UNIVERSITY OF
LIVERPOOL

PERCEPTIONS, EXPERIENCES AND HEALTH SECTOR RESPONSES TO INTIMATE PARTNER VIOLENCE IN MALAWI: THE CENTRALITY OF CONTEXT

Thesis submitted in accordance with the requirements of the
University of Liverpool for the degree of Doctor of Philosophy

by

Lignet M. Chepuka

March 2013

LSTM
LIVERPOOL SCHOOL
OF TROPICAL MEDICINE

For

The next generation of couples/ families that through this work they may understand the pain of Intimate Partner Violence and endeavour to build healthy relationships

Abstract

BACKGROUND: The health sector has 'duty of care' to provide comprehensive health services to survivors of violence, to act as a referral point, to collect and document evidence, to report data on violence and to engage in preventive services. In Malawi, 48% of women experience some form of intimate partner violence (IPV) and a significant number report conditions requiring health care services, although few actually report to health services, which are in turn limited in scope and availability. Understanding how health care providers, relevant stakeholders and IPV survivors perceive the role of health care services in IPV is necessary to promote the development of context-relevant and sustainable health care interventions.

AIM: To understand the health service responses to IPV in Malawi from a wide range of perspectives

OBJECTIVES:

i)   to critically analyze written legislation, policy and strategy documents in relation to IPV and the health sector in Malawi;

ii)   to describe the perceptions and experiences of IPV and of health sector responses among survivors of violence, community members, health care workers and other key stakeholders in Malawi;

iii)   to estimate the extent of intimate partner and sexual violence from a health service uptake perspective using proxy determinants at one referral hospital in Malawi

iv)   To explore the policy implications of the study findings for the health sector responses in Malawi

METHODS: In 2011, a multi-method situation analysis was conducted in three areas of Blantyre district, with additional data collected in Mangochi and Lilongwe districts. Seventeen relevant national documents were analyzed. A total of 10 focus group discussions (FGDs), 2 small groups and 14 individual interviews (IIs) were conducted with health care providers; 18 FGDs and one small group discussion were conducted with male and female, urban and rural community members; 12 in-depth interviews (IDIs) with survivors; 26 key informant interviews (KIIs) with donor agencies, GBV service providers, religious institutions; police officers and other stakeholders were conducted. A review of 3,567 register records for the month of January 2011 was done in Queen Elizabeth Central Hospital and police records on violence cases in Blantyre for the same month were reviewed. Qualitative data was analyzed using the 'framework' approach, assisted by NVIVO 9 software. Hospital records were analyzed using Epi Info™. Feminist approaches and the ecological framework for analysis of violence informed data analysis and interpretation. A range of quality assurance measures were undertaken and data were triangulated across all methods: policy analysis, interviews and records reviews.

FINDINGS: A review of legislation and policy combined with qualitative stakeholder interviews revealed conflicts, gaps and lack of awareness of the available documents that undermined coordinated health sector responses. Survivors, community members and health care workers revealed that IPV is perceived as a massive, though under-recognised problem. IPV in its various forms was seen as widespread and normalised, except perhaps in the perceived severe forms (such as femicide and child rape). IPV, though considered as shameful, was not necessarily a very private matter with involvement of neighbours, families, friends and significant others. Various factors at individual, interpersonal, society and institutional levels were described as affecting under-reporting, access to services and responses from sources of support.

The review of registered data confirmed that IPV is generally underreported in health services and that relying on trauma as a proxy for IPV against women would prove difficult to implement. This multi-method approach highlighted the importance of diagnostic identification and the difficulties of universal screening. The actual role of health services in IPV seemed fuzzy from the service user's perspectives and narrowly confined to the bio-medical model or acute model of health service

provision. However, both potential service users and health care providers were optimistic about new developments such as 'One Stop Centres' and about the potential role of health services, particularly those linked to HIV programmes. They suggested these be provided as a continuum from prevention to rehabilitation.

CONCLUSIONS: This study found a range of laws and policies that define and promote action to prevent IPV in Malawi. These have had some positive influences on both community norms and health sector responses. However, ineffective promotion has limited their effectiveness. In addition there are gaps and inconsistencies that reduce their potential in guiding the health sector response to IPV. The study explored stakeholders' perceptions of IPV, the health sector response and the factors shaping it. This revealed a complex web of interconnected socio-economic, cultural, political and institutional factors. Perceptions of violence are culturally normative and related to gender roles and expectations. The inclusion of male voices on IPV against men, and using emic definitions of violence revealed conflicts between women's and men's interpretations of IPV, particularly with regard to sexual violence and the transgression of gender and marital roles. The specific socio-economic and cultural context strongly favours a conflict resolution model of responding to violence, which raises questions about the mandate and the potential roles of the health sector. Most stakeholders perceive IPV as a significant problem and recognise multiple impacts on health. However there is a clear disconnect between the magnitude of the problem and the health sector response. Nevertheless, the health sector is well placed to play a leadership role and has some resources, such as HIV Testing and Counselling staff and curricula to offer in a multi-sectoral response.

Proxy determinants as reflected in the health service registers proved to be inadequate due to poor reporting and recording, and under-reporting to health services. Under-reporting was influenced by a range of inter-connected barriers to formal help-seeking, including normative attitudes and ineffective responses by both informal and formal sources of support. However, knowledge was generated about the challenges to recording and reporting IPV in this setting.

The study findings suggested a number of key opportunities for improving the health sector response to IPV in Malawi that may be appropriate in this specific context and considered their potential sustainability.

Declaration

The material presented in this thesis is as a result of my own work and has not been presented, nor is it currently being presented, either in part or wholly as part of any other degree or another qualification

Table of Contents

List of Figures

List of Tables

List of Acronyms

CBDA	Community-Based Distributing Agents
CCPJA	Child Care Protection and Justice Act
CDC	Centers for Diseases Control
CH	Central Hospital
CHAM	Christian Health Association of Malawi
CHRR	Centre for Human Rights and Rehabilitation
CSA	Child Sexual Abuse
DHMT	District Health Management Team
DIP	District Implementation Plan
EC	Emergency Contraception
EHP	Essential Health Package
GBV	Gender-based Violence
GENET	Girls Empowerment Network
GOM	Government of Malawi
HCW	Health Care Worker
HMIS	Health Management Information System
HTC	HIV Testing and Counselling
HSA	Health Surveillance Assistant
HSSP	Malawi Health Sector Strategic Plan
IDIs	Individual in-depth interviews
IIs	Individual interviews
IHS	Integrated Household Survey

ILO	International Labour Organisation
IPV	Intimate Partner Violence
KIIS	Key informant interviews
MDGs	Millennium Development Goals
MDHS	Malawi Demographic Health Survey
MEGEN	Men for Gender Equality Now
MGDS	Malawi Growth and Development Strategy
MHRC	Malawi Human Rights Commission
MoLGRD	Ministry of Local Government and Rural Development
MoH	Ministry of Health
NCD	Non-communicable diseases
NGO	Non Governmental Organisation
NGOGCN	Non Governmental Organisations Gender Coordinating Network
NSO	National Statistical Office
NYCOM	National Youth Council of Malawi
OSC	One Stop Centre
PDVA	Prevention of Domestic Violence Act
PEP	Post exposure Prophylaxis
POW	Programme of Work
QECH	Queen Elizabeth Central Hospital
SRHR	Sexual Reproductive Health and Rights
SSA	Sub Saharan Africa
STI	Sexually Transmitted Infection

SWAP   Sector Wide Approach

SWO   Social Welfare Officers

UNAIDS   Joint United Nations Programme on HIV/AIDS

VAC   Violence against Children

VAW   Violence against Women

VCT   Voluntary Counselling and Testing

VHC   Village Health Committee

VSU   Victim Support Unit

WHO   World Health Organisation

Chapter 1: Introduction to the thesis

The introductory chapter of this thesis gives the rationale, justification and structure of the thesis. The study was built on the understanding that the health care sector has an important role to play in violence prevention but there is a limited health care response to IPV in resource-poor settings, including Malawi, and a growing need for context-relevant interventions in sub-Saharan Africa. The study aimed to understand the health service response to IPV in Malawi from a wide range of perspectives to inform development of a context-relevant health care response. The following were the specific objectives:

1   to critically analyze written legislation, policy and strategy documents in relation to IPV and the health sector in Malawi;

2   to describe the perceptions and experiences of IPV and of health sector responses among survivors of violence, community members, health care workers and other key stakeholders in Malawi;

3   to estimate the extent of intimate partner and sexual violence from a health service uptake perspective using proxy determinants at one referral hospital in Malawi;

4   To explore the policy implications of the study findings for the health sector response to IPV in Malawi

1.1 Rationale and justification for the study

Violence is an enormous global public health problem that increases the risk of injury, disease and poor mental health, overburdens the health systems while also impeding economic and social development [1]. Each year 16 million people around the globe receive treatment for violence related injuries, and results in about half the number of deaths due to HIV/AIDS, roughly equal to deaths due to tuberculosis and 1.5 times the number of deaths due to malaria. In the year 2002, violence accounted for an estimated 1.6 million deaths globally; of these 37% were due to interpersonal conflicts, including intimate partner violence. The brunt of the burden is felt in resource-poor and middle-income countries [2], with higher levels in Africa and in low and middle-income countries of America.

Deaths from violence are just the tip of an iceberg. For every death, non-fatal injuries due to violence lead to dozens of people hospitalized, hundreds of emergency department visits and thousands of doctor's appointments[3]. Over and above these deaths and injuries, violence has numerous non-injury health consequences, including high-risk behaviours, such as alcohol and substance misuse, smoking, unsafe sex, eating disorders and the perpetration of violence

and, these risk behaviours contribute in turn to such leading causes of death as cardiovascular disorders, cancers, depression, diabetes and HIV/ AIDS [4].

Violence, takes different forms, ranging from war to homicide, from assault to child maltreatment and intimate partner violence. Its consequences can profoundly affect the fate of infants and children, grown men and women, as well as nations. Most violence related deaths occur in peaceful countries and are often self- inflicted , and perpetrated by people known to the survivor, such as parents, intimate partners, friends, and acquaintances [5]. Intimate partner violence, in particular, is the most common form of violence and greatly exceeds the prevalence of all other forms of physical and sexual abuse in women's lives [6]. IPV poses a major challenge for public health not only because it is an important risk factor for a range of health problems, but also because it can be a strategic entry point for violence prevention and more broadly because many forms of violence occur within the family where habits are formed for successive generations [6].

Legislation and policy on violence, including intimate partner violence, are variously interpreted and used in different contexts and while they are influenced by international policy there is a strong local influence that both reflects and shapes prevailing cultural beliefs about violence. A good example of this is the lack of statutes on rape in marriage in many contexts.

There is also a growing awareness of the need for health care workers to respond and offer better health services to the cases of violence that they encounter [4, 7], but there is a lack of serious intervention in sub-Saharan Africa [7, 8]. Survivors in these settings have extremely limited access to adequate emergency medical services, psychosocial help, and legal assistance [1]. Most violence interventions have been implemented in the developed world [9], and have yet to be systematically implemented and monitored for their impact in low- and middle-income countries where the problem is the largest and the potential prevention gains are the greatest [5].

Health care services, and particularly reproductive health programs in developing countries, provide an important site of opportunity to address the needs of abused women, as most women come into contact with the health system at some point in their lives. In addition, reproductive health services have a long history of dealing with counselling and sensitive issues like HIV and AIDs [10]. However, the role of health services in resource poor settings is debated[10, 11]. Some experts feel that HCWs in resource settings can function in a supportive

role by making sure that survivors are not revictimised in health care settings or actively identify survivors through asking all women about their experiences of abuse or identify those at risk for abuse [10]. To identify those at risk health care workers may need to come up with a list of proxy conditions for IPV [10]. In recent years emphasis is also being placed on primary prevention of IPV [12, 13]. Understanding how health care providers and consumers of health services including survivors of abuse, conceive the burden of IPV and the role of the health care services in preventing violence can help to lay the foundation for relevant and sustainable preventive health intervention.

1.2 Structure of the thesis

The thesis follows a logical interconnected structure as seen in the conceptual framework (fig 1.1)

Chapter 2 locates the study in relation to previous research. The chapter first presents the magnitude of IPV as estimated in international and regional literature. Theoretical explanations with regards to causes of IPV are then presented, and the attitudes towards
IPV are examined, followed by a review of multiple consequences of IPV. The chapter ends by examining the health care sector responses and debates surrounding screening for IPV in health services.

The local literature on IPV in Malawi is presented in *Chapter 3*. The chapter also briefly introduces Malawi: its location, population, political, social and economic situation, and the health status of its people; the social and family structures, the gender-based violence situation and the health sector response are covered.

Chapter 4 details the research methodology used in this study. It justifies choices and use of methodology and supports the credibility of the research, including researcher positionality.

Chapter 5 presents an assessment of the legislative and policy environment and frameworks governing the health sector's response to IPV. The chapter seeks to explore the content, awareness, and perceived usability and relevance of legislative and policy documents governing the health sector response to violence in Malawi. This assessment combines critical analysis of the legal and policy documents with qualitative research findings drawn from interviews conducted with key informants, health care workers (HCWs) and other stakeholders.

Chapter 6 describes the perceptions and experiences of IPV as obtained from individual in-depth interviews with men and women who had accessed IPV services, and FGDs conducted with community and HCWs, and Key informant interviews with other key stakeholders such as NGOs, donors and police. Data on the perceptions and experiences of IPV are organised along the themes that were generated from the data and prior issues: the spectrum of intimate relationships and constructions of marriage; understandings and definitions of various forms of IPV; its perceived magnitude; its forms; its causes; and consequences, including perspectives on IPV and health.

Chapter 7 This chapter explores perceptions and experiences with informal and formal sources of support for IPV, considering the barriers and enablers to help seeking; the role of different actors including the actual and potential role of the health services from the point of view of survivors, communities and health care workers. Routine record review data from a tertiary referral hospital are presented as a case study to further define the potential and actual health services responses.

Chapter 8 discusses how the main research findings relate to the reviewed literature in chapters 2 and 3; and responds to the research questions. The chapter also outlines the contribution the thesis has made to the existing body of knowledge on IPV, and makes suggestions to future areas of research. Finally, the chapter draws conclusions by synthesizing the main research themes.

Figure 1.1 A conceptual map of the thesis

Chapter 1: Introduction

Chapter 2: Theoretical foundation and international context

Chapter 3: Background and Local context

Chapter 4: Methods

Qualitative

Quantitative

KIIs

FGDs

IDIs

Register review

Chapter 5: Analysis of the legislation and policy environment

Chapter 6: Malawian perspectives on IPV

Chapter 7: Perceptions of IPV services in Malawi

Chapter 8: Discussion and conclusions

Chapter 2: Literature review

2.0 Introduction

This chapter locates the study in relation to previous research on IPV in Africa and identifies gaps that informed the development of data collection instruments. Both published and grey sources were consulted for literature on intimate partner violence (IPV). Considering that the body of knowledge on IPV is ever growing, the review on prevalence, risk factors for, attitudes towards and health effects of IPV focused on studies done in Africa and on multinational studies that included samples from Africa. In this section, proximity was considered: i.e. research that is closely related to my own in the following areas: perspective; objective of the study; and geographical closeness. This does not disregard the fact that Africa is ethnically, culturally and religiously diverse. In addition, the different countries' educational and economic backgrounds vary. Whilst embracing the heterogeneous conditions of Africa, African studies are especially relevant, due to the somewhat shared context. However, there was an exception to this for the healthcare response literature and interventions for IPV. Most of the literature included here was international literature because less work has been done in Africa and other developing countries.

The chapter has been organized into seven sections: Section 2.1 presents the definitions and conceptualizations of IPV. It explores how the definitions of IPV have evolved over the years, why some scholars advocate for broader definitions of IPV and presents the definitions used by the thesis. Section 2.2 presents the scope of IPV, starting with an overview of the global picture and then concentrating on African countries, mostly in sub-Saharan Africa. Section 2.3 outlines and discusses theories of the causes of IPV; section 2.4 examines evidence for risk factors for IPV, the gender symmetry and asymmetry debates are discussed and geographical variations and similarities in the extent and risk factors for IPV are outlined. Section 2.5 presents research that links IPV to negative health outcomes and how women cope with abuse in their relationships and help seeking strategies. The final section, health care responses to IPV, discusses the literature highlighting the role of the health sector in preventing and responding to IPV, and gives an overview of the existing interventions to improve health sector for IPV highlighting those that have been tried in African contexts. International literature is cited more here than other sections due to limited interventions in Africa. This section includes the debates surrounding screening for IPV in health care settings and those involving mandatory reporting of IPV.

2.0.1 Search strategy

The following Data bases were searched: ISI web of knowledge, Scopus, Science Direct, Proquest, EBSCI, OVID SP, Pubmed, CSA Illumina, HINARI and relevant websites such as that of the World Health Organization. The following were the search terms that were used either in combination or isolation using Boolean terms and /or, " ", or aesterik*

Violence/ Interpersonal violence/ Wife abuse/

Spouse abuse/ Dating violence

Health/ Healthcare/Health care response/Health care policy/ Health systems/ Health care delivery systems/ Public health

Intimate partner violence/ Intimate partner abuse/ Partner abuse

Battered women/ Domestic violence/ Wife battering/wife beating/spousal violence

Emotional abuse /psychological violence

Sexual violence/ Rape/ Sexual harassment

Gender violence/ Gender-based violence/ gender based violence

Victim*/Survivor

Developing countries/low resource countries/underdeveloped

Africa/sub-Saharan Africa

Post rape care/ Post-rape care/ Post rape care interventions

2.1 Defining and conceptualising Intimate Partner Violence

2.1.1 Defining violence

The World Health Organization (WHO) working group 1996 defines violence as: *"the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community that either results in or has a high likelihood of resulting in injury, death, psychological harm, mal-development or deprivation"* [4]. There are various typologies of violence (see Figure 2.1). From the public health perspective, violence is divided into three categories: self-inflicted, interpersonal and collective violence, which are differentiated by the type of perpetrators: 1) interpersonal comprises intra-family violence which can be perpetrated by the spouse, parent or other close relatives; and violence by strangers or known people on streets and public sites; 2) collective, which is committed by states, organized groups, organized crime and may also be social, economic or political; and, finally, 3) self-inflicted, like suicide, attempted suicide and self-abuse. Violence is also classified according to its nature/form and expression such as physical, sexual, psychological

and neglect or deprivation (see the bottom section of Figure 2.1).Human rights and gender activists categorise violence against women and girls under the umbrella term of gender-based violence (GBV), emphasising the point that violence is inflicted on them based on their gender. However, it has been argued that understanding each type of violence separately is important, as factors that perpetuate or ameliorate it may differ [14]. The red boxes in Figure 2.1 locate IPV on this proposed typology

Figure 2.1: Typology of violence[4]
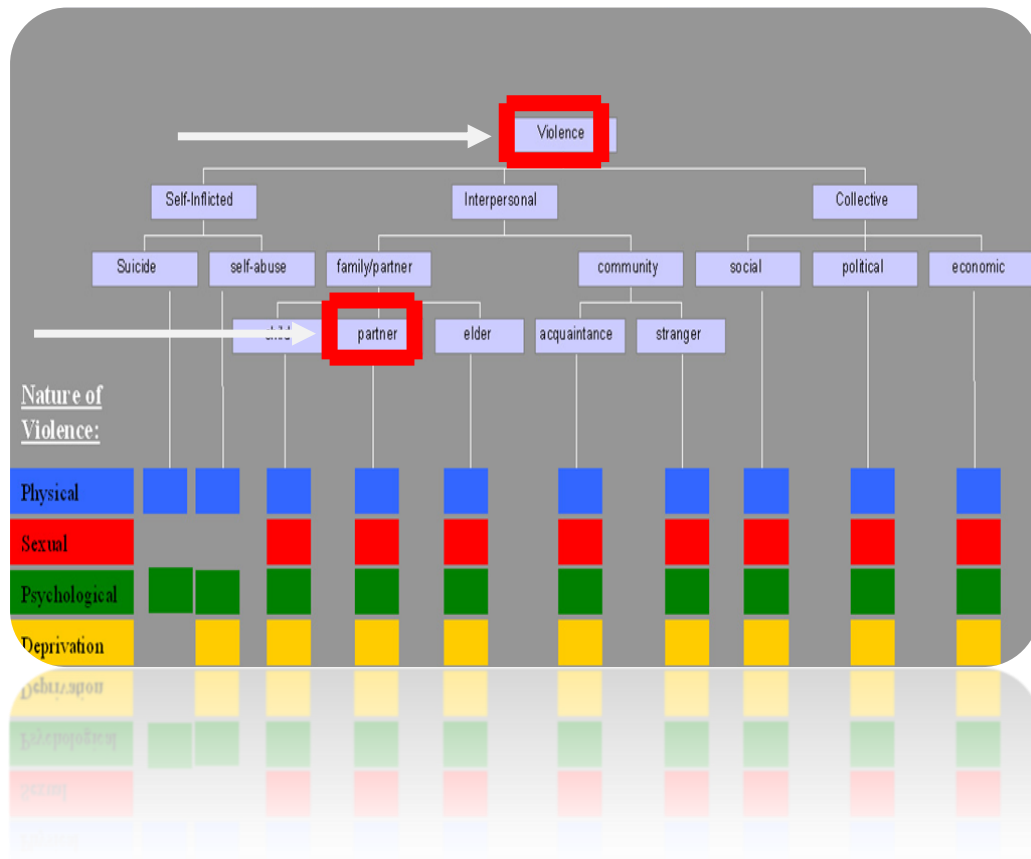
2.1.2 Changing terminologies

Intimate partner violence has over the years been conceptualised in different ways. Early gender-based violence (GBV) researchers referred to it as 'battering', labelling those who suffered it as 'battered women' and its perpetrators as 'batterers'. The concept 'battered woman' pointed to the repetitive nature of both physical and psychological abuse women suffered at the hands of their husbands/partners [15]. However, the concept was disfavoured for reducing all women who had at one point experienced abuse to their experience, and for shifting the blame to the victim rather than to the individual who is responsible for the syndrome [16, 17]. The term 'wife abuse' replaced woman or wife battering. The concept wife abuse, however, was perceived as too exclusive in the light of evidence indicating that

violence does occur in other types of intimate relationships (e.g. same sex, cohabitating and dating couples, and couples in the process of separation and divorce) [18, 19], and is also perpetrated against men [20]. Consequently, the term 'domestic violence' (DV) was adopted [21].

