risk factors identified in other post-conflict and African settings (Clark et al., 2010; Ezard et al., 2011; Roberts et al., 2011).

Both men and women described the multiple and interrelated social, health and economic consequences of IPV on women and their families (i.e. research objective two). In addition to the physical and mental health consequences of IPV on women that have been reported in other settings (Campbell, 2002; Ellsberg et al., 2008), participants in this study focused on the impact of IPV on child development and the families' future. Children were described as lacking family education, money to pay school fees, parental role models, good nutrition and health. Further, participants described how living in an unstable and violent household negatively affected children's interaction with community members, as the entire family could become isolated and disrespected in the community. Male and female participants in this study described households with IPV as unable to progress or have stability in their lives. A cross-sectional study in Sri Lanka with children exposed to war reported that family violence (e.g. child abuse, child witnessed IPV) was more strongly related to child PTSD outcomes than exposure to conflict related to the war (Catani, Jacob, Schauer, Kohila, & Neuner, 2008). Parents in abusive relationships expressed concern over their children's development and behavior. Male and female participants stated that they made an effort to hide IPV from their children by trying to limit IPV to their bedroom or times when children were sleeping, but as a strategy, this is rarely effective, as children often hear or witness the

IPV even if the parents do not believe they are aware. Research has demonstrated that children can experience negative health and social effects of IPV regardless of whether they directly witness the IPV or not (Asling-Monemi, Naved, & Persson, 2009; Roman & Frantz, 2013). Further, studies have shown a relationship between childhood exposure to IPV in the household and experience of physical violence as discipline in childhood with male perpetration and female experience of IPV in adulthood. Yet, not all children exposed to IPV in childhood will use violence in their adult relationships (Eriksson & Mazerolle, 2015; Hotaling & Sugarman, 1986). In rural, post-conflict DRC male and female participants described IPV as a concern for their child's future development including their future use of violence, therefore, interventions should consider addressing the family, including prioritizing child development, as an opportunity to prevent and respond to IPV. Programs may consider prevention strategies with young adolescents or newly married couples to prevent IPV in relationships related to learned behavior in childhood and trauma and conflict related stresses that may increase risk for use of violence (e.g., unemployment, inability to provide for family).

Prevention strategies to address IPV may address multiple levels of the ecological framework to increase possibility of sustainable impact. In this study, men and women described their individual efforts to prevent IPV and reduce the negative impact of IPV. These strategies included use of placating behaviors (e.g., women trying to meet husband's needs, remaining calm despite violence) and husband's reporting they limited IPV to psychological violence and controlling behaviors to prevent negative outcomes associated with physical violence (e.g., injuries). Use of different individual strategies represent a desire among women and men to hide or minimize IPV as to not jeopardize their standing in the family or community and to reduce negative impact of IPV on female partner. Men also described their efforts to reduce alcohol consumption or conflict associated with their alcohol consumption. These individual efforts by both men and women demonstrate opportunity for interventions to focus on prevention of IPV and strengthen the family. Participants also describe microsystem interventions that exist in families and communities including 'counseling" and/or "mediation" focused on resolving problems through dialogue and prioritizing family and child outcomes (M. J. Hindin, 2003) as part of a traditional response to prevent and respond to IPV. These interventions engage family, friends and respected persons in the village in providing counseling to the couple to develop strategies to resolve their specific problems including improving communication between the couple, strengthening the bond between the couple and increasing investment and planning towards family and children's future. Most women described a need for men to be educated on their responsibilities towards their family, develop effective communication skills with the wife about household decisions, and engage the community to prevent and respond to IPV. These traditional responses engage the couple in prioritizing the family well being and planning for the future and reorienting male response to conflict or difficulty. Participants also described the need to address exosystem factors including loss of trust between community members and investment of community in family well-being as a result of conflict and instability. Therefore, future intervention planning should consider the importance of family prosperity to community well-being, reinforce traditional family and community driven response to IPV, increase trust between community members and reduce acceptability of IPV.

In other settings, including one post-conflict setting, three interventions that have been evaluated for effectiveness in addressing IPV included both men and women; 1) IMAGE in South Africa focused on reducing IPV and HIV through a combined microfinance and gender education intervention (Jan et al., 2011; Kim et al., 2007; Pronyk et al., 2006); 2) a combined group savings intervention with gender dialogue groups in India (Gupta et al., 2013); and 3) a gender education focused program called Stepping Stones in South Africa (Jewkes et al., 2008). The education component of these interventions address different topics that are related to microsystem, exosystem and macrosystem risks for IPV such as conflict resolution, communication, household decision making and expectations, and gender norms. The studies reported reduced IPV rates or changes in gender norms related to their gender-based education component (Anderson, Campbell, & Farley, 2013). Shifts in gender norms and incidence of IPV are possible when interventions are carefully designed with community involvement and include key stakeholders including perpetrators and survivors of IPV (Harvey, Garcia-Moreno, & Butchart, 2007; Michau, 2007). The inclusion of both men and women in the design and implementation of interventions may ensure lasting changes to underlying risk factors for IPV as well as provide strategies for prevention and response (Women's Refugee Commission, 2009). While family and community resources may exist, accessing them can be challenging because, as in other settings, IPV is considered a household problem and should remain in the family. Men and women who perpetrate and experience IPV, respectively, in this study and in other settings have reported fear of judgment, isolation and stigma for self and the family as limiting their access to community-based and institutional support services (Ogunsiji et al., 2012). Awareness of IPV in a household by the larger family and community may lead to social isolation of all family members including exclusion from communal activities and decision-making, stigma and avoidance of members of the household and lack of support in times of need. As a result, interventions should use the ecological framework to account for the multi-level and interrelated risk factors for IPV and the potential social (e.g., judgment by family, social isolation) and economic (e.g., time spent in counseling/meetings and away from economic activities) consequences of accessing services for IPV. Further, integrating trusted community members in lay counseling with programs that address contextual, post-conflict factors (e.g., unemployment, lack of trust in community, alcohol consumption, trauma experiences) and reinforce the strength of the family may have a more sustained effect on IPV prevention by addressing multiple risk factors for violence (Catani, 2010).