In her analysis of the term 'domestic violence', Dempsey (2006) identified three key constituent elements, namely: 1) violence, 2) domesticity and, 3) structural inequality. She observes that the element of domesticity is critical in distinguishing domestic violence from other generic forms of violence. It locates violence to the home: a private sphere where conduct is protected from external scrutiny. Under this account non-domestic violence is conceptualized as 'public', understanding that it is taking place in open or public spaces. She argues that the public –private dichotomy has historically led to fewer prosecutions of domestic violence assailants even when the survivors have actively sought help from the justice system. Domesticity also points to a type of relationship typically characterized by intimacy, familial ties or a shared household; for example, spouse, parents, children, siblings and current or former intimate partner [22]. In spite of this, the appropriateness of using the term domestic violence interchangeably with IPV has been questioned, since it is argued that domestic violence encompasses other forms of violence such as violence against children and elders, which occur in the sanctity of the home [19].

2.1.3 IPV is not only physical acts of aggression

Initially IPV was synonymous with physical violence or battering [19]. This conceptualization reflected the initial focus on the physical violence experienced by married, heterosexual women [19]. This traditionalist's perspective of restricting the definition of IPV to physical acts is mostly adopted by criminology and sociology [22], used in many epidemiological studies[23-26], and has enabled researchers to compare findings across studies [27]. The separation of physical from non-physical violence is seen as exceptionally problematic in domestic violence research. Opponents to this proposition argue that domestic violence does not only encompass beating, frightening with a weapon and slapping [28], but encompasses all forms of violence, including any behaviour that demeans or controls the partner including the direct use of physical force, sexual coercion, psychological attacks and structural inequality [22]. These arguments began in the 1990s, when evidence from qualitative studies revealed that women suffered from many non-physical acts of violence [29]. However, some of the non-physical violence acts are most difficult to define, such as psychological violence, which

often appears to be used interchangeably with emotional violence [29]. Hamby also acknowledges the role of sexual behaviour in intimate relationships and highlights the importance of including sexual violence in IPV studies [30]. In spite of the definitional difficulties, the IPV definition that includes non- physically violent aspects of power and control, such as financial abuse, is favoured for more accurately representing the experiences of women living in abusive relationships [31]. This is a position commonly shared by most domestic violence advocates and feminist researchers and supported by the ecological framework for analyzing violence [32].

2.1.4 Gender symmetry debates

Considerable debate in IPV research has centred on whether it is primarily men who are violent in intimate relationships or whether there is gender symmetry in perpetrating violence[18, 33]. Family violence researchers argue that both men and women are equally violent, proposing a model of gender symmetry, which contravenes feminist beliefs about gender asymmetry in IPV (see section 2.3.3). Johnson argues that differences observed between feminists and family violence researchers could arise from methodological differences resulting from selection bias. Family violence researchers rely on population based quantitative surveys while feminists have relied heavily on qualitative research and recruited their samples from shelters and other service centres[16]. The WHO expert meeting on health sector responses to IPV recognises the on-going gender symmetry debate. Based on lessons learnt from the British crime Survey, they proposed that population based studies with DV modules should include questions about fear, injury and contextual factors that may help to compare and contrast experiences of men and women.

2.1.5 Johnson's typology of violence

Johnson (1995) tries to answer the gender symmetry-asymmetry by constructing a typology of violence that aims to reconcile the differing perspective by demonstrating that there is a range of IPV from the classic male to female violence, to the couple who engage in mutual violence, through to the less common female aggressor and male victim [21]. Johnson's typology includes: 1) Intimate terrorism (IT), 2) situational couple violence (SCV); 3) Violent resistance (VR); and 4) separation motivated couple violence (SMCV)[16]. Intimate terrorism describes an on-going pattern of violence and coercive control that is almost exclusively committed by men and is likely to: frighten the victim; lead to them seeking a

protection order, shelter, or a divorce; result in injuries that require medical attention; and draw the attention of others who report incidents to authorities [34].

Intimate terrorism is seen as a product of patriarchal traditions of men's right to control "their" women. It is similar to 'wife beating' or 'battery'. It focuses on physical aspects of IPV [16]. SCV is a form of IPV where arguments escalate to verbal aggression and ultimately to physical aggression. It does not involve a general pattern of coercive control [16]. VR is a response by many of the women (and the few men) who are trapped in a relationship with an intimate terrorist. Johnson suggests that the observed differences between family violence and feminists researchers could be due to the influence of sampling bias and methods of data collection [16] which mean that researchers are studying different forms of violence based on the samples recruited.

What is apparent from the literatures above is that scholars differ in their conceptualization of the problem of IPV and it has also been argued that a broader definition better represents the experiences of abused individuals. In the next section, the researcher presents definitions used for the study and justifies their selection in this study.

2.1.6 Definitions used in this thesis

This study uses the term **IPV** as opposed to DV. In doing so, the study differentiates violence between partners (within intimate relationships) from violence between persons known to each other (including relatives, some of whom could be members of the domestic household) and violence between strangers. Feder has argued that there is no intimacy in DV [35], but this study recognizes that there are many non-intimate partnerships in any social setting, so it maintains intimate to single out the type of relationship under study. The definition is inclusive of other forms of non-marital intimate relationships but confines itself to hetero-sexual relationships for contextual reasons. **'Intimate relationship'** in this thesis refers to dating or pre-marital relationship, cohabiting, or marital relationships. Nonetheless, due to the frequent use of the term domestic violence in the literature, this term may appear in the literature review especially where other people's work is cited. The terms wife abuse or beating and spousal violence are also used due to their frequent use in Demographic Health Surveys.

The WHO defines IPV in the World Report on Violence and Health: as any form of behaviour within an intimate relationship that causes physical (slapping, kicking, hitting or beating) sexual and psychological harm (intimidation or constant humiliation). It includes

acts of physical aggression, psychological abuse or forced sexual intercourse or any form of controlling behaviour (isolating the person from family and friends, monitoring their movements and restricting access to information or assistance) [4]. The same definition is adopted by the East Central and Southern African Health Community [36]. This definition of IPV was favoured by the thesis at the onset of the study for various reasons: 1) the study is informed by both feminist approaches and the ecological framework and public health perspectives; 2) GBV literature from Malawi (see chapter 3) reveals that communities view IPV from a broad perspective; and 3) finally the health focus of the study made it appropriate for this thesis. However, the definition changed slightly as the thesis progressed because the study sought local definitions of IPV (for justification of this, see the methods and chapter 3).

The term 'Intimate ppartner' is used to refer to a person with whom a woman has or has had an intimate or close relationship, though not necessarily of sexual nature. Such persons may include a spouse, former spouse, live-in partner or former live-in partner (cohabiting), boyfriend/girlfriend or former-boyfriend/girlfriend.

In describing the abused, the thesis uses the term survivor as opposed to the word victim. The word victim is a dominant focus in international women's rights and the term has been used to lobby the law. Critics have observed that the term victim reinforces gender and cultural essentialism and that the focus fails to take advantage of the liberating potential of feminist insights [37]. The word survivor originates from a behavioural model, which locates a certain degree of agency among survivors of violence to end violence. Survivor theory posits that survivors actively utilize help-seeking behaviours of various types as a response to abuse [38]. This challenges the concept of victim who is depicted as passive waiting for help and the perception that women engage in learned helplessness as a primary coping mechanism [38]. In some literature the ''victim'' and ''survivor'' dichotomy denotes the stage at which abused women are. For example, Platt used the word victim referring to the situation of people who were still in the relationship with the perpetrator and survivor was used when referring to those who had exited abusive relationship [39]. Collins argues that abused women continuously engage in efforts to survive conditions in which they live by seeking help, persisting through adversity and adaptation as survival mechanisms for themselves and their children [38]. It is the intention of this study to portray women as agents in help seeking, hence, the adoption of the word survivor.

2.2 Magnitude of intimate partner violence

Having looked at the operational concepts for the study in the previous section, this section presents the magnitude of IPV starting with statistics estimating the scale of the problem at international level, and then turning to regional literature to get an understanding of the extent of IPV in Africa. The study does not only intend to assess the extent of the problem, but also to understand reasons for the variations observed in different settings.

2.2.1 Global Perspective

Intimate partner violence is undoubtedly recognised as a wide-spread phenomenon, cutting across national boundaries, race, ethnicity, religious divides and educational backgrounds to affect the lives of millions of people, especially women and children, on daily basis [28] Physical and sexual intimate partner abuse forms the largest proportion of abuse that women are exposed to in their life time [14], but the proportion of women reporting IPV varies across countries [40]. Variations in data collection instruments and study design in domestic violence studies have made the data unreliable and difficult to compare data across countries [41]. Multi-national population-based studies and the inclusion of the domestic violence module in the demographic health surveys (DHS) have made it easier to compare cross-country data. These population-based multi-national studies on domestic violence have revealed a lifetime prevalence of 15%-75% IPV and sexual violence rates of up to 26% in the participating countries [40, 42]. More African and Latin American women reported having experienced more intimate partner violence than European and Asian women in a synthesis of 23 sets of DHS data that involved 19 countries across the globe [43]. Despite the availability of documented evidence of the magnitude of IPV, gaps in the data still remain. In many cases violence is underreported, leading to under-recognition and limited resource allocation to deal with it [44]. The cultural stigma surrounding the subject of violence often makes women hesitate to report abuse for fear societal of condemnation [45].

2.2.2 Magnitude of IPV against women in Africa

There is a growing literature estimating the extent of IPV in African countries. These studies range from systematic reviews [46] to qualitative studies [47-49] and involve different population groups including pregnant women [50-59], HIV-positive women [60-65], and homicide cases [66-69]. Rates of IPV, physical, sexual, motional, cultural and other forms of violence studies in Africa are presented in Table 2.1 range widely between settings and studies and available literature depend more on where and why studies were done than providing a comprehensive

view of the burden. Thus the range of prevalence rates may result from sampling and measurement biases as well as differences in contextual factors responsible for the production of IPV. Most of these studies measured physical aspect of domestic violence. Few reported emotional violence and deprivation.

Table 2.1: Studies on magnitude of IPV in Africa

Type of IPV	Range of rates	Studies	Source of data (country)
All IPV	39.8% - 72%	Alio et al.,[70] Deyessa et al., 2009	Sub-Saharan Africa Ethiopia Rwanda
Physical violence	17% -52.6%	Abuya et al., 2012, Adekeye, 2008, Akmatov, 2008, Alio et al., 2009b, Alio Ap Fau - Salihu et al., 2011, Ameh et al., 2007, Andersson et al., 2004, Deyessa et al., 2009, Deyessa et al., 1998, Dibaba, 2008, Djamba and Kimuna, 2008, Dude, 2009, Emenike et al., 2008, Ezechi et al., 2004 Fonck et al.,2005	Kenya Nigeria Egypt Africa Cameroon Nigeria Southern Africa Ethiopia Ethiopia Ethiopia Kenya Nigeria Kenya Nigeria Kenya
Sexual violence	12.9% -21.5%	Abuya et al., 2012, Alio et al., 2009b, Alio Ap Fau - Salihu et al., 2011, Djamba and Kimuna, 2008, Dude, 2009, Emenike et al., 2008, Ezechi et al., 2009.	Kenya Africa Cameroon Kenya Rwanda Kenya Nigeria
Emotional/psycholo gical violence	12.9% - 52.3%	Abuya et al., 2012, Alio et al., 2009b, Alio Ap Fau - Salihu et al., 2011, Ameh et al., 2007, Dude, 2009, Emenike et al., 2008, Ezechi et al., 2004.	Kenya Africa Cameroon Nigeria Rwanda Kenya Nigeria
Economic violence	30% - 46%	Ammar, 2006, Ezechi et al., 2004	Egypt; Nigeria
Verbal abuse	51.7%	[71]	Nigeria
Deprivation	6.2%	Ameh et al., 2007	Nigeria
Social violence	35%	[72]	Egypt
Cultural violence	19%	Ammar, 2006	Egypt
IPV during pregnancy	2%-57%	Shamu et l., 2011 Ameh, 2009 Efetie and Salai, 2007 Gyuse and Ushie, 2009 Hoque et al., 2009 Ntaganira et al.,2008 Umeora et al .,2008 Olagbuji et al ., 2010 Kaye et al., 2006	Africa Nigeria Nigeria Nigeria South Arica Rwanda Nigeria Nigeria Uganda
Homicide	50.3%	Abrahams, 2009	South Africa
	0.75 murders/year (males)	Adinkrah, 2007	Ghana
	72(f) (1990-2005)	Adinkrah, 2008	Ghana

2.2.3 Magnitude of intimate partner violence against men in Africa

However, evidence indicates that a certain proportion of men are abused by their female partners although very few studies have explored this. In available studies the prevalence of female to male violence ranged from 0.0023%- 84.2%[26, 73, 74]. The most frequent form of abuse cited by men was verbal abuse (76%), followed by sexual violence (58.9%) [73]. Examples of the verbal and physical abuse encountered by men were: being cursed/ making demeaning remarks about them, challenging their authority, not receiving adequate attention, public humiliation and making jokes at their expense. With regard to acts of sexual violence men reported the following: not being allowed to have sexual intercourse by their partners; being compelled to have sex when tired or ill; withdrawing when the man is ejaculating; making jest about the man's penis size; and unpleasant jokes about men's sexual performance[73].

Studies reveal the gendered nature of interpretations of abuse and it raises the question of whether some of the actions described can really be seen as abuse. Although women can also be physically violent towards their male partners, the vast majority of intimate partner abuse is perpetrated by men against their female partners. The prevalence of husband battering was very low, at 0.0023% in the retrospective study involving 220,000 patients seen at a primary care setting in Nigeria. Medical records over a period of five years were used to retrieve the information. Victims sustained scratches, bruises, welts, and scalds. Low prevalence rates were attributed to men's unwillingness to disclose domestic violence and that most men experience psychological abuse which is culturally not regarded as violence in Nigeria[74].

2.2.4 Prevalence of IPV in dating or premarital intimate relationships

Dating violence or pre-marital intimate partner violence is also a serious problem among teenagers and young adults in sub-Saharan Africa [75]. In a study that investigated the determinants of SV among students in Eastern Ethiopia secondary schools found that as high as 70% of the young men self-reported to have perpetrated SV and 68% of the young women were survivors of at least one instance of SV. About 56% of the young men and 52% of the young women admitted to have experienced sexual harassment, such as verbal remarks) [76]. In a survey of school students in Cape Town and Mankweng (South Africa) and Dar es Salaam (Tanzania) in a multinational randomised control HIV trial 10.2%−37.8% reported experiencing IPV, 3.1%−21.8% reported perpetrating IPV, 8.6%−42.8% reported being both survivors and perpetrators [77]. Swart found that 52% of girls and 49.8% were involved in

physically violent relationships [78], whilst Oduro found that 51.2% of the girls who had experienced sex were forced [79].

2.2.5 Summary

Although there are variations in the prevalence of IPV within and across countries, the literature reviewed has demonstrated that IPV is prevalent and it is a problem at global level, regional and national levels that cuts across the age divide. A lack of consistency in measurement of the timing of abuse and acts of abuse may have accounted for variation in the observed prevalence rates but the data may also be pointing to differences in contextual or cultural factors in the production of IPV, making it very important for developing contextual understandings. Many studies have used a narrow lens of viewing IPV, as they have concentrated on measuring physical IPV, and to some extent sexual abuse at the expense of other forms of abuse such as psychological and economical abuse, yet these are reported in high percentages in the studies that have attempted to measure them. The next section examines the various theoretical explanations, which have attempted to explain the reasons for the prevalence of IPV.

2.3 Theories of causes of IPV

Understanding the causes of IPV is much harder than studying a disease because IPV is a product of social contexts. The social conditions producing it may vary from one country to the other [23]. Consequently, the causes of IPV have been debated over the years, and very little consensus exists regarding its causes [80], because the existing evidence on causation appears to be relatively weak from the epidemiological perspective [23]. In spite of this, many theories have existed and evolved over time to try to identify the reasons for IPV [81]. These theories are not mutually exclusive, and they all seem to acknowledge the role of abuse of power in the perpetration of violence although they approach this from a different theoretical orientation [81].

This section will focus on the following theoretical perspectives : 1) psychological (sometimes referred to as 'life course' perspectives, 2) sociological perspective or family and systems theory, 3) feminist perspectives, 4) cultural explanations, 5) 'culture of violence' explanations and 6) the socio-ecological theory. Cultural explanations and 'culture of violence' theories are found particularly in the African domestic violence literature [82].

2.3.1 Psychological perspectives ('life course theories') of the causes of IPV

Life course research is concerned with developmental issues and therefore focuses on the longitudinal or temporal progression of people's lives [83]. Psychologists and psychoanalysts have used the "life-course perspective" to focus on understanding the perpetrators' and at times the victims' malfunctioning family of origin [84]. Under this, the 'social learning theory' has been used to explain the intergenerational transmission of IPV in a cycle of violence. 'Role modelling' is central to the theory [85]. Violence is seen as a learned behaviour that an individual acquires through their interactions with others such as role models provided by the family (parents, siblings, relatives, and boyfriends/girlfriends), either directly or indirectly. These are reinforced in childhood and continued in adulthood as a coping response to stress or a method of conflict resolution [85]. There is strong evidence linking witnessing of intra-parental violence in childhood to victimisation, perpetration and having supportive attitudes towards violence later in adulthood. There is also evidence suggesting that children with a history of physical abuse as a child (especially the male child) grow up to become abusers in intimate relationships [86]. The life course perspective is also helpful in understanding IPV occurring at different stages in life; for example violence occurring at different stages of married life for example early marriage, pregnancy and later in life [87]. However, critics of the theory view its solely environmental approach as overly simplistic. For example, it is argued that familial resemblance may also be due to genetic factors because families share both genes and environments[88, 89]. Additionally, external influences such as use of drugs and alcohol abuse can play a role [90].

2.3.2 Sociological perspective:- 'family violence' as a cause of IPV.

'Family violence' theory also locates violence within the family unit and argues that the family as a unit or system has the potential for generating frustration and conflict. Violence tends to increase under conditions of positive feedback, which involves social circumstances that increase vulnerability to violence. Self-concept of the individual as a violent person, the role expectations of the victim, high community tolerance for violence, and low power of the victim are specified as some of the positive feedback processes which produce an upward spiral of violence. Factors that reduce the level of violence (offering 'negative feedback') include low community tolerance for violence, public attention and support [91]. This perspective represents a shift from the individual pathology to examining socially deviant behaviours that individuals are engaged in, such as alcohol and drug abuse. Violence in this

model is seen from the perspective of 'gender neutrality' or 'gender symmetry' as a 'double stream' – that is, the problem of both sexes [90]. The theory holds that the cause is dysfunctionality of the whole family system (perpetrators and victims). The theory has been criticised for exclusively focusing on imbalances of power within the home and ignoring the societal conditions that influence these power imbalances within the family [90].

2.3.3 Feminist theories of the causes of IPV

The feminist model has evolved over the years due to diverse perspectives within feminist movement. While early feminists focused solely on gender as a category for analysis, other feminists (e.g. feminists of colour, international and lesbian feminists) propose the importance of examining the intersections between gender and other systems of oppression such as race, class, national origin, sexual orientation and disability [92, 93]. Despite the diversity of feminist theory, the centrality of gender in understanding IPV has been asserted by many[82, 92-94]. Lenton considers inadequate any theoretical model that excludes measures of gender inequality, considering that gender is one of the major variables along which power is divided, but is rather sceptical about placing the whole picture of IPV at the feet of patriarchy [92].

Feminist theories centre on power inequalities between men and women, and focus on giving voices to the disempowered [90]. In the feminist model, violence is a 'one-way street'; that is, from male to female or 'gender asymmetrical'. Violence both creates and maintains men's power over women as female partners [95], therefore, violence is framed as a structured oppression which upholds the patriarchal privilege rather than deviating from it. In many cases, violence is synonymous to power; and failure to use power or threat may be perceived as a sign of weakness [90]. Men can, therefore, be seen as equal to 'batterers' or perpetrators and women equal to 'the battered or victims'; and aggressive women are seen in the lens of self-defence [93, 94]. However, feminist models can also acknowledge the strength, resilience, and agency of women and strives toward the goals of female empowerment and self-determination [93], and some feminist theory also acknowledges that some men can be subject to abuse, especially when they do not fit established gender norms – e.g. gay and effeminate men [96].

The most influential depiction of the dynamics of domestic violence is the power control wheel where the more powerful person will exert influence on the less powerful. In the power control wheel gender inequalities form the core of domestic violence while abusive

behaviours form a pin wheel spreading out from the core, and the physical and sexual violence are represented at the outer edges of the wheel. The aim is to emphasize the central role of structural inequality in understanding what counts as domestic violence , to establish 'conceptual connections' between different types of abusive behaviour, and to suggest that abusive control may be as much, if not more, of a problem than acts of physical violence [22].

The theory also helps to explain why some women may fail to exit abusive relationships, a phenomenon described as 'learned helplessness'. According to this model violence occurs in three repeated stages or cycles. The first stage is the tension building stage where the man gets angry and the woman remains calm to avoid abuse. This is followed by actual violence and then the 'loving' or 'honeymoon' phase. During the loving phase, the man tries to reconcile with his wife, assuring her that he still loves her at the same time as blaming her for the abuse, creating a false sense of re assurance for potential change. Feminist models challenge male entitlement and privilege as well as the traditional notion that domestic violence is a private family matter [95]. Thus, feminists demand public solutions, including the establishment of programs and services for women, who are abused, treatment for their male partners, and the involvement of the criminal justice system to hold men accountable for their violence.

Critiques of feminists theories have argued that they do not fully explain women's aggression and same –sex couples violence and also why some men beat and rape women when others do not, even though all men are exposed to cultural messages that place men in a position of superiority and grant them power to control women [97].

2.3.4 Cultural theories of the cause of IPV

Culture defines the spaces within which power is expressed, where gender relations are negotiated and gender roles re-defined. Cultural contexts are critical to the analysis of gender-based violence and are always applicable, since everyone has culture. 'Culture' has been blamed for the high prevalence of IPV in Africa, because of traditional customs and norms that support male dominance [82]. In this theory, culture is directly linked to widespread attitudes that support wife battering based on transgressing these gender norms. Other indirect explanations involve unequal power within intimate relationships, the impact of polygamy and dowry, double standards regarding male and female sexual behaviours, disputes over men's failure to meet traditional economic obligations and the women's failure to fulfil traditional wifely roles [82]. Cultural explanations may only provide an explanation of

variations in how violence is perceived and responded to among different ethnic groups [97]. However, the theory is contested on the grounds that culture is dynamic, African societies are diverse and that multiple interpretations of tradition exist [82]. There is thus a need for differentiating between cultural and patriarchal traditions [90]. Cultural explanations may be used to excuse individual for taking responsibility for their actions [98]. There is also a danger or cultural chauvinism in this theory; in that cultural explanations for violence may inherently assume that non-Western cultures are inferior to Western cultures.

2.3.5 'Culture of violence' theory of the cause of IPV

The high prevalence of domestic violence and violence against women in modern Africa has also been partly attributed to the harsh treatment Africans received from their colonial masters. This is particularly illustrated by post -apartheid South Africa where rates of IPV and rape are high. The repressive culture has been maintained through continued civil wars [82]. Gerladine Maone (1966) observes that the systems of oppression and domination that colonisers used are identical to the strategies men use to have dominion over women. Colonisers used all forms of violence against the colonised including exploitation of economic resources, which has been compared to men's current control of global economic resources [98]. In addition, it is argued that that patriarchy and colonization are closely linked and it is this connection that keeps the structures of gender violence so well entrenched[98]. However, this understanding has been contested on the basis that it may rationalise men's violence and absolve them of responsibility for their own actions by pushing the blame on the colonisers.

2.3.6 The socio-ecological theory of the causes of IPV

Formulated in 1977 by Bronfenbrenner, 'ecological theory' was first applied by Heise to explain the causes IPV in 1998 [99], with the aim of integrating individual with social-cultural theories of the causes of IPV, showing how a range of influences and contextual factors help to shape individual behaviour [99, 100]. The framework has since been revised to accommodate current evidence on the causes of IPV originating from both high and low income countries. The previous framework was limited in that it was mostly based on evidence from High income countries and limited ethnographic studies from low income countries. The advantage of the theory is that it can help to identify consequences and treatment options as well as causes. It also protects against oversimplified explanation [101].

The ecological perspective views IPV as a multifaceted problem emanating from an intersection of various factors at individual, interpersonal, community and society levels[97, 101, 102]. The ecological model consists of 4 concentric circles (see figure 2.2). The most inner circle represents the individual factors. These are personal history factors that each individual brings to his or her own behaviour and relationships, including biological factors, demographic factors, low educational attainment, substance use and prior history of abuse. The next cycle, the interpersonal cycle represents the immediate context in which abuse takes place frequently i.e. family or other intimate or acquaintance relationships. The third level, the community level known as meso level by Bronfenbrenner, encompasses the characteristics of institutions and social structures, both formal and informal such as work and neighbourhood that influence victimisation and perpetration of violence. Finally, the macro system which looks at larger society issues that influence rates of violence. These include cultural norms that support violence as a means of conflict resolution and policies and laws including health, economic, educational and social policy [99]. This level informs and structure organisation of behaviour at the lower levels of the social ecology.

The revised framework has been colour coded to illustrate the strength of evidence linking particular factors to IPV. The blue colour represents strong evidence while green is moderate and pink is weak evidence. The framework has also been revised to include specific circles on male partner and women, their relationship, and within this the conflict arena and IPV (see figure 2.2). Heise states that any effort to prevent partner violence is based on an implicit theory of what leads particular men to abuse their partners. This type of framework sets up a basis for a risk-theory of IPV, thus the following section 2.4 examines closely the risk factors for IPV.

Figure 2.2: the revised conceptual framework for partner violence

Gender order	Norms	Violence in childhood	Interaction	Childhood violence
Lack of economic rights & entitlements for women	Acceptance of wife beating	Harsh physical punishment	Non-equalitarian decision making	Child sexual abuse
Discriminatory family law	Male right to discipline/ control female behaviour	Witnessing parental violence	Poor communication	Other childhood traumas
Ease of divorce for women	Tolerance of harsh physical punishment of children	Other childhood traumas	High relationship conflict	Witnessing mother being beaten
Composite measures of gender inequality	Stigma for divorced or single women	Psychological dysfunction		**Attitudes**
		Antisocial behavior	**Conflict arena**	Tolerance of wife beating
	Norms linking male honour to female purity	Adult attachment issues	*Situational triggers*	Socio-demographic
Cultural factors	Family privacy	**Attitudes**	Sex/ infidelity	Young age (for current violence)
Collectivist versus individual cultural orientation	**Lack of sanctions**	Accepting of violence as a means to resolve conflict	Money/distribution of family resources	High educational attainment (protective)
Emphasis on women's purity & family honour	Lack of legal or moral sanction for violence	Acceptance of partner violence	Children or in-laws	**Low social support**
Economic factors	Others do not intervene	Gender hierarchical or transitional attitudes	Division of labor	**Factors that operate differently in different settings:**
Level of development	**Neighbourhood**	**Alcohol abuse**	Male drinking	
Women's access to formal wage employment	Community violence	**Gender role conflict**	*Patriarchal triggers*	Women's employment
	High unemployment	**Delinquent peers**	Female challenge to male authority	Participation in credit schemes or other development programs
	Low social capital	**Sociodemographic**	Failure to meet gender role expectations	Asset ownership
	Poverty	Young	Assertions of female autonomy	
		Low educational level		

2.3.7. Summary

This section has presented but not exhausted various theories that explain the origins or causes of violence. The section has looked at models that focus on individual factors (e.g. life course), structural inequalities (feminist perspectives, cultural and culture of violence), and those that have applied multifaceted layers to analyse IPV causes (ecological models). Although the above theories differ in their focus with regard to the underlying causes of IPV, some aspects of the causes of violence are shared by all. These include: the multifaceted and

complex nature of the problem of IPV; the life course aspect of IPV (that is, the role of childhood trauma); and the role of society in creating and maintaining IPV. Considering the complex nature of IPV, I argue for an integrated or ecological theory for this thesis. For details on how the ecological framework has informed this thesis see (chapters 4.1 and 8.1).

2.4. The web of risk factors for IPV

This section presents the risk factors for IPV. Jewkes conceptualises IPV as caused by a web of risk factors comprised of interconnecting and overlapping components that interact to produce IPV. She observes that IPV is increased in settings where the use of violence is normal, and in these settings, sanctions against abusers are often also low [23]. The following sections review the evidence for major risk factors identified by Morrison, focusing on those that were found to be prominent in the literature from Africa at each level of the ecological framework as summarised in table 2.2 below [103]. Additional triggers or risk factors such as pregnancy and family planning are added based on evidence coming from studies conducted in Africa. Young age too has been cited in many studies.

Table 2.2: Risk and Protective Factors for IPV (based on ecological framework)

Individual level[a]	Relationship level[b]	Community level[c]	Societal level[d]
Socialization and learning			
Witnessing intimate partner violence as a child (+)[e]		High neighbourhood crime rate (+)	Cultural norms that support violence as an accepted way to resolve conflicts or to punish transgressions (+)
Suffering abuse as a child (+)	Association with gang members, delinquent, or patriarchal peers (+)	Absent or maladaptive teaching of alternatives to violence (+)	
Power relations and patriarchal gender norms			
Absent or rejecting father (+)	Male control of household decision making and wealth (+)		Norms that support male dominance over women and that require women's obedience and sexual availability (+)
	Controlling behaviour by the husband (+)		
	Multiple partners or wives for the husband; number of unions for the woman (+)		Policies and laws that discriminate against women in social, economic, and political spheres
	Differences in spousal age and education (+)		
Human capital and employment			
Female education level (−)	Economic hardship (+)	Lack of economic opportunities for men (+)	
Male education level (−)			Access and control over economic resources for women (+/−)
Women engaged in income generation activities (+/−)			
Life cycle			
Age of woman (−)	Length of relationship (−)		
Triggers			
HIV status of man or woman (+)	Male alcohol and substance abuse (+)		

Key: + indicates a risk factor; − indicates a protective factor; +/− indicates an ambiguous factor.

2.4.1 Individual level

Major factors emerging as significant at the individual level are: age, witnessing IPV as a child, experiencing childhood physical abuse, pregnancy, and issues around HIV status and use of Family Planning. .

2.4.1.1 Age

In a study analysing data from the multi-country study on Domestic Violence and Health younger age of women was strongly associated with increased risk of past year IPV in all sites (significant in 12). A similar pattern was seen in bivariate analysis for partner's age. Older age of the woman was often associated with increased risk of IPV, but in only three out of fifteen sites was older age of the partner associated with increased risk of IPV [104].

2.4.1.2 Witnessing IPV as a child and or experiencing childhood physical abuse

Studies from various settings in Africa have found a strong association between history of witnessing parental violence and experiencing physical abuse during childhood with perpetration of in adult life [23, 105-110], and IPV victimisation among women [109, 111]. There is also evidence suggesting that women with history of witnessing parental violence exhibit strong attitudes supporting use of violence in intimate relationships [109].

2.4.1.3 HIV and IPV linkages

HIV prevalence rates among women are consistently high throughout the world, but the rates of IPV among HIV positive women in Africa pose a unique challenge [112]. African HIV-positive women have consistently reported high rates of IPV victimisation [71, 113-118]. HIV testing has also been reported to be a trigger for IPV [88]. The relationship between HIV and GBV is complex (see Figure2.3). Violence increases women's risk through forced or coercive sexual intercourse with an infected partner. Forced sex can lead to trauma to the vaginal wall that can increase the likelihood of transmission [119]. The threat of violence in a relationship can influence women's power and their ability to negotiate the conditions of sexual intercourse; this can include the frequency of sex [119] as well as condom use [120].

Men who are abusive to their partners are more likely to report both premarital and extramarital sex partners, to have experienced STI symptoms or received an STI diagnosis in the past year and somewhat less likely to disclose infection status to wives than their non-abusive counterparts [121]. They are also more likely to be HIV positive [122], to impose risky sexual practices on partners [110, 118, 123-126], and to anticipate a negative reaction if diagnosed HIV positive (e.g. spread the virus intentionally, sleep with a virgin) compared to the non-abusive men [26].

Gendered inequalities between men and women have long been identified as a key driver in the HIV epidemic [122]. Women are also exposed to HIV infection at a younger age than their

male peers; this is often due to them having older sexual partners [127]. Gendered roles and relations place women and girls in a socially and economic subordinate position to men and boys. This can lead to women's economic dependence, which can reduce women's ability to negotiate safer sex putting them at risk of both IPV and HIV and making these co-epidemics. In sub-Saharan Africa, notions of masculinity can equate being a man with dominance over women as well as sexual conquest and risk-taking[128]. This behaviour has been associated with less condom use, more sexually transmitted infections, more sexual partners as well as increased frequency of sex, more abuse of alcohol, more transactional sex and higher rates of IPV [122]

Figure 2.3 Pathways through which GBV and gender relationship power inequity might place women at risk of HIV infection[122]
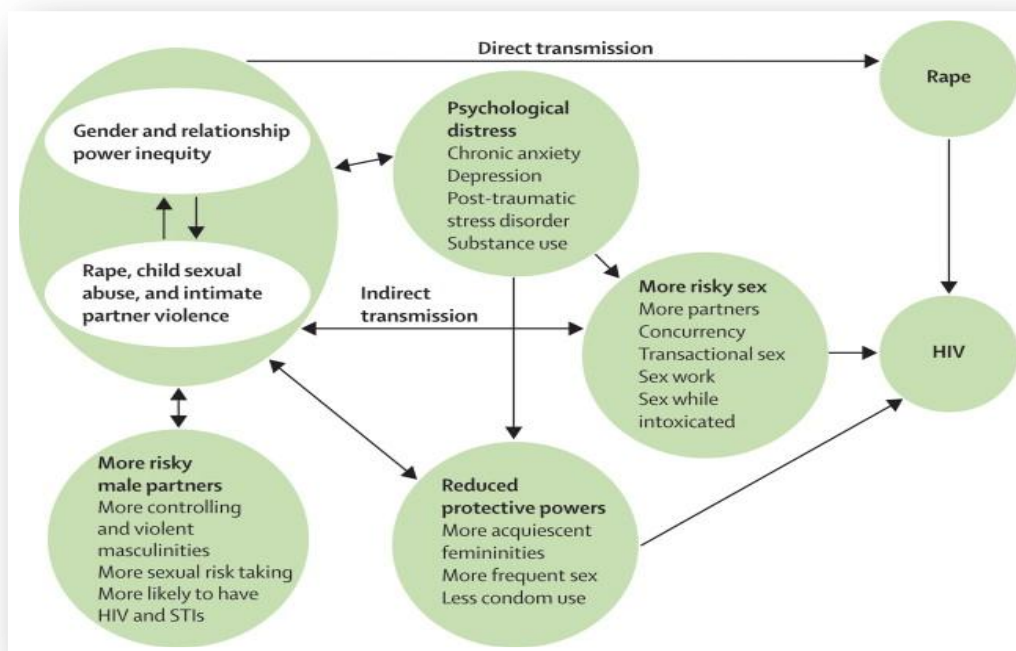
2.4.1.4 Family Planning and IPV

The association between IPV and family planning has been examined in several studies in sub Saharan Africa. These have focused on the relationship between domestic violence and use or non-use and unmet need of family planning methods. IPV may interfere with women's use of family planning methods although the direction of this association is not fully understood due to reliance on cross sectional studies and inconsistent results[129, 130]. For example, DHS data in six sub-Sahara African countries (Cameroon, Kenya, Malawi, Rwanda, Uganda and Zimbabwe) showed greater and more frequent use of modern contraception among women with history of both physical and sexual violence. The researchers concluded that women who experience violence may be motivated to use contraception to prevent pregnancy or else protect themselves against contracting HIV/AIDS and other sexually transmitted infections [70].

On the contrary, wife beating was associated with low contraceptive use prevalence rates in Egypt. The rates were even lower for women who experienced three or more beatings during the past year [131]. Echoing these findings a Nigerian study found low prevalence rates of modern contraception use among women who experienced or were threatened with violence at one point in their past [132]. However, an earlier study that examined the relationship between unmet need for contraception and violence against women in six different locations (three rural and three urban) in South western Nigeria in 2004 did not find domestic violence to be a strong factor influencing contraceptive use and unmet need for family planning [133].