This study has several limitations. Although elevated levels of IPV have been reported in populations that have experienced conflict-related trauma, human rights violations and displacement, this study did not specifically ask participants about how their experiences during the prolonged conflict affected their intimate relationship, including IPV. In other studies, conflict-affected Congolese have described deterioration of family and community structures due to war (Kelly, VanRooyen, Kabanga, Maclin, & Mullin, 2011; Kohli et al., 2012). In this study, participants described the loss of traditional community support systems as related to increased alcohol consumption, distrust between family and community members and lack of strong local leadership. Participants in this study and others also described the post-conflict environment including high unemployment, household financial stress and deterioration of traditional, community and institutional

support as negatively impacting family relationships including IPV (Kelly et al., 2012; Slegh et al., 2014). This study focused on IPV perpetrators and survivors, but did not capture the perspective of local leaders (e.g., religious leaders, traditional chief, administrators, health care professionals) and community members. The authors did not identify in qualitative interview differences in male perpetrator and female survivor reports of risk factors, consequences and suggestions for family and community-driven responses to IPV. Such differences may exist and may be useful to understand in intervention design, but may be better identified in a representative quantitative survey. Understanding whether there are differences in risk factors for IPV and acceptable family and community-driven responses by gender or other covariates (e.g., age, wealth, family history of trauma, years of marriage, neighborhood) may ensure that intervention strategies are appropriately designed and targeted. For example, some studies find that women and people living in disadvantaged communities more often support the belief that a man has a right to use violence with their spouse (Uthman, Moradi, & Lawoko, 2009); this belief may impact female health outcomes, how children are educated in families regarding marital relationships and whether women access resources to protect, prevent and support themselves and their families. Lastly, only 18 individuals participated in the qualitative study. While the researcher monitored for saturation on the research questions, interviews with more perpetrators and survivors of IPV could have captured more detailed information on experiences of IPV and with family and community driven responses to prevent IPV.

Conclusion

Implementing culturally acceptable, community-based prevention and response programs to IPV is an opportunity in post-conflict environments where communities are already working towards strengthening relationships and rebuilding traditional infrastructures. Survivors and perpetrators described the multiple social and behavioral risk factors for IPV in rural, post-conflict areas (e.g., household economic stress, peer influence, male perception of female disobedience or loss of authority, alcohol use). This study provided new information on the way in which IPV negatively impacts child health and development, family well-being and future social, health and economic outcomes. Further, this study provides insights into the existing, but previously undocumented, indigenous ways in which men, women, families and communities are responding to IPV. The social norm of IPV, men’s desire and efforts to reduce the impact of IPV and women’s requests for assistance indicate that communities need and want support in improving on family and community-driven responses (e.g., family and community counseling, improving couples communication, planning for families future). In the DRC where interventions to prevent and reduce IPV have been given insufficient attention, participants in this study proposed family and community focused interventions (i.e., approaches focused on the microsystem) as an opportunity to reduce IPV in rural eastern DRC where men, women and children have experienced prolong conflict. Participants supported the need for multisectoral, multi-level interventions when describing risk factors for violence (e.g., alcohol use, male unemployment) that would remain unchanged by traditional intervention (e.g., counseling, shelters). Therefore in addition to education and counseling programs, integrating services with strategies to address other post-conflict micro and exosystem contextual factors that exacerbate existing risk for IPV

such as elevated alcohol use, male unemployment, changing gender roles such as women working outside the home to support the family, trauma and economic instability should be explored. Future research with local leaders and community members will provide a more comprehensive understanding of how traditional family and community-driven response to IPV can be reinforced to reduce microsystem (e.g., male alcohol consumption) and exosystem (e.g., acceptability of IPV) risk factors for IPV, design and deliver messages to change social norms that promote and sustain IPV and provide counseling and education to couples related to communication and shared decision making for a healthy family. Interventions should be developed and implemented in a participatory manner, with input of a range of community members (men and women) including IPV perpetrators and survivors and address the multilevel individual, microsystem and exosystem risks and outcomes of IPV.

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Research highlights

- IPV negatively affects individual and family health, economic and social states
- Characteristics of post-conflict environment may increase risk for IPV
- Communities need support and partnerships to improve IPV prevention and response
- Family-focused interventions may be acceptable to male perpetrators and women
- Integration with psychosocial interventions may increase acceptance and outcome