Another Nigerian study demonstrated that many men have less supportive attitudes towards use of family planning methods. About 80% of men interviewed felt that they would be embarrassed, annoyed, and somehow be indifferent and dissociate themselves with any complications arising from the use of contraception if they found out that their spouse secretly used contraceptives, although wife beating was considered the worst response [134]. Clandestine use of contraception is associated with men's disapproval and violence. Wide spread use of contraception was interpreted as a sign of rebellion or marital unfaithfulness, and as such some men resort to violence on mere suspicion that women are using contraceptives. Other men think that contraceptives cause diseases or infertility, or make women become more interested in sex, so they beat women who use them [49].

2.4.1.5 Pregnancy and IPV

Pregnancy does not stop IPV[135] and sometimes it can be a period of increased risk for intimate partner violence [46]. The multi-country study on women's health and domestic violence found prevalence rates of domestic violence in pregnancy of 1%-28%. The prevalence rates in many study sites ranged from 4%-9% [136] (see Figure 2.4). A meta-analysis of 13 African studies on IPV during pregnancy [46], and on 19 DHS data [137] found IPV prevalence rates that ranged from 2% to 57%, with Africa showing one of the highest prevalence rates of IPV during pregnancy globally [46].

Battering may predate, begin and /or escalate in frequency or severity during pregnancy[138-140]. The multi-country study reported above found that many women had prior history of IPV but in three of the ten study sites, about 50% of the women had experienced violence for the first time during pregnancy [136]. However, three Nigerian studies found higher IPV prevalence rates predating pregnancy than during pregnancy, contradicting the WHO findings [56, 138, 139], and the lowest levels of IPV were reported during the post-partum period [56]. Pregnant women report more psychological/emotional violence than other forms of violence [52, 53, 141]. These experiences may vary by stage of pregnancy. An urban Nigerian study found that physical violence was common in the first trimester than the other trimesters while sexual violence was more common in the third trimester.

Risk factors among pregnant women for increased IPV during pregnancy include: young age, low socio-economic status, alcohol and drug use, sexual risk taking behaviours, cultural factors pertaining to pregnancy and HIV-positive status [46]. High levels of IPV among pregnant women have been linked to increased provider initiated antenatal HIV testing [46].

Figure 2.4 The prevalence of physical domestic violence in pregnancy: findings from the WHO multi-country study on women's health and domestic violence against women, adapted from [135].
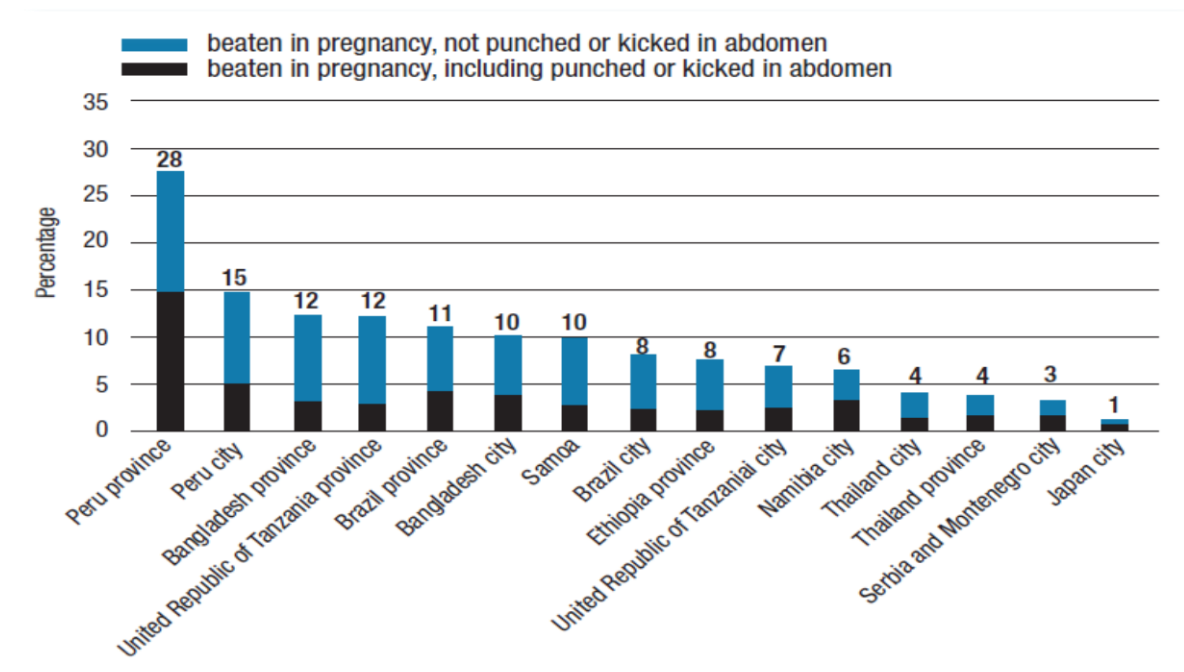
2.4.2. Interpersonal level

The major factors emerging at the interpersonal level were: relative educational status, alcohol abuse, decision making imbalances, extramarital affairs and age differences within a couple.

2.4.2.1 Relative educational status

The relationship between IPV and education status is rather complex and studies have yielded inconsistent results with regards to the role of education as a risk or a protective factor. A qualitative study in Ghana found that higher levels education did not protect women from partner abuse [142]. These findings were echoed by Egyptian and Cameroonian studies [24, 143]. However, other studies found relatively low levels of abuse among highly educated women [107, 144-148], but high perpetration of violence among men with low education [149, 150]. Lower rates of IPV were found only when both men and women had high education status [23, 24]. Some studies have shown that the woman's education is only effective in protecting her from certain forms of IPV. For example, Akmatov found woman's education independently protected her from physical violence [24].

Researchers who have found education to be a protective factor against IPV have hypothesised that women with secondary education or higher education may have a wider opportunity of choosing men that are less likely to be abusive, and that education may improve negotiating power if the man and the woman have similar levels of education [150]. Others associate education with increased career and employment options and ability to exit an abusive relationship [151], as well as increased ability to access information and use available resources [152]. Some studies have found that the relationship between education and violence is U shaped, offering protection at the lowest and the highest levels [145, 152, 153]. These studies have also concluded that the role of education is context specific with it acting as risk factor in more conservative settings [145], leading to calls for greater gender equality in education opportunities [24, 150].

2.4.2.2 Alcohol abuse

Alcohol consumption is associated with increased risk of all forms of interpersonal violence including IPV [23]. IPV has been found to be more frequent when both partners are involved in alcohol abuse [154], when alcohol is consumed before sex [145, 146, 155, 156]; and problem alcohol use results in severe forms of IPV [54, 157-160]. There seem to be both biological and sociological reasons for this. Medical, biological, and psychoanalytic fields associate dis-inhibins such as alcohol with impaired judgement[161, 162]. However, the same could be a learned behaviour[23]. Heavy drinking may be used as a resource to assert power and control in the intimate relationship. This may particularly be true among men who are concerned with demonstrating their masculinity and may try to accomplish this symbolically by drunkenness, by dominance over women, and by the exertion of physical force on others [163]. Alcohol use may also lead to household neglect, thus creating marital or relationship tension and consequent violence [54].

2.4.2.3 Decision-making imbalance

Imbalance of power among the members of the family including between the couple has been associated with increased relationship violence [92]. In a South African study among 4,948 currently married or partnered women, aged between 15-49 years found that economic dependency increased the chance for abuse in the female partner. In addition, male-dominated and female-dominated families both had a higher frequency of violence and a higher likelihood of more severe wife beating [164]. Similarly, a Ghanaian study found that

families that made decisions together were less likely to report having experienced violence than those with unequal decision making powers [165].

2.4.2.4 Extra marital relationships

Intimate partner violence has also frequently been associated with multiple sexual partners. In study that explored the perpetration of sexual violence in intimate relationships among men in South Africa found that men who had more than one current partner were likely to perpetrate sexual violence against their intimate partner[110]. Similarly a study among low income families in Kisumu, Kenya found that about 68% of their study participants reported that assaults resulted from disagreements over extramarital marital affairs [166]. Multiple sexual partners were a consistent risk factor for IPV in multinational study that involved eight southern African countries. History of having two or more partners in the last 12 months was strongly associated with partner physical violence [26].

2.4.2.5 Spousal age differences

There have been contradictory findings on spousal age differences as a risk factor for IPV. Several studies in the African continent have documented that age differences between the couple is a risk factor for IPV. Differences in spousal age have been interpreted as increasing the risk for IPV through power imbalance in the couple[24, 55, 103, 139, 167-169]. In contrast, analysis of data from the multi-country study of the World Report on Domestic Violence and Health found that associations between IPV and an age-gap of at least 5 years between the woman and her partner were weak in most settings and the direction of the effect was context dependent. Weak associations were also seen in the other direction for age-gaps favouring either the woman or her partner [104].

2.4.3. Community level

The major factors emerging at the community level from African studies appear to be attitudes towards IPV and locality.

2.4.3.1 Attitudes towards IPV

Significant proportions of men and women in sub-Saharan Africa accept IPV as justifiable punishment in certain circumstances and within certain boundaries of severity and the social cost of physical violence to the perpetrator is low so long as boundaries are not crossed [170]. For example wife beating may be accepted if the wife disobeys her husband, commits

adultery, refuse sex with her husband, fails to care for children or burns food [170-177]. This tolerance may result from families or communities emphasising the importance of maintaining the male-female union at all costs, police trivialising reports of domestic strife, or lack of legislation to protect women [23].

Although attitudes supporting use of violence appear to be universal in sub- Saharan Africa, levels of acceptance of wife beating among women vary within and across countries [177, 178]; and between men and women[109, 170, 176, 177]. For example, a review that assessed levels of acceptance of wife beating among women using data from 67 DHS (1995-2007) from 48 countries revealed a large range of prevalence rates from 10%-90% [178]; but the reasons for this range are not identified. Furthermore, in most of the sub-Saharan African countries where IPVAW is widely accepted as a response to women's transgressing gender norms, men find less justification for the practice than do women [109, 170, 174, 179-181]. Positive attitudes towards IPV are associated with both perpetration in the male and victimisation in the female.

A study among men in Cape Town, South Africa found that men who reported perpetrating violence against a partner in the past 10 years held positive attitudes towards wife beating[182]. Similarly, women who approved of wife beating in one or more circumstances were significantly more likely to be victimised than women who reported no history of IPV[109].

2.4.3.2 Locality

Some studies have found that community-level factors such as living in communities where violence is more tolerated, gender inequality and patriarchal ideologies persists and where there is generally widespread use of violence with increased reports of IPV experiences[23]. Using data from ten countries, Hindin and colleagues found that, in Kenya, Malawi, and Zimbabwe those reporting IPV live in communities where proportionally more women and men agree with one or more justifications for wife beating[183]. Similarly The widespread of violence in the Niger delta was correlated with attitudes for and domestic violence among women in that region [184]. In South Africa, participating in community violence or fights at work place was highly associated with perpetrating violence in the home [110].

2.4.4 Summary

This section has discussed the evidence for a range of risk factors for IPV that are particularly relevant in the Malawian context, Some factors, such as alcohol use, witnessing violence as a child, and supportive attitudes to IPV, appear to consistently increase the risk of IPV across

many contexts. The relationship between IPV and some other important factors such as education, pregnancy, family planning use and HIV status is more complex and the evidence suggests that their roles as protective or risk factors may be more context-specific. Context is also critical in shaping the responses of victims or survivors, the resources available to them and the environments in which they cope with abuse (Lindhorst et al 2008). The next section examines how survivors respond to IPV by examining the help seeking options and their coping mechanisms.

2.5 Help-seeking options and coping strategies by IPV survivors

IPV causes a great deal of psychological distress for its survivors [185], including not only the stress of discrete battering incidents, but also the strain of anticipating future battering [186]. The strategies that people use to minimise stress are called coping strategies [187]. People cope with stress in two major ways: 1) 'problem-focused' or 'active' coping and 2) 'emotion-focused' or 'avoidant-oriented' coping [188]. These are differentiated by the effect of the action taken to overcome stress [188]. In the case of abused women, 'problem-focused' coping might be talking to an abusive partner the day after a violent incident in the hopes of preventing such abuse in the future or calling the police. Examples of 'emotion-focused' coping might be engaging in physical exercise when worried about the possibility of an assault or talking to a friend about how frightened one is [189].

2.5.1 Coping with IPV

A literature review on coping strategies among abused women found that abused women use a variety of coping strategies [185]. One of the coping mechanisms women often use when faced with domestic violence is endurance. Endurance signifies commitment to the relationship despite on-going abuse and sometimes it may mean surviving in the present [190]. In a descriptive quantitative study among 184 maternity patients in Namibia women explained that they endured abusive relationships for the benefit of their children, lack of ownership of resources and for religious reasons. The study also found that religious coping strategies varied between ethnic groups [48]. A Ugandan study identified four key coping strategies commonly used among adolescent pregnant women they interviewed as: 1) Minimizing damage: minimizing the impact or severity of violence; 2) Withdrawal: leaving the relationship, social withdrawal or resignation to fate; 3) Retaliation (revenge and fighting back); and 4) Seeking help or social support.

Women who used the first two strategies - minimising damage and withdrawal - employed emotion-focused strategies whilst the last two strategies could be described as problem-focused approaches [191]. Use of emotion-focused strategies was associated with low self-esteem, hopelessness, and alcohol abuse [191], and studies involving adolescent women have found greater reliance on emotion-focused approaches [47, 191, 192]. Although survivors in the above studies tended to rely on emotional focused coping and sometimes used both , studies have tended to emphasise problem-focused approaches [192]. The next section focuses on one of the problem focused strategies - help seeking – which it is particularly important to understand to develop health sector responses.

2.5.2 Help seeking for IPV

Studies in various settings globally indicate that many survivors of IPV rely on informal sources of support (people within the victim's social network, including family, friends, neighbours or colleagues) in the help-seeking process for IPV[193-199]. A population-based study in Serbia found that 52.5% of women who experienced IPV disclosed abuse to friends or family [197], whilst an Australian study found that 75% sought informal help [194], and in Botswana 51% reported IPV to relatives [198].

Chatzifotiou explains that the process of disclosing violence and help seeking often progresses slowly from friendly talk, to consciously seeking help and recognising that they do not deserve violence [199]. Once the process of disclosure has started , survivors may no longer be able to conceal or normalize the actions of their violent partners [195]. Seeking informal help then often represents the first step in the help-seeking process and the outcome, including a victim's own perceptions about the responses of others can shape subsequent help-seeking decisions [193]. Many survivors would approach formal sources only after the informal sources have been consulted and / or are not forth coming [194, 200]. However, positive reactions of family and friends may result in more formal or professional help-seeking decisions, including the utilisation of law enforcement, counsellors, crisis accommodation and financial support [185, 193]. Liang Liang, Goodman, Tummala-Narra, and Weintraub describe a decision-making model wherein women go through three stages: (a) defining the problem; (b) deciding to seek help; and (c) selecting a source of support. This is influenced by individual, interpersonal, and socio-cultural factors at each stage[201]. This process may take a very long time leading to delay in seeking help even from informal sources [199].

These findings are supported by other studies[190, 202, 203]. Shame, shaming the family and embarrassment are some of the commonest factors interfering with disclosure of violence[201, 204, 205]. Barriers to seeking help from health services include: lack of a conducive environment for disclosure because of lack of privacy; inappropriateness' of the responses from the health care professionals [201]; and time constraints for providers [205-207]. There seemed to be fewer resources for support for sexual abuse regardless of who the perpetrator or form of abuse was. Narratives from married female adolescents in Uganda indicated that they got very little support or were reprimanded if they complained about forced sex from a husband, since sex is "an obligation in marriage". Even those that experienced non-partner sexual abuse felt that secrecy or silence was more advantageous than disclosing to sexual abuse or coercion [47]. A study that explored examined the links between use of family planning and violence found that women cope by hiding evidence of family planning and do not feel able to report violence for fear of ending the marriage [49].

Gracia uses the metaphor of the tip of an iceberg to illustrate the extent of underreporting in IPV[208]. According to this metaphor, most of the cases are submerged and invisible to society. She observes that although some studies have analysed factors that motivate or inhibit women affected by domestic violence to report it, what we need to know is whether or not all those unreported cases are really invisible in the social environment surrounding the victims (friends, family, neighbours, social services, public health sector). She questions whether the submerged part of the iceberg a matter of ignorance (nobody knows, sees, or hears), or is a matter of social silence and inhibition (people know, but choose not to tell or help) [208].

2.6 Health consequences of IPV

IPV is a significant public health problem, associated with myriad health conditions [209, 210], often with long- term as well as immediate effects [210]. Evidence suggests that violence also increases the risk of poor mental, maternal and child health while also impeding economic and social development[4, 211]. It has been estimated that rape and domestic violence account for 5 % of the healthy years of life lost to women of reproductive age in developing countries. At a global level the health burden from gender-based victimization among women age 15 to 44 is comparable to that posed by other risk factors and diseases already high on the world agenda, including HIV, tuberculosis, sepsis during childbirth, cancer, and cardiovascular disease [212]. Violence may be more appropriately conceptualized as a risk factor (determinant) for health problems than as a health condition in itself [103].

2.6.1 Physical health consequences of IPV

IPV may result in a significant amount of traumatic injuries. A study involving 8051 medical chart reviews, in 2 emergency departments in New Zealand discovered that women who reported DV- related injuries were different from those who reported unintentional injuries in relation to the nature, anatomic site of injury, and follow up treatment for injuries. The study found that 9% had history of assault mostly by their partner or former partners. These women were three times more likely to present with contusions or ill-defined signs and symptoms (e.g. painful limb) than their counterparts, and twice as likely to present with internal injuries, fractures to the head, spine or trunk or open wounds, but less likely to than those with unintentional injuries to present with open limb fracture, sprains, strains or musculoskeletal injuries. Women presenting with assault-related injuries were almost 13 times more likely to have sustained injuries to the head than were women presenting for treatment of unintentional injuries. Women presenting for treatment of assault were less likely than those with unintentional injuries to present with injuries to the lower back, hip, thigh, knee, lower leg, foot, elbow, hand, or forearm [213].

A review of the 2008 Nigerian DHS data revealed that women who experience IPV suffer frequently from sprains, dislocations or minor burns, and less frequently from wounds, broken bones, broken teeth or other serious conditions, and severe burns [214]. Although violence can result in such direct physical injuries, it is a has become increasingly clear that injuries represent only the tip of the iceberg of negative health effects [103]. An Australian study estimated the health risk of IPV using the burden of disease methodology and found that IPV accounted for 2.9% of the total burden of disease and injury for women of all ages in the state of Victoria, but for ages 18-44 years it accounted for 7.9% [215].

Gynaecological problems constitute the largest physical health consequences for IPV, including sexually transmitted infections, vaginal bleeding or infections, fibroids, decreased sexual desire, genital irritation, painful intercourse, chronic pelvic pain, and urinary tract infections [39]. Recent studies suggest that IPV, particularly sexual violence is associated with increased gynaecological visits and gynaecological surgical interventions [216], termination of pregnancy or induced abortion [59], sexually transmitted infections [217], increase clandestine use of contraception among women [49] and urinary incontinence and fistula [218]. The causal connections however, could only be speculative due to the cross sectional nature of the studies.

2.6.2 Health consequences of IPV among HIV-positive people

Violence within a relationship may mean women are less likely to access HIV testing and treatment services because of the fear of disclosing their sero-status to their partner [219]. Further, women who have experienced violence (including sexual abuse in childhood) have more risky sex [112, 220], including having more sexual partners, older partners, engaging in transactional sex and sex work [122]. IPV also impacts on the prevention of mother-to-child HIV transmission. Perceived risk of or existing violence may influence disclosure or partner notification by HIV-positive women [221]. It may be a barrier for behavioural modifications after knowing one's sero-status, including barrier methods and breast feeding practices, especially where there is poor couple communication and negotiation [222].

2.6.3 Health consequences of IPV in pregnancy

There is a substantial body of literature demonstrating negative health outcomes for women experiencing IPV during pregnancy see figure 2.5. IPV directly and indirectly affects the mortality and morbidity of both infant and mother [223]. In addition to the negative impact of IPV on women's health generally, specific physical health outcomes for mothers who experience IPV during pregnancy include complications from physical assaults on the pregnant abdomen [224]. History of physical, sexual and psychological abuse may result in higher risk of unintended pregnancy [59], low birth weight [59, 225, 226], greater utilization of health care services [225], ante-partum hospitalization [59, 225, 226] induced abortion [59, 227], premature labour [225, 226], late entrance into care [225], and pre-natal substance use [225]. Spousal emotional violence is highly associated with recurrent fetal loss [130, 227].

However, the role of mediating factors in poor foetal outcomes such as substance use, maternal stress and presence of other sexually transmitted infections have been acknowledged [228]. A comparative study seeking to explore the association between IPV and premature s labour did not find IPV to be an independent factor but one of a range of lifestyle behaviours such as smoking, alcohol intake and high rates of syphilis among study participants[229]

Figure 2.5 Outcomes of IPV during pregnancy documented by the WHO multi-country study on women's health and domestic violence against women, adapted [135]
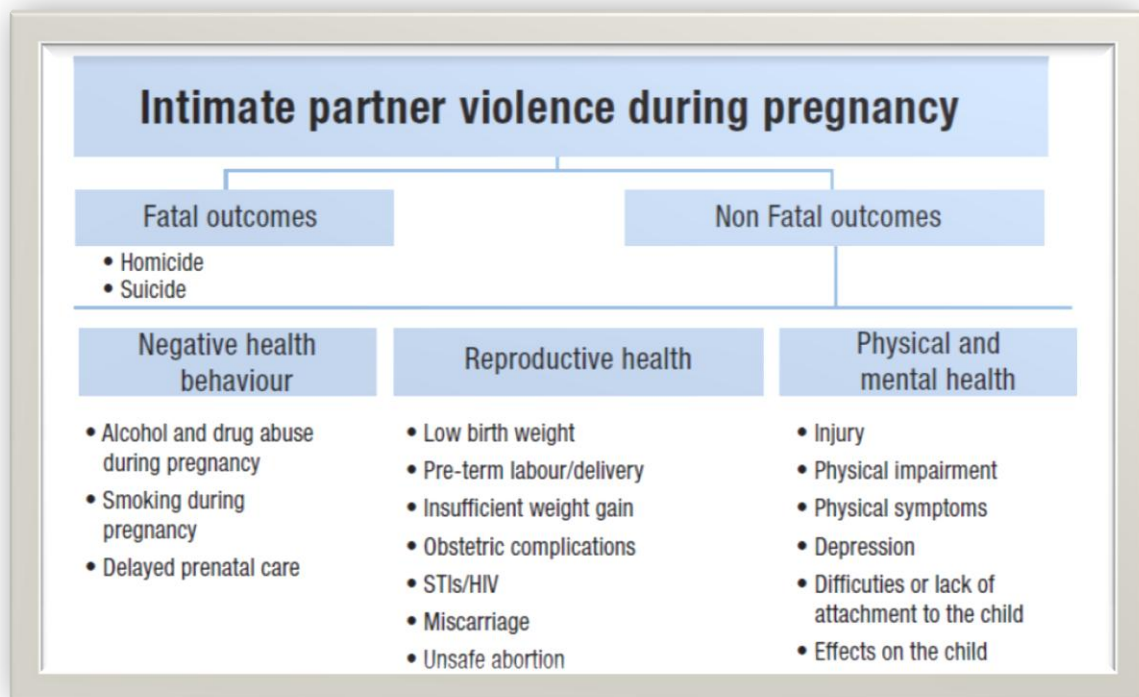
2.6.4 IPV and mental health consequences

IPV is associated with various mental health problems [168, 230]. The association between IPV and poor mental health outcomes has been documented in many international and regional studies with statistical significance in many of the cases. For example, the multi-country women's health and domestic violence study found that IPV and poor mental outcomes were statistically significant in all ten study sites [231]. The commonest mental health consequences of IPV include: depression [232-234], post traumatic disorder syndrome, anxiety, self-harm and sleep disorders [235], emotional distress [234], suicidal thoughts and attempts [234], and history of memory loss [236]. Seers and Toye found in Victoria, Australia that poor mental health and substance abuse contributed to 73% and 22% respectively of the disease burden attributed to IPV [215].

2.6.5 IPV and Homicide

Death from intimate partner has rarely been investigated in most parts of the sub Saharan region. However, some countries like South Africa and Ghana have tried to retrospectively document these lethal consequences of IPV. In South Africa, for example, the overall

prevalence rate of femicide was 24.7% per 100,000. Of the women dying from IPV, 52.1%were killed by cohabiting partners, 27.9% by husbands, and 18.5% by non-cohabiting boyfriends and 31.6% had a known history of IPV [66]. Killing spouses was more common in Ghana among poor and working class victims and assailants [67].

2.7 IPV as a health care problem

Despite the massive health consequences of IPV, its recognition as a public health policy issue is recent and may date back to some 30 years ago when for the first time in the US, the Surgeon's general report identified the control of violence among the 15 health priority issues following increased number of homicide and suicide cases among young African Americans[237]. Until then concerns about violence against women were exclusively in the hands of criminology, sociology, psychology or psychiatry [238]. Violence received a boost to its status as a public health issue in 1996, when the World Health Assembly (WHA) declared it a leading public health problem through the leadership of the WHO. The meeting requested WHO to document the burden of violence, assess the effectiveness of programmes with particular attention to women and children and promote public health activities to tackle the problem internationally and nationally [237]. Subsequently, the WHO established the Violence and injury prevention office in 2000, published the World health report on violence in 2002[237], and the WHO multi-country study on women's health and domestic violence in 2005 [136].

2.7.1 Efforts to strengthen health care response

Efforts to strengthen health service responses to IPV, especially violence against women, have been concentrated in the industrialised countries [103] and especially in the USA [6]. However, here has been a growing awareness in the health sector in low and middle income countries of the need to improve their response to cases of violence that they encounter, and to help identify women experiencing violence and refer them to specialized services [239].

2.7.1.1 Violence prevention

There has been growing awareness of the need for health providers to improve their response to cases of violence that they encounter, and to help identify women experiencing violence and refer them to specialized services [7]; not only because of the massive health consequences of IPV and the significant contribution that public health workers can make in reducing the consequences of IPV [240], but also because of the importance of making prevention core to all

efforts against violence [241]. Underlying this approach is the belief that violence can be prevented [4]. The WHO adopted the Public Health Approach framework which aims at stopping violence before it happens or attacking it upstream to reduce the health burden of violence in the long term [12].

Wolfe and Jaffe (1999) describe public health interventions as those that act "along a continuum of possible harm: (1) primary prevention to reduce the incidence of the problem before it occurs, (2) secondary prevention to decrease the prevalence after early signs of the problem, and (3) tertiary prevention to intervene once the problem is already clearly evident and causing harm". Examples of primary prevention programmes are school based dating violence programmes; these programmes aim to reduce prevalence of psychological problems or disorders thus reducing new cases of partner violence. Examples of primary prevention programmes have been implemented and evaluated in the African context using randomised controlled trials [242], and on reported IPV prevalence. The Sisters for Life programme reduced IPV by 55% in two years these include the Stepping stones Programme and Sisters for Life programme, both in South Africa[14]. Both of these interventions were designed to reduce HIV prevalence but evaluations showed that both had an impact [14]. Secondary interventions include identifying and supporting all women who are experiencing violence through universal screening, with the goal of breaking the cycle of violence before it escalates [243].

Tertiary prevention strategies are designed to reduce the impact, duration and consequence of men's violence against women, such as 'batterers programmes' that aim to prevent further abusive behaviour. Another example of primary prevention comes in the form of programmes that aim at fostering empowerment among women and supporting institutions, community and government policies that promote healthy relationships between men and women and foster a sense of community and appreciation for diversity, and peaceful resolution of conflict The Health care sector can perform a primary prevention or health promotion role in conjunction with other agencies, and function in by integrating health messages on IPV in their routine health promotion messages, promoting positive parenting and fathering, and engaging the youth in youth health friendly services [244]. Harvey stresses that the choice is not between primary prevention and interventions to assist survivors [13]. However, in recent years emphasis is being placed on primary prevention because it is an area of violence prevention that has received little attention [13, 245], and a lack of recognition of violence prevention as important public health priority and a legitimate public health activity

in most ministries of health serves as a major challenge for advancing the violence prevention agenda in the health sector [4].

2.7.1.2 IPV screening debates

The first step in the health sector response to IPV is to identify IPV survivors. Screening is one option for identifying survivors that has been debated extensively. Some medical professional bodies in the US American Medical Association(AMA) recommend screening for IPV in the health sector [246]. Screening in health care settings means actively seeking to identify a disease or pre-disease condition in individuals who are presumed or presume themselves to be healthy. It requires routine use of specific tests, standardized questions, or exam procedures [247]. However, the U.S. Preventive Services Task Force (USPSTF) and the Canadian preventive task force do not recommend universal screening of adult women for IPV due to lack of evidence for or against screening [248-250], making universal screening for IPV in medical settings a controversial topic [103, 243, 251]. Opponents of universal screening argue that there are no reliable screening tools for IPV to detect the condition early; and thus minimise physical, psychological and economic harm [252]. Unfortunately in the case of IPV, due the complex nature of IPV, there is no gold standard against which tools used to screen for IPV can be measured [253]. The Conflict Tactic Scale, which is frequently used in measuring interpersonal violence in population-based studies, is unsuitable for use in the clinical set up because it is lengthy[251, 254].

Other short and valid IPV screening tools in healthcare settings exist[246]. However, the tools are inconsistent in what they measure as abuse [35]. For example, the Hurt, Insult, Threaten, and Scream(HITS)measures physical violence or threats only, the Women's Experience with Battering (WEB)does not ask about specific acts of abuse, necessitating further inquiry if proper documentation in the medical record is to be made, and the On-going Violence Assessment Tool (OVAT) only targets abuse in the past month [35]. Most of the tools also have a wide range of sensitivity. The Partner Violence Screen (PVS) had some of its psychometric measures as low as 35% [246, 254]. Some studies have recommended use of combined measures to overcome inherent weaknesses in screening tools [255]. Rabin observes that inconsistencies in the way abuse is asked about in different screening tools may contribute to lack of evidence for support universal screening for IPV[246]. Opponents of universal screening of IPV suggest that a better approach is to engage in selective screening

of women who show signs of abuse, while screening all women in selected services such as reproductive health, mental health, and emergency service [103].

Proponents of universal screening cite high prevalence of IPV in both general and specific patient populations. They argue that routine enquiry is an essential component of quality care for women in detecting domestic violence, and increases the rate of referrals to community resources, resulting in improved quality of life and fewer violence-related injuries [103, 256]. Klevens (2009) argues that asking women with injury is not screening but a diagnostic tests as screening targets people without symptoms of the target condition. Proponents further contend that screening only women with symptoms of abuse is tertiary prevention, and may result in missed opportunities and introduce disparity in the care provided to clients [251]. Moreover, there is a lack of consistently discernible clinical features for survivors of violence and many survivors present with health problems other than injuries [238]. They suggest that IPV preventions need to move towards primary and secondary prevention [243].

Nonetheless, scepticism also exists regarding the appropriateness of universal screening in the developing world. Some feel that it may not be feasible in most developing economies because of the scarcity of resources and time pressures on health personnel and may result in more harm than good if providers are unprepared to respond appropriately, if privacy and confidentiality cannot be ensured, or if the community does not have adequate referral services [103].

In recent years few sub-Saharan health care services have piloted IPV screening interventions. Research findings show that there is high acceptability for screening for IPV both from the health care providers and from women[257-261]. However, there is a disconnect between acceptability and actual implementation and sustainability of screening programmes in health services. A quantitative study that assessed acceptability of IPV screening among 507 women in Nigeria found that 76% of women viewed IPV screening in the health setting as an acceptable intervention but only 7% of the women were screened by providers, and providers concentrated on screening people from certain ethnic tribe and religious grouping [258].

Similarly, a qualitative study that evaluated an intervention that integrated IPV screening into VCT services in South Africa found that not all women were screened for IPV during the initial phase and counsellors had stopped screening by the end of the year [257]. Most of these were small-scale academic orientated studies. However, Kenya is embarking on a national

health services IPV screening programme, following a pilot acceptability study at Kenyatta hospital. Lessons learnt from their feasibility study may influence practices in other sub – Saharan African region [261].

Individual and systemic factors have been blamed for lack of sustainability of IPV screening programmes. Individual provider barriers include: gendered attitudes of health care providers [259, 262]; social position of the provider in their respective communities [257] and gender of the provider [259].

System- level barriers include:

- lack of assessment of personal attributes and attitudes when selecting candidates for training [257, 262];
- questionable proficiency in basic skills[257, 262];
- inadequate management and supervision[257];
- provider burnout [257];
- insufficient financial incentive for providers [257];
- lack of guidelines[259];
- inadequate rooms[259]; and
- inadequate time and heavy workload of providers [259].

2.7.1.3 Training of health care providers (HCP)

Training forms one of the components of a comprehensive response to GBV, since healthcare providers need to have the skills to both identify and appropriately respond to cases of IPV that they encounter [263].

Most of the interventions that have been evaluated in industrialised countries have aimed at improving individual provider prevention practices, [264]. Most training programmes developed in the industrialised countries used didactic methods of teaching for a short period of time, usually consisting of single 1-3 hours sessions [265], lacked standardized outcomes and clinical performance measures [265], and were evaluated after a short implementing period and recorded limited success [266]. Garcia-Moreno argues that 1-3 hour short in-service education training programmes are unlikely to change health care providers' attitudes, values and prejudices surrounding IPV, which many disregard as a health problem [267, 268]. She advocates for training content that: address issues of power and abuse in HealthCare Providers' own lives, at work, and in society; improves providers' professional skills; and addresses their values and attitudes towards violence against women [267].

IPV training among health care providers in sub- Saharan African curriculums has been limited, and very little research documents the impact of such training. One model program for the training of health care workers on GBV in Southern Africa has been tried out in South Africa [263]. The programme aims to build the capacity of health care providers in identification, management and referral of survivors to appropriate services and build collaboration partnerships between key stakeholders. An evaluation found that training can improve motivation of HCP to work in violence prevention, and improve professional skills to deal with violence issues at a personal level. However, systems-level challenges were perceived as a major barrier to effective responses [263]. Kim and Motsei integrated a gender violence training module as part of an on-going reproductive health curriculum in South Africa [269]. The training was limited to four days and was conducted in phases. In the first phase, providers participated in focus group discussions where their perceptions and attitudes towards gender violence were elicited. The second phase was the intervention phase, which aimed to raise self-awareness of gender issues among these professionals in their personal capacity as members of the society before turning to their professional role. The evaluation of the programme showed that the programme was successful in raising self-awareness of the health care providers, all participants viewed it as a valuable experience, and a turning point, whilst some took on projects to deal with issues of violence in their communities and wished such a programme was scaled up in all nursing training programmes [269]. However, the authors conclude that more needs to be done to inform the development of appropriate training strategies for health care workers, particularly in developing countries [269].

2.7.1.4 System-wide approaches

To date rigorous evaluation of programmes on the health sector response to IPV are limited [14, 103, 264], but programmes in the industrialised world have now expanded beyond approaches focused on individual providers to include system wide changes to ensure sustainability of the programmes [103, 264]. This involves: strengthening policies, protocols, and norms; upgrading the infrastructure of clinics to ensure privacy and adequate supplies; training all staff, including managers, to respond appropriately to gender-based violence; building referral networks; and ensuring that staff are trained to ask women about violence, provide emotional support and emergency medical treatment, assess a woman's level of danger, provide crisis interventions, document cases, and make referrals [103].

Unlike interventions in the industrialised world, which started by focusing on individual practitioners' skills, a review of health sector responses to IPV in low and middle income countries found that interventions in the developing world has involved service integration of IPV service into health services [7]. Three models of service integration were identified and these include: (i) selective integration (provider-and/or facility-level integration); (ii) comprehensive integration; and (iii) systems-level integration (multi-site). The following were the notable differences in the models: (i) selective integration offered limited services without external referrals (counselling and group therapy) (ii) in comprehensive integration most services were offered at one site e.g. One stop crisis centers, and (iii) systems-level integration offered a wide range of basic skills at one site with external referrals to other sites [7]. The review also identified several potential sites as entry points for integrating IPV services into mainstream health provision including: primary health care, the emergency room, family planning services, and pediatric and adolescent reproductive health services.

The majority of the services in existing interventions were linked to reproductive and sexual health services, with a few located in the admissions and emergency departments[7]. Integrating IPV services into existing reproductive health services especially for IPV against women has several advantages considering that women rarely seek health services for violence but they frequently come in contact with reproductive health services at some point in their reproductive age period[10]. This is particularly relevant for sub-Saharan Africa where DHS data indicate that up to 95% of women receive some sort of antenatal or family planning care; creating a window of opportunity to intervene for IPV given the enormous reproductive health burden of IPV in Africa[10]. However, there is a limited in-depth analysis of the potential role of reproductive health care service providers in Sub-Saharan Africa[10], in addition to a lack of serious health care intervention in Africa [7].

2.7.1.5 Legislation, policies and guidelines

The lack of prioritisation of VAW as a priority issue in national policies is seen a hindrance to developing a national response within the health sector [239]. However, many countries have specific legislation and policies stating the mandate of the health sector in addressing violence against women [103]. Adopting such policies, even though they often lack specificity, is a critical step in sensitizing health providers and program managers to violence as an important health issue [103]. It has been noted that implementing policies that have no legal backing is difficult [270]. Legislation legitimises the problem [271], and shape how the problem

is responded to [271-273]. For example, enactment of aggressive domestic violence laws (requiring mandatory reporting of IPV and subsequent prosecution) in the US resulted in lowered IPV incidence in 5 of the 6 states where the laws were implemented, although fear of partner arrest could have mediated.

In Malaysia, the passing of the DV bill in 1993 and its enactment into law in 1996 led to a coordinated response to issues of violence against women and the birth of One Stop Crisis Centres (OSCCs) [271]. In contrast, limited and restrictive sexual violence legislation in Kenya resulted in a lack of enforcement of some aspects of Health Ministry post-rape policies (Kilonzo et al, 2009b). For example, the Division of Reproductive Health developed a form with detailed examination and legal documentation criteria for clinical notes, which could be used in court to supplement the inadequate police form (MoH 363/PRC1 form). However, the form remained a health sector document and examining clinicians did not always adhere to it, because it was not recognised by the law or required in court. Further, requirements for delivery of evidence by a medical doctor, was also problematic, as nurses and clinical officers are first-line providers for treatment and care in a context where medical doctors are few, especially at decentralised levels [272]. Theobald and colleagues noted a lack of policy implementation, often termed 'policy evaporation' as a major challenge facing gender mainstreaming advocates in Africa [274]. Poor dissemination could be a contributing factor [275] towards policy evaporation [276].

2.7.1.6 Mandatory reporting of domestic violence in health care settings

Mandatory reporting of domestic violence by health professionals is one legislative response that has been adopted for several decades in a number of states in the United States (US), with the intention of improving: survivor identification, safety and care; collection and documentation of DV data, health care response to DV; and assisting law enforcers to hold perpetrators accountable [277, 278]. A literature review conducted in 2007 found no data to support the view that mandatory reporting laws improve the safety of victims (or the view that the laws endanger victims)[279]. A study among physicians revealed that most physicians have mixed perceptions about the importance of legislation that mandates health care providers to report DV to police. On the one hand, the legislation was perceived as a potential barrier to care, and as likely to lead to escalation of violence or abuse, violate survivor's confidentiality and rob them of their autonomy in decision making. On the other

hand, most physicians also agreed that the law improves the collection of useful statistics, the prosecution of perpetrators, and physician responsiveness.

In addition, more than 90% of respondents in each specialty agreed that mandatory reporting is necessary under special circumstances such as: children or guns in the home; pregnancy; obvious injuries or repeated complaints of partner abuse; or immediate threats to a patient's safety [280]. A survey that sought perceptions of 1218 women in twelve emergency departments in California and Pennsylvania in the US found that a majority of women supported mandatory reporting but non-abused women were more likely (70.7%) to support mandatory reporting than abused women (55.7%)[281]. In a different study 81% of the women supported the existence of mandatory reporting , but 45% reported that this would place them at greater risk for abuse [282].

2.7.1.7 Psychosocial and emotional interventions

There is some evidence supporting the use of psychological interventions to improve the health outcomes of women who disclose violence [239]. There is some debate about whether this should be provided at the individual, couple, or group level and limited evidence. Evidence from Africa on the impact of individual counselling evaluated impact on risk factors for IPV but did not explore impacts on IPV itself. In South Africa six sessions of counselling among women seeking IPV services decreased HIV risk when compared to a single workshop[283]. In Namibia brief motivational interviewing was successfully used in alcohol reduction programmes, although the impact on IPV was not formally evaluated[284].

A review of current available treatments for partner violence in the US, comparing counselling provided to the victim, the perpetrator, and the couple who wish to remain together, has shown that couple or group counselling is more effective in reducing low-level couple violence compared to studies that involved the victim or survivors only [21]. However, it recommends that a ladder approach to counselling services is used and so that counselling is tailored to meet the specific needs of the individual survivors based on their stages. More extreme cases of violence were also excluded from this approach. However, a WHO expert meeting recommends that referring women for standard marriage counselling services is contraindicated [239]. In addition, health care services are recommended to develop specialised counselling services, and to distinguish between counselling offered to sexual violence survivors and survivors of domestic violence [239]. There is some evidence of the effectiveness of couples counselling on other health outcomes in sub-Saharan Africa. A

focus on couples' communication has improved family planning in Malawi [285]. Couples HIV Testing and Counselling (CHTC) combined with IPV screening interventions that address gender inequalities have improved PMTCT outcomes[286-290]

2.7.1.8 Fatality or case reviews

Death represents the most extreme form or outcome of violence against women and women are much more likely to be killed by intimate partners than by anyone else [291]. The World Health Organization (WHO) estimates that 40 to 70% of all women killed are murdered by an intimate partner [4]. Deaths from violence have rarely been investigated in most parts of the sub Saharan region [69], and the limited data documenting this lethal consequence of IPV comes from studies conducted in South Africa [69]. In one South African study that retrospectively examined records of 705 female homicides with known perpetrators found that 52.1% were killed by cohabiting partners and 27.9% by husbands [66], these deaths were not random as most of them had previous history of IPV. Blunt trauma and strangulation were the commonest cause of IPV related deaths[68, 69]. Regular on-going reviews may offer an opportunity to identify relevant points of intervention; however , empirical literature documenting the effects of this strategy is rare [238].

2.8 Summary

This chapter has presented reviewed published and unpublished work on IPV with focus on African studies with the exception of the healthcare response literature and interventions for IPV. Section 2.1 presented the definitions and examined the various conceptualizations of IPV and arguments for or against each conceptualization, leading to the adoption of broader and open approach to the conceptualization of IPV in this study. In section 2.2 the study presented the scope of IPV, starting with an overview of the global picture and then concentrating on African countries, mostly in sub-Saharan Africa. The literature revealed that IPV is a global problem that cuts across age, educational, social economic, ethnic and religious boundaries, but that there is significant variation between contexts that may to some extent represent differences in data collection methodologies, but is also likely to reflect the role of context in shaping IPV. The gender symmetry and asymmetry debates were discussed and male experiences of IPV were acknowledged and influenced the inclusion of male perspectives in this study.

Section 2.3 then outlined and discussed the various theories that have tried to explain the causes of IPV. The section highlighted the fact that individual theories inadequately explain

all aspects of the origins of violence, with the result that the study uses the ecological model as it tries to bring together all the theoretical explanations in a comprehensive way. The study is also framed within the feminist approach because of the prevailing patriarchal cultures in Africa. Section 2.4 examined evidence for risk factors for IPV, drawing on the international literature but focusing on the major risk factors emerging from African studies. The coping strategies used by female survivors and help seeking strategies were presented in Section 2.5. The reviewed literature showed that survivors use emotional focused strategies more than they use active coping strategies and many utilize informal than formal sources of support. The links between IPV and negative health outcomes was presented in Section 2.6. A wide range of negative health outcomes of IPV have been clearly established, including physical health outcomes such as injuries, HIV infection, negative pregnancy outcomes, and death, as well as mental health outcomes.

The final section, health care responses to IPV (2.7), discussed the literature highlighting the role of the health sector in preventing and responding to IPV. The reviewed literature gave an overview of the existing interventions to improve the health sector response to IPV but highlighted those that have been tried in African contexts. This section revealed that much work on IPV in the health sector has been implemented in the developed world and there are very few interventions tried out in the African contexts. There have been several programmes that have shown success in primary prevention in evaluations in South Africa. Of the interventions tried out training of health care workers and screening for IPV in the health sector appeared to be the most common. While training aimed at improving the individual provider's skills, screening aimed at actively identifying survivors of IPV so they can be referred to relevant services. Both of these interventions lack rigorous evaluation and to date have shown no effect in preventing abuse. Debates regarding the safety of IPV screening in low resource countries were also presented. Approaches that comprehensively integrate IPV services into health services exist in the developing world but have not been systematically evaluated. Counselling and particularly couple counselling appears to be the only promising secondary prevention method for IPV but more work needs to be done.

Chapter 3: Background of to the information study: National Context

3.0 Introduction

This chapter presents a brief background of Malawi. Section 3.1 locates the country and provides details about its population at the time of study. Section 3.2 provides information about its political, social and economic status. In section 3.3 the information about the country's health status is presented so as to provide the context under which the health sector responses to IPV are considered. The social and family structures in Malawi (outlined in section 3.4) make an important contribution to the understanding of the causes and consequences of IPV and the thesis methods need to be rooted in these structures as well. The study also builds on what is currently known about the current gender-based violence situation (section 3.5) and how the health sector is responding to IPV in Malawi (Section 3.6). The chapter ends with a summary in section 3.7.

3.1 Malawian population and geography

Malawi is a sub-Saharan land locked country located south of the equator (see figure 3.1). It is bordered to the north by Tanzania; to the east, south and southwest by Mozambique; and to the north and northwest by Zambia. The country is 901 kilometres long and ranges in width from 80 to 161 kilometres. The total area is 118,484 square kilometres of which 94,276 square kilometres is land and about 475 square kilometres is water [292]. Administratively, the country is divided into three regions: the Northern, Central and Southern Regions, which are further divided into 28 districts (six in the North nine in the Central, and 13 in the South). The districts are sub-divided into Traditional Authorities (TAs) presided over by Chiefs. Each Traditional Authority is made up of villages (the smallest administrative units) presided over by village headmen/women [293].

The Malawian people are of Bantu origin said to have migrated from the Congo basin between 13 and 16th century [294]. The country is ethnically and linguistically heterogeneous with 13 languages and varied dialectics spoken. The indigenous languages co-exist alongside the English language which is regarded as the official language. The *'Chewas'* are a dominant group and their *'Chewa'* language has been used as the national language since 1968 [294].

In 2008, an estimated 13,187,632 million people were living in Malawi. The population is largely young with youth aged 15 years and below making up 45% of the population [295, 296]. Females constitute 51% of the total population. Of these, 42.2% are of the reproductive age

group (15-49 years). The annual growth rate is at 2.8 per cent with the total fertility rate (TFR) of 5.7 births per woman [297]. It is projected that Malawi will have 38 million people in 2040 [298].

Figure 3.1: Map of Malawi showing neighbouring countries
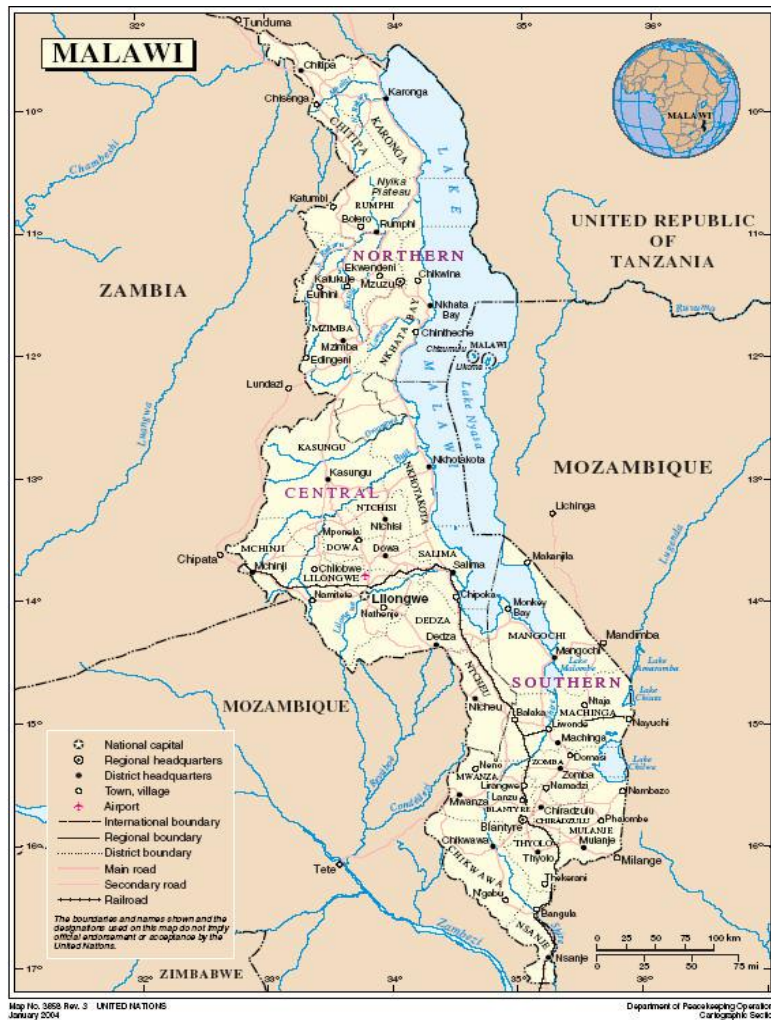
3.2 Political, social- economic and education context of Malawi

Malawi became a British protectorate in 1891, gained its independence in 1964, and became a Republic in 1966. The country followed a single party system of government from independence until 1994 when the first multi-party democratic system of government was introduced. This shift saw the adoption of a written democratic constitution in 1995, which incorporates the democratic principle of separation of powers among the three branches of government namely; the executive, the legislature and the judiciary. It also contains provisions for the observance, protection and upholding of rights and freedoms for all [299]. The Constitution of Malawi (1995); Section 24, Sub section (2) states that women have the right

to full and equal protection under the law and have the right not be discriminated against on the basis of gender or marital status [300]. A more detailed legal and policy analysis in relation to IPV and health sector responses is given in Chapter 5 of this thesis. Malawi is among the few sub-Saharan African countries that have remained politically relatively stable since independence.

Despite its political stability, Malawi is among the world's least developed countries. It has a human development index value of 0.4 and is ranked 171 out of 187 countries on the Human Development Index [301]. The poor performance on the development indicators shows the extent of poverty and gender disparity in the country [302]. Historical, geographical and political factors have combined to make poverty reduction a hurdle [303, 304]. Poor agriculture, business and education policies adopted by the previous governments have resulted in the creation of a small and highly educated middle-class elite rather than expanding education and opportunity for the majority of citizens [303]. Nearly half (52.4%) of the Malawian population live below the poverty line [292]. This means that slightly over 6.5 million people out of the 13 million people survive on less than one U.S. dollar per day. The Gross Domestic Product (GDP) is about US$4.7 billion and GDP per capita is US$310. The economy is heavily dependent on agriculture, including the declining tobacco industry, which contributes more than 90% of its export earnings [292].

The country is predominantly rural with about 85% of the population living in rural areas. However, rural to urban migration is very high resulting in a sex disparity in terms of residency. Between 2004 and 2005, 51%t of the male population was in the urban areas and 49% in the rural areas, whilst 49%of the female population was in the urban and 51% in the rural areas [296]. It is widely accepted that rural and urban areas are substantively different. Urban settings are characterized by predominantly nuclear families; relatively less conservative culturally; where it is common place to have social interactions with strangers; and economically relatively much more developed such that access to information and services is much higher. All interact in determining an individuals' health. This is comparatively different to rural areas where consanguineous families are more popular; culturally much more conservative, social interactions are mostly with relatives or acquaintances, economically relatively underdeveloped such that access to information and services are very limited. It is not difficult to believe that individuals living in these different environments exhibit different health behaviours [305]

The urban geographies in many of the cities in Africa including Malawi are different to cities on the other continents[306]. Urban areas in Africa are increasingly composed of small islands of well-being that are spatially and socially segregated from rapidly growing and increasingly impoverished masses. Riley cites Blantyre as a typical example of a city where densely crowded settlements, vast tracts of undeveloped land, traditional villages, mountains, river valleys, commercial and industrial areas, and low-density suburbs all mark distinct kinds of spaces within the municipal boundaries [307]. Over 65% of Blantyre city residents live in unplanned areas occupying only 23% of the land HABITAT perceives the continued development of slum areas in and around the cities and the towns in Malawi as a typical manifestation of urban poverty [306], as a result the differences between rural and urban areas of Malawi can be theoretical in some cases (see figure 3.2).

Figure 3.2: slums and shelter in urban Blantyre [308]-

A gender disparity in terms of sources of income from both informal and small agricultural household enterprises exists in the country[302]. The 2005 Integrated Household Survey (IHS2) revealed that women earn nearly half the amount of their male counterparts in similar informal enterprises [296]. Women form the majority of people working in the agriculture sector. About 70% of the agricultural workers and 80% of food producers in Malawi are women [309]. Female-headed households are poor compared to male-headed households[296]. In 2010, Malawi scored low on the overall Gender Status Index and the Women's Progress Scoreboard because of having few women that are involved in political and in decision-making positions[309].

Sixty-four percent of the Malawian population is literate (able to read and write in Chichewa or English) with notable gender, regional and residential differences in literacy levels. The IHS2 showed more men in urban than rural, and Northern than Central and Southern regions were literate [296]. However, the country has achieved gender parity with respect to primary and secondary school enrolments with girls slightly surpassing boys (84% girls as compared to 82% boys). This has partly been attributed to the free primary school education policy introduced in 1994 [309]. Although, the country may take glory in achieving gender parity with respect to primary and secondary school enrolments, the picture isn't good for tertiary education. The survival rates to standard eight (last grade at primary school level) in 2010 showed that girls (68.0%) are still lagging behind boys (73%). This is of particular concern, considering that education is central to the achievement of greater equality in society [310], to

the improvement of health status for the nation as indicators tend to be worse among people with little education or no education [311] and for the reduction of gender-based violence since levels of education shape experience of violence in Malawi [297].

3.3 Sex, premarital relationships and age at marriage

The average age of marriage is 17.4 and by age 18 almost 50% of the girls in Malawi would have married [312]. According to Population Reference Bureau this is an improvement from what it was a decade ago. Although people are delaying getting married, literature suggests that the number of young people engaging in pre-marital sex appears to have increased. A population based study involving 4,301 adolescent girls and boys aged between 12-19 years old found that 21% of the adolescents were sexually active at the time of the survey. However the proportion of sexually active adolescents varied by gender. Three per cent of the girls compared to 19% of the boys aged 12 to 14 reported being sexually active; and 37% of the girls compared to 60% of the boys age of 15 to 19 had engaged in sexual activity. The study also found that over half of the girls who reported being sexually active were married whilst 52% of the boys were not [313]. Statistics from the population Reference Bureau indicate that boys are more likely than girls to have engaged in sex before the age of 15 [312].

A qualitative study with adolescents revealed that young people take a utilitarian approach to sex, where sex is conceived as a natural, pleasurable and routine activity within their social relationships [314]. In relation to reasons for engaging in sexual activity, a quantitative study revealed that 85% of the boys and 55% of the girls engage in sexual activity because they liked it [313]. The gender differences observed in this study could be partly be explained by a large proportion of girls (38%) and a relatively smaller proportion of boys (10%) reporting their first sexual activity was forced [313]. Violence issues are covered in greater detail in section 3.6.

3.4 The health status of Malawi

Malawi's health indicators are among the worst in the world. Life expectancy at birth is low, child mortality is estimated at 110 per thousand live births; this is relatively high but marks a tremendous improvement from previous statistics. Under five mortality is higher among rural and poor populations [315]. Malnutrition is endemic. In 2005, 43 per cent of the under five children were stunted and 18% were severely malnourished [296]. The major factors contributing to malnutrition include: low availability and access to food in terms of quantity, quality and diversity; poor child care practices; poor hygiene and sanitation, low availability

and access to optimal health care services and maternal IPV [316] Table 3.1 below presents some selected health indicators.

Table 3.1 Malawi health profile

	Country	Regional ver.	Global aver.
Total population estimates 2010 (thousands)	14,901	-	-
Urban population (%)	20	38	50
Gross national income per capita (PPP international $)	860	2448	10,869
Life expectancy at birth (years)			
Male	44	52	66
Female	51	56	71
Both sexes	47	54	68
Adult mortality rate probability of dying between age 15 and 60 per 1000 population	599	383	176
Maternal mortality ratio per 100000 live births	460	480	210
Probability of dying under five (per 1 000 live births) both sexes	92	119	57
Prevalence of HIV (per 1000 adults aged 15-49	110	47	8
Prevalence of TB (per 100,000) population	174	332	178
Physicians per 10,000 population	0.2	2.2	-
Nurses per 10,000 population	2.8	9.0	-

Adapted from World Health Organisation Statistical Information System [315]

The health system in Malawi is generally hit by chronic shortage of skilled health care providers. As shown in table 3.1 there is acute shortage of nurses: 2.8 nurses per 10,000 of the population against the regional acceptable level of 9.0 and 0.2 doctors against the acceptable level of 2.8. In spite of this situation, utilisation of health services with regards to contraceptive prevalence, antenatal and birth attendance including child immunisation are high [315]

Statistics on HIV show that the country's HIV prevalence among adults aged 15-49 is at 10.6% [297]. The gender disaggregated data reveal that more women (12.9%) than men (8.1%) were living with HIV by 2010. Young women aged 15-19 have a prevalence rate that is

higher (4.2%) than that of males (1.3%) of the same age. Within the 20-24 age groups, the prevalence is still higher amongst females (6.4%) as compared to 2.8% for males. The inequality between men and women influences power structures and vulnerability to HIV [302]. Most new infections occur within long-term stable sexual relationships [317]. The current drivers thought to facilitate the spread of HIV, include: multiple and concurrent sexual partnerships; discordance in long-term couples (one partner HIV-negative and one positive) where protection is not being used; low prevalence of male circumcision; low and inconsistent condom use; suboptimal implementation of HIV prevention interventions within clinical arenas including the provision of HIV Testing Counselling (HTC) and late initiation of HIV treatment; and TB/HIV Co-infection [317, 318]. Regarding access to HTC some studies have shown that routine opt out counselling and testing offered at health facilities are less likely to reach the poor households and there is urban bias in provision of counselling and testing [319, 320], more women than men are accessing Anti Retroviral Treatment (ARTs) [317, 318, 320, 321].

3.5 The social and family structures

Malawi has two family structures or lineage systems: the matrilineal and patrilineal systems [322]. The matrilineal system is the most widely practiced system covering most of the central and Southern regions, while the patrilineal system is predominantly practiced in the Northern region, some parts of Chikhwawa and the whole of Nsanje district in southern Malawi. The major differences between the two systems lie in the payment of the bride price and in the line of descent. In matrilineal systems, descent follows the female lineage and residence is matrilocal (the man moves in to stay with the wife at her village and is considered a migrant) [322, 323]. Children born to the family belong to the wife and their maternal uncles called '*eni mbumba*'(owners of *mbumba*) [323] or '*nkhoswe*' *(*guardians) [324] over their '*mbumba*' (the sisters and their children). The leadership role over the *mbumba* is entrusted to the eldest brother or the eldest maternal aunt if there is no brother in the family to take the *nkhoswe* role [324]. Although all of the male kin, regardless of age, are said to be *nkhoswe,* in practice age is important and the elder males actually take the role[325].

The *nkhoswe* has multiple roles including: instilling discipline in the *mbumba*; allocating land and other resources; presiding over important decisions such as marriage ceremonies, resolving conflicts and dissolution of marriages (in this position they also serve as marriage counsellors or advocates), health care seeking; funeral arrangements and succession and inheritance processes. As such they may be referred to as traditional marriage counsellors.

Marriage without *nkhoswe* approval is not recognised culturally [324]. In spite of the multiple roles of the *nkhoswe* they do not have the power to dissolve marriages unless either or both of the spouses has consented to such [324]. There is a general perception among people that the matrilineal system may simplify the process for initiating divorce among women since the husband lives in her village [322]. Giving guardianship responsibility to uncles may be viewed as minimising the husband's role, reducing his social-economic activities since he produces crops on a land allotted to him by the *nkhoswe*. This may limit husbands' control over the use of what they produce making men less obliged to invest in their wife's village [326].

Under the patrilineal system, on the other hand, descent is through males and residence is virilocal; that is the wife leaves her home village to reside at her husband's village [324, 326]. A family then becomes an integral part of the father's lineage. The eldest male on the husband's side plays the role of *nkhoswe* [324]. In this system marriages are validated by paying 'lobola' (the bride price). In case of divorce, children are left in their father's custody and in case of death of the husband, the woman is supposed to choose another husband from the family or return to her home [323]. The system makes it hard for women to initiate divorce [322]. However, the patrilineal system is thought to be more protective in terms of women and children's social security as men may feel obliged to care for their family unlike in the matrilineal system where the responsibility of children is given to maternal uncle [326].

It is also important to note that elopement marriages named differently in the local language are a common occurrence in Malawi. A study by Malawi Human Rights Commission found that the common reasons for elopement may include: 1) defying parents of either side who object to the -would- be marriage, 2) avoid payments that are associated with certain marriages such as bride price or other payments associated with marriage rites, 3) intending couples find procedures for contracting marriages too involving or too demanding to follow, 4) and sometimes it is done out of sheer childishness. The study noted that there are consequences attached to elopement as relatives may refuse to acknowledge the existence of such a marriage and/or bury the dead if it happens that one of them die in such a relationship [327]. This may also have implications in the case of IPV as many people rely on relatives for support with IPV as discussed in the following sections.

3.6 Gender-based violence in Malawi

Violence is endemic in Malawian society [328]; and in recognition of this Malawi included a domestic violence module in its Demographic Health Survey for the first time in 2004

MDHS. Most of the published literature reporting domestic violence in Malawi has used DHS data [297, 316, 328-334]. To date DHS seems to be the most consistent source of information for IPV in Malawi, making it possible to study trends over time. Review of the 2004 and 2010 DHS findings allows evaluation of the trends of violence in the country. Gender based violence (GBV) is defined in the MDHS according to the UN definition as any act of violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty; whether occurring in public or private life. Domestic violence is also defined. Although the two MDHS surveys cite different sources for their definitions, their definition of domestic violence is similar in both documents. For the majority of indicators, the two MDHS surveys were measuring the same things, making it possible to compare trends over the 6 year period.

Specific efforts to improve disclosure by survey participants were made in the 2010 MDHS through following WHO safety recommendations for conducting domestic violence studies. This led to changes in the questions and additional training in techniques for sensitive questioning. As a result of these improved methods and training more disclosures of violence would be expected in the 2010 MDHS. The trends in MDHS results for 2004 and 2010 are shown in figure 3.3 and discussed in detail below (including trends in subgroups).

Figure 3.3: Trends in violence between MDHS 2004 and 2010
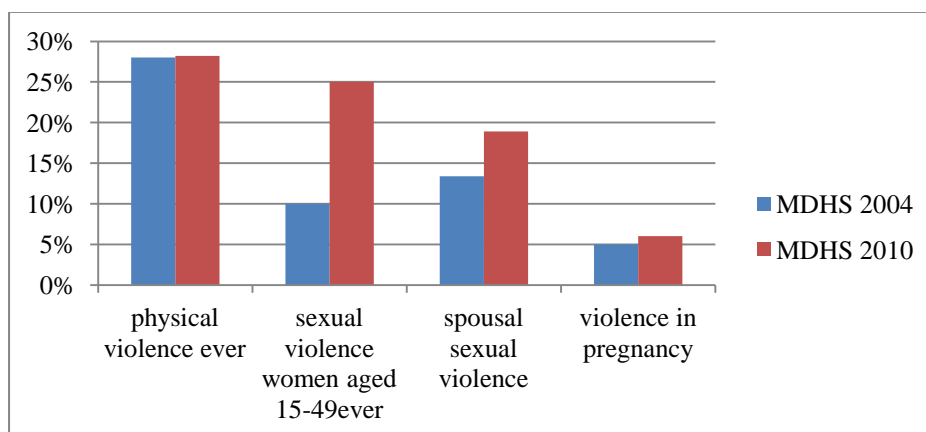
The subsections of 3.5 below present local understandings of violence. They look at how various forms of violence present in the Malawian context and how these are perceived when they manifest in different forms of relationships. The section goes further to examine the link between IPV and health including its impacts on child health.

3.6.1 Understandings of violence

Diverse conceptualizations of violence exist in Malawi. Studies have described a wide range of responses with regards to behaviours that are perceived as violence. A translation disparity exists between the English notion of violence and its corresponding concept of *"nkhanza"* in Chichewa that effects the way that violence is 'defined' and also the use of Chichewa to define violence in interviews (this is discussed further in section 4.1 of the methodology). The concept of *nkhanza* as applied in Malawi covers a wide range of abusive behaviours as opposed to the physical violence in literature which clearly distinguishes physical harm from other forms of cruelty and abuse [323]. For example, participants in a study on community perspectives on gender-based violence (GBV) in eight districts of Malawi described GBV as anything bad that disturbs the livelihood of the community [300], meaning there was no gender dimension to the definition. Most of the descriptions draw on the diverse and widespread nature of the problem, and the complexities surrounding it and many people approach violence from a cultural context and interpret it based on the interpersonal relationships involved. Researchers working on violence in Malawi have commented that the local conceptualizations of violence often challenge those conceptualizations found in violence literature [323, 335].

3.6.2 Physical violence

Despite this array of understandings of violence, Malawians identify intimate partner violence (IPV) as a problem in the country. The overall prevalence of IPV in reviewed studies ranged from 23%-68 %. Battery or physical violence was the most frequently cited form of domestic violence [297, 299, 323, 328, 336, 337]. The two most recent MDHS surveys (2004 and 2010) reveal both the magnitude of the problem and the failure of current interventions to impact on this with the percentage of women who report having ever experienced physical violence and the percentage experiencing physical violence in the past 12 months has not changed significantly in the six year period. Approximately 1 in every 3 women reported having experienced physical violence since the age of 15 years in both surveys, with close to 15% experiencing physical violence in the 12 months preceding the surveys. In 2004 more rural than urban women reported having experienced physical violence, whereas in the 2010 MDHS more urban than rural women reported having ever experienced physical violence. In both surveys current and ex partners remained the major perpetrators of physical violence.

The overall percentage of women surveyed in the MDHS who have reported ever experiencing physical violence during pregnancy in Malawi has remained about the same

over the past six years (5% versus 6%). Women with no living children were twice as likely as women with at least one living child to have experienced physical violence during pregnancy. The findings revealed that violence increased in the first 2 years of marriage and then decreased over time. Further exploration is required to understand the association between the onset of violence and violence during pregnancy.

In a study conducted by Saur (2003), participants mentioned that physical violence was an unavoidable tool in resolving conflicts. This was viewed in a broader context of existing gender inequalities. References were also made to physical abuses patients experience in hospitals, corporal punishment in prisons and wife beatings committed by high level politicians [323]. The quotations below emphasise how men and women normalised gender violence: *kukangana ndiye banjalo* ('squabbles form part and parcel of marriage') and *kumenyako ndi mamkwala a banjalo (*'beating is the cure for marriage') [300]. Researchers observed that some women fail to recognise their experiences as acts of GBV and appreciated the difficulties women may have faced to label their experiences violence when they had always regarded them to be normal [300]. Wife beating is divided into two categories: educational beating which is acceptable and considered normal and violent beating. Educational beating was described as when a man slaps a woman or uses a stick to beat the woman while violent beating is when a woman sustains fractures or loses blood. Educational beating was perceived as a sign of love intended at bringing about behaviour change rather than divorcing the wife. Women admitted sustaining bruises in the face from the beating, but perceived it to be normal and admitted that they chose to lie if questioned by friends giving the reasons such as having been bitten by a wasp [323].

3.6.3 Sexual violence

Malawi also has high rates of sexual violence. While findings of the 2004 MDHS and 2010 MDHS are difficult to compare, reflecting the fact that sexual violence was explored in greater depth in the 2010 survey, they do show high overall prevalence rates in both surveys. With 25% of all women age 15-49 in 2010 having experienced sexual violence compared to 10% in 2004. Both found sexual violence to be highest among young women aged 15-19 and 23.5% of young women in this age group reported having experienced sexual violence by the age of 10-14. Overall, intimate partners were the most commonly reported perpetrators of sexual violence. Thus while Malawian law fails to recognise the existence of sexual violence within marital relationships, women themselves recognised and reported sexual violence in their relationships.

In a study that was conducted by Kathewera –Banda and others in Nkhota-kota district, women defined sexual violence as being forced to have unprotected sex, even in situations where both partners are HIV positive, knowingly infecting someone with HIV and as non-consensual or forced sex specifically within intimate relationships, including marriage. However, there is a blurred boundary for marital rape. Some people in Malawi expressed that they do not believe that forced sex can occur within the confines of marriage, and felt that women have a marital obligation to engage in sexual activity with their husbands/partners; a belief that is backed up by the legal system in Malawi as it does not recognise marital rape [335] As such, sexual violence in Malawi is differentiated from rape, with rape being interpreted as ''a woman being forced to have sex by someone who is not her partner' [335].

The existence of sexual violence, particularly, marital rape was contested in some studies in Malawi [300, 323]. Marital rape was described as unrecognised in the country; as no man rapes his own wife and men admitted that it would be very hard for people to accept this concept. A study that was conducted in eight districts of Malawi, found that most men interviewed in all the districts felt they had perpetual right to sex regardless of the woman's circumstances. Although men denied the existence of rape in their families, most women interviewed admitted to have been raped by their husbands but they thought it was normal and went unreported [300].

Forced sex was perceived as high in young people's relationships[338-340]. In a multicounty study on sexual initiation, 38% of adolescents in Malawi reported they were "not willing at all" to have sex at their first sexual experience (mostly in their dating relationships). Malawi had the highest reported cases of sexual coercion among the four African countries where the study was conducted [339]. Adult sexual coercion was an issue in a qualitative in-depth study conducted among 23 disabled women, aged between 18-61 years, in Blantyre. The study focusing on disabled women's experiences revealed that disabled women reported being tricked into sexual relations with men who later abandoned them when they became pregnant, refusing to support the children they had fathered[341].

In general there is a lot of silence surrounding violence issues in Malawi. Roughly one in three women who experience physical or sexual violence never tell anyone about it, and nearly half never seek help [297]. Among women who seek help for the violence, most of them sought help from their own family (17%) and in-laws (16%). Others went to friends and neighbours, elders and religious leaders. Only 3% went to police and the 2011 DHS does not

mention reporting to the health sector. Silence surrounding the issue of rape was also discovered in a study that was conducted among 364 female students of ages 16-36 years at Chancellor College using self-reported questionnaire. In this study rape was defined as being forced to have sexual intercourse without consent. The study yielded a response rate of 55%. Of the students that responded 12.6% were raped on campus of which 48% were raped by boyfriends, 17% by acquaintances and 26% by others and some at home by male relatives. Of these 61% reported the case to no-one, 39% somewhere, 22% to parents but none mentioned the college administration, police or hospital. Although the study might have suffered from a low response rate with the possibility of over reporting due to selection bias, there is a chance that those that did not respond might have been victims too [340]. Similarly, a Baseline Survey for the Community Mobilisation against Gender-based Violence, HIV and AIDs Project in Kanengo found that of the 68% of the women who admitted to have suffered from GBV in the past twelve months prior to the survey only 24% reported cases to marriage counsellors, and the rest thought it was a private matter. Although men were in some cases victims of GBV, they were found unwilling to disclose violence [299],

3.6.4 Intimate partner violence a phenomenon for men and women

Studies in Malawi have demonstrated the gendered nature of intimate partner violence. Although IPV affects both men and women violence against women is perceived to be higher than violence against men. Seventy per cent of participants in a study on social cultural factors perpetuating GBV in Malawi reported that men abuse women in their communities compared to 30% who reported that some men do experience violence from women [342]. The 2010 DHS reported a rate of 13:1 male to female violence [297]. These experiences are gendered based on the social cultural expectations of men and women. Examples of IPV against woman include: wife beating, too frequent sex, neglect, husband refusing to have sex with her, not allowing the wife to prepare food, social isolation, marital rape, having secret concurrent relationships and unequal division of love to co-wives. On the other hand, forms of violence against men gender norm transgressions and include: not preparing food for them, women having extramarital relationships, women fighting back when men are disciplining them and denying them freedom to drink and associate with friends, refusing to have sex with husband, disrespectful to the husband, unwelcoming behaviour, soaking clothes when he is about to go away, not warming bathing water for husband, not preparing or warming food for husband, gambling and neglecting house hold chores and chasing husband away when tired of him [323, 342].

3.6.5 Causes of violence

Gender transgression (women acting against gendered roles and expectations) is associated with IPV in Malawi [334, 342]. Barkvoll (2009) using the 2004 MDHS data found that women who had controlling husbands had a 57% probability of experiencing intimate partner violence when compared to 24% whose husbands were less controlling. 'Controlling behaviours' were defined as being angry or jealous if she talks to other men, frequently accuses wife of unfaithfulness, doesn't permit her to meet her female friends, tries to limit her contact with her family, insists on knowing where she is at all times and he doesn't trust her with any money [334]. Cultural norms that perpetrate gender inequality between men and women were blamed for IPV against women in many studies [323, 335, 336]. Examples of the cultural norms included polygamy and payment of the bride price among others [323], and not having sex with a woman who is menstruating and during post-partum abstinence has been given as one reason why men engage in extra-marital sex [342]. differences over sexual matters were also perceived to be an underlying factor for wife battering [323]. (See also chapter 2.3.3)

Supportive attitudes towards IPV are also prevalent in Malawi [328]. Studies have documented a strong association between attitudes towards violence and the prevalence of violence in Malawi [330, 336]. Saur (2003) says generally physical violence against women in Malawi is not tolerated but educational beatings form part of conflict resolution methods and is tolerated by society (see chapter 2.4.3. under community risk factors for IPV).

Levels of education shape experience of violence in Malawi[297, 343]. The 2010 MDHS showed that the experience of violence reduced with higher levels of education. Women whose husbands had an increased level of education experienced less spousal violence. The greatest variation by husband's education is observed for emotional violence. Nearly one in three (29%) of ever-married women whose husbands have no education have experienced emotional violence as compared with 23% whose husbands have secondary education or higher. The reason for this is theorised that education enables people to use and extend their capabilities, develop skills, improve their livelihoods and increase their earning potential. Education also empowers people to participate in decision-making and in the transformation of their lives and societies. Education is central to the achievement of greater equality in society, including between men and women [310]. However, a study that analysed the role of education on IPV using the 2004 MDHS data did not find a significant difference in the reported experience of IPV between the educated and non-educated women [331]

The role of alcohol abuse in IPV is significant in Malawi[300, 336, 344], as is the case elsewhere (see also chapter 2.4.1). Alcohol is readily available in a range from traditionally brewed beers to more expensive company brewed beers. Men's use of alcohol is not stigmatised but has implications at individual, family and community levels including gender based violence [345]. Alcohol intoxication accounted for 18% of economic abuse, over a third of physical (36%) and a third of sexual violence cases (33.2%) and a quarter of emotional violence cases in a population based study on IPV in Malawi [168]. Similarly women who reported that their husbands use alcohol were much more likely to report having experienced IPV than their counterparts who were married to non-alcoholics in both MDHS [346, 347]. Alcohol intake was associated with family arguments, economic abuse, with wife beating neglect and rape including incest in a qualitative study that sought to understand the impact of men's drinking on their wives [345].

The other factor that is significantly associated with IPV is age. A study that analysed 2004 DHS data showed that emotional violence tends to increase with age whilst sexual violence tended to reduce with increased age. For sexual violence the differences were more pronounced when ages 30-34 and 45-49 were compared. Women in the ages 15-19 reported less emotional IPV while physical IPV was common in the age categories of 25-29. The study however, did not find significant differences between urban and rural dwelling [331] (see also chapter 2.4)

3.6.6 The links between HIV and IPV in Malawi

Increasingly the link between violence and the HIV/AIDS pandemic is being emphasized as research shows the association between experiences of violence and HIV risk, with violence as both a cause and a consequence of HIV/AIDS. There are a range of structural factors in Malawi that could be contributing to this including insufficient economic, educational, socio-cultural, and legal support for adolescent girls. Many of these may be seen as the root causes of girls' vulnerability to HIV through exposure to unprotected sexual relationships and primarily relationships that are transactional and age-disparate [348]. This was further supported by recent data from a cluster randomized trial in Zomba district Malawi demonstrating the impact of cash transfers on reducing HIV prevalence in never-married women aged 13-22 [349].

Current HIV policy makes explicit that this link is a significant contributing factor in the epidemic and sets out actions to respond to it [318] However, the link between the two needs to

be explored further as studies are also indicating that IPV is not consistent as a determinant of HIV globally. These conclusions were drawn by a recent study which compared self reports of IPV and laboratory HIV test results of women in 10 countries: Dominican Republic, Haiti, India, Kenya, Liberia, Malawi, Mali, Rwanda, Zambia and Zimbabwe who participated in Demographic and Health Surveys (DHS) conducted between 2003 and 2007: The study found no consistent association between physical and sexual IPV and HIV after adjusting for confounding factors. Whilst acknowledging several limitations inherent in the study design including selection bias, un reliable measures of IPV used in DHS data and the cross sectional nature of the study, the study argued against focusing HIV prevention funds to adult IPV prevention [329].

3.6.7 The intersection of maternal IPV and poor child health outcomes

Violence against women and violence against children are in many cases intertwined within communities. Maternal IPV is associated with poor child health outcomes. A comparative analysis of DHS Surveys from Malawi, Kenya, Honduras, Egypt and Rwanda[316] reveals a link between maternal IPV and child malnutrition. The study found marginal associations between maternal exposure to IPV with severe stunting and under-2 mortality in Malawi. Maternal IPV was perceived as one of the causes of miscarriages and premature deliveries in a study of perceptions of preterm birth in southern Malawi. This was linked to forced heavy work load and abdominal punches during pregnancy [350] In addition, the findings underscore the importance of incorporating efforts to prevent violence against women into a wider range of maternal and child health programmes.

3.7 Help-seeking behaviours

Help-seeking behaviours amongst survivors of violence remained poor in the 2010 MDHS. 36% of survivors of physical violence told no-one about it, and 48% sought no help. Yet among those who reported physical violence in the last 12 month (47.6%) report injuries which may need medical attention (43% report cuts and bruises, 15.5% burns and dislocations, 15% deep wounds broken bones and teeth). Among those who report sexual abuse 34.4% report similar injuries. If help was sought, the majority used the traditional systems rather than formal systems. Between 17-18% of women sought help from their own relatives and in-laws, 3 % from the chiefs, 4% from friends and 4 % from police.

The problem of help seeking has also been highlighted by other studies [299, 336]. A study on intimate partner violence in Malawi [336], found that only 4% of women sought help from the

police after rape, and most received a service that differed significantly from available protocols. Of those women who did report to the police, only 43% were informed of their right to a medical examination.

3.8 Health sector responses to violence in Malawi

The Ministry of Health (MoH) is a government agency whose core business is setting the agenda for health in Malawi [311] and responding to the health consequences of violence therefore comes under its remit. It is responsible for raising the health status of all Malawians through the development of a health delivery system capable of promoting health, preventing, reducing and curing disease, protecting life, and fostering the general well-being and increased productivity, and reducing the occurrence of premature death [351]. The MoH collaborates with other relevant stake holders including the Christian Health Association of Malawi (CHAM) to achieve its mandate [311], all of which recognise and respond to violence in various ways. The Malawi Health Sector Strategic Plan (HSSP) (2011-2016) highlights the roles of health care workers (HCWs) in dealing with gender based violence at every level of the health delivery system presented below.

3.8.1 The health delivery system

This section gives an overview of the structures for health delivery in the public sector in Malawi to enable the reader to better contextualize the findings of this thesis. The primary current health sector responses focus directly on physical treatment of survivors of violence and indirectly through dealing with health consequences in HIV, STI, family planning and reproductive health services. An in-depth stakeholder analysis of health sector policies is given in section 5.2 and of strategic directions is given in section 5.3. Despite the chronic shortages of staff and other resources, health services are provided for free in all public health institutions [311]. Health services in the country are delivered at three different levels, namely primary, secondary and tertiary level and each have an actual or potential role to play in the health sector response to violence described briefly below.

Primary level

The primary level includes community initiatives, health posts, dispensaries, maternity facilities, health centres, and community and rural hospitals. At community level, health services are provided by cadres such as health surveillance assistants (HSAs), community-based distributing agents (CBDAs), village health committees (VHCs) and other volunteers, mostly from NGOs. HSAs perform multiple overlapping promotive and preventive health

services including HIV testing and counselling (HTC) and provision of immunization services. VHCs work in collaboration with HSAs to promote primary health care activities through community participation. The work of HSAs gets supported by the Health Centre. Health centres are responsible for providing both curative and preventive Essential Health Package (EHP) services. At a higher level there are community hospitals (also known as rural hospitals), which provide both primary and secondary care, and each has an admission capacity of 200 to 250 beds. While this level has the potential for violence prevention in practice the main role at this level is upward referral for specific post rape care services.

Secondary level

District hospitals constitute the secondary level of health care. They act as referral points for both health centres and rural hospitals, and have bed occupancy of 200 to 300 beds. They handle both inpatient and out-patients. Most of the CHAM hospitals provide services at secondary level. Services for post rape care including post exposure prophylaxis for HIV (PEP) are located here.

Tertiary level

The tertiary level consists of central hospitals (CH) that provide referral health services for their respective regions. Central hospitals offer specialised services. Currently, they are four central hospitals, namely Queen Elizabeth in Blantyre (1250 beds), Kamuzu in Lilongwe (1200 beds), Mzuzu District (300 beds) and Zomba central and Zomba mental (450 beds). A comprehensive referral system within the health services links these various levels of the delivery system. The roll out of One Stop Centres (described in this section) has started at tertiary level.

3.8.2 Health sector reforms

The Malawi health sector has undergone reforms such that the provision of health services has been decentralised in accordance with the 1997 decentralisation policy and decentralisation act. Understanding reforms to the sector is important to the study because any potential recommendations by the study have to come within this framework.

The MoH at national level is no longer responsible for service delivery as this has become a responsibility of the Ministry of Local Government and Rural Development (MoLGRD). However, MoH and MoLGRD are practising similar to what Annan (1999) described as a 'double hierarchy' model of decentralisation in that, the MoH at national level is responsible for development of policies, standards and protocols and for providing technical support for

supervision, whereas the district assemblies are responsible for implementing the services [352] . The District Health Management Teams (DHMTs) are responsible for managing health sector funds under the responsibility of the local authorities. The local authorities follow the District Implementation Plans (DIP) to implement activities. However, the health ministry is concerned that DIPs are good for long term planning and not for the meeting of the immediate needs of health services (HSSP 2011-2016). Figure 3.4 below shows the governance of the MoH both at national and district level.

Figure 3.4: the health delivery system in Malawi adopted from [311]
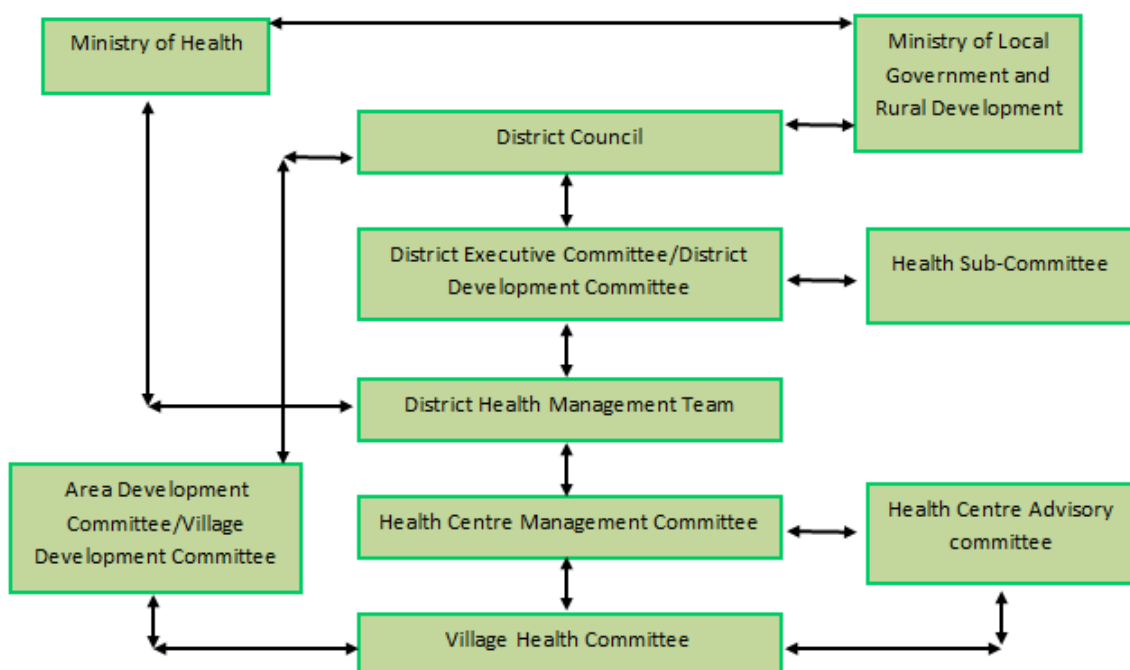
Health Sector- Wide Approach (Health SWAp), EHP and Programme of Work (POW)): In 2004, the MOH and development partners started implementing a (SWAp). The SWAp integrates all vertical disease programmes and their finances into the Essential Health Package (EHP) so that technical efficiencies can be achieved[353]. There is no 'official' definition of what the SWAp is, but it is a common framework for planning, budgeting and performance. SWAp uses a basket funding approach where directorates plan their activities and draw funds from the pool [354]. It was guided by a six-year joint POW2004-2010, the priorities of which revolved around the provision of the EHP. The EHP is a package of basic health care services meant to address health problems that contribute to increased disease burden but violence was not include in this package. Eleven major conditions that

predominantly affect the Malawian poor were targeted. These reforms were introduced as a way of ensuring equitable and accessible essential health care to the people of Malawi after recognising that investments made in the health sector had not produced significant gains in health status [353]. Provision of the EHP is seen as a way for enhancing achievement of the health related millennium development goals (MDGs), and as a departure from the 'balkanisation' of the health sector by donors which led to 'islands of excellence' operating within the public health structure [354].

The introduction of EHP necessitated the implementation of the service agreement between the GoM and Christian Health Association of Malawi (CHAM) hospitals. This was done to promote the delivery of EHP and improve access to basic health care in rural areas. CHAM is quite critical for the delivery of EHP considering their location in most rural areas where close to 85% of the Malawi population lives [353]. In addition, the Ministry of Health implemented a comprehensive and integrated routine HMIS country-wide [355]. The HMIS supports the EHP and is seen as an integral part of the national health system because it aims to provide relevant, reliable, updated, current, reasonable, and complete data for those managing health from community to central levels. The HMIS reports on the EHP components in a way that act as indicators of service delivery and utilisation throughout the public and formal health sector[353]. However, violence issues were not part of the EHP making monitoring of the problem in health services nearly impossible.

3.8.3 Malawi Health Sector Strategic Plan 2011-2016

The Program of Work (PoW) which covered the period 2004-2010 has been replaced by the Malawi Health Sector Strategic Plan (HSSP) (2011-2016) . The HSSP frames gender-based violence as a determinant of health, recognising the high rates of violence in the community and low rates of reporting to the health sector as well as the limited progress over the last decade. It sees violence as a risk factor for mental ill health and for trauma and vice versa. The focus of the HSSP is on the effective delivery of the Essential Health Package and in this regard violence is captured under non-communicable diseases including mental health and trauma. Annex 8 (An EHP for Malawi defined by level of health care delivery) includes GBV in small print alongside a list of NCDs such as hypertension, diabetes and hearing loss that require systems for targeted and routine screening at primary health care level. No actual indicators on health sector responses to violence are captured in the indicator matrix provided in Annex 10 of the HSSP.

One Stop Centres: The health care system is also providing four One Stop Centres (OSCs) for survivors of violence. These are operating out of referral hospitals, and in various degrees of operation. Centres in Blantyre and Zomba are complete, while construction on centres in Mzuzu and Lilongwe were to commence in 2013. Plans to roll these services to District hospitals are underway based on lessons learnt from the referral hospitals. One Stop Centres (OSCs) aim to provide coordinated and comprehensive services to women, child, and male survivors of sexual, physical and gender-based violence. All the necessary services (including health, social services and police) are meant to be provided under one roof. Advantages of OSCs are two-fold. On one side, survivors can get comprehensive package of services at one place, minimizing the secondary trauma. Most importantly, OSCs house the necessary response to rape victims. In the case of rape the administration of PEP can be done within 72 hours. Further still, coordinating the different multi-sectoral actors in one place increases the chance of cases reaching prosecution and higher rate of conviction therefore ensure justice and safety for survivors. This is because evidence can be collected expediently and all the referral systems for victims are in one place. Linkages to NGOs and faith based organization will further ensure that psychosocial services are provided to victims of abuse (Government of Malawi, 2012).

Whilst these services are now expanding and treatment given to all adult survivors, the policy, advocacy and clinical focus remains very much on children and on sexual violence. The centres are able to reach small percentage of women and children affected by violence. One Stop Centres were initiated with a paediatric focus. They started as a response to violence against children, are supported by UNICEF and have the backing of paediatricians. However, the health sector recognises that it has a duty to care for the women and children. The Ministry of Health in Malawi has decided to step up the mandate of OSCs, extend their Duty of Care and provide greater action to both prevent and respond to violence against women and children.

3.9 Summary

This chapter has provided the general background information about Malawi focusing on the social, economic, and political and health situation of the people of Malawi. It has also explored the gender violence situation in Malawi paying particular attention to IPV and how the health sector is responding to this vice. The literature reviewed has also demonstrated that diverse conceptualizations of violence exist in Malawi. Despite this array, it is clear that IPV is a major problem that disproportionately affects women and is driven by strong

patriarchal and pervasive traditional beliefs. Help seeking behaviours for violence have remained poor and most of the survivors do not seek help from formal sources, particularly health services which are set up to respond to more extreme levels of physical and sexual violence focused at tertiary level.

Chapter 4 Research Methodology and Design

4.0 Introduction

This chapter details the research approach, justifies choices and use of methodology and supports the credibility of the research [356, 357]. Kilonzo argues that the health service delivery cannot be seen as entirely disparate from other sectors on the continuum of care [358] and this premise underpins the research approach. As stated in chapter 1.1 the ecological framework presented in 2.3.6 has been used to help frame the design of the study. Its focus on the broader social factors enables the thesis to analyse the policy and legislative context of the health sector response (chapter 5); and see how these influence the functioning of the lower (inter-personal) levels of the ecological system (see 2.3.6). The interconnectedness of various levels of the ecological framework allowed the thesis to examine factors beyond the immediate setting (health sector), including the responses in other sectors and how these affected or influenced each other, and institutional policies (government and community regulations and norms).

Understanding the wider environments in which people live and make choices was crucial for this study as these have a greater impact on health outcomes [198]. In addition, factors responsible for IPV may also be responsible for the nature of the health care response[358]; making understanding of perceptions of IPV very important for the thesis. For example, in this study many participants perceived IPV as a private family affair and as result counselling services for IPV were absent in health services because health care providers felt that it was not their responsibility. Figure 4.1 shows how the study design and methods relate to the revised ecological framework. At the individual level the study recruited both male and female survivors of intimate partner violence and at community level groups of younger and older men and women as well as various key stakeholders in violence prevention. This helped the study to understand the complexity of experiences, responses to IPV and how best to serve the interests of women and men whose lives are negatively affected by the violence in their intimate relationships.

Figure 4.1: Illustrates how the ecological framework informed the research design
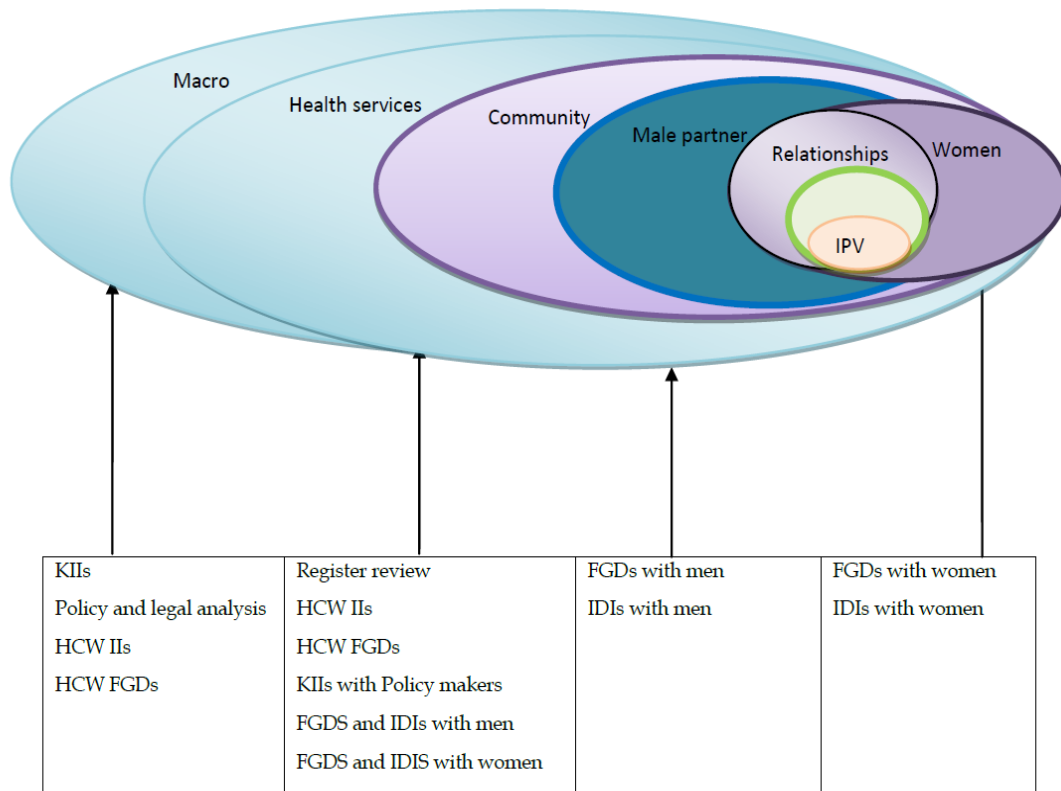
The following research questions reflect the objectives set out in chapter 1 and also reflect factors on the different levels of the ecological framework:

1. How does the health related legislative and policy environment promote or hinder the health sector response to IPV in Malawi?
2. How do different stakeholders perceive IPV and the health sector responses to IPV in Malawi?
3. To what extent can health services rely on proxy determinants to identify intimate partner and sexual violence from a health service uptake perspective in Malawi?

For the macro-social and health sector level research question 1 tries to understand the influence of the legislative and policy environments; for the institutional or community and individual levels research question 2 tries to understand the perceptions of IPV as public health problem, the responses of health services and those of relevant others; and at the institutional level research question 3 tries to understand the burden of IPV in health services.

Table 4.1: Relationship between research questions and methods and the ecological framework

Research question	Methods	Sections	Focus Level
How does the health related legislative and policy environment promote or hinder the health sector response to IPV in Malawi?	Policy and legal analysis Key informant interviews*	4.5	Macro (national level)
How do different stakeholders perceive IPV and the health sector responses to IPV in Malawi?	Key informant interviews with policy makers and other stakeholders	4.6.1; 4.7.2; 4.8.1; 4.11.2	Macro (national level)
	Focus groups, small group and individual interviews with health care workers	4.6.2; 4.7.1; 4.8.2; 4.8.3	Meso (district level) Blantyre Mangochi Lilongwe
	Focus groups with village health committees and individual interviews with Health Surveillance Assistants	4.6.2; 4.6.3	Micro (village level) Blantyre Mangochi Lilongwe
	Focus groups with community members, marriage counsellors and community victim support units	4.6.3; 4.8.2	Micro (village level) Blantyre
	In-depth interviews with service users ('survivors')	4.6.3; 4.8.4; 4.11	Micro (village level) Blantyre
To what extent can health services rely on proxy determinants to identify intimate partner and sexual violence from a health service uptake perspective in Malawi?	Register reviews	4.9	Meso (district level) Blantyre

*data from community FGDs and IDIs in Blantyre also included in analysis

4.1 Justification of research methodology and thesis epistemology

Selecting the appropriate design to answer research questions is not a technical choice but rather an ethical, moral, ideological and a political activity[359]. Maxwell in his interactive model of the research design identifies the research question as central to the design. Along with these, he identified a group of other environmental factors including: research skills, the available resources, perceived problems, ethical standards, the research setting, and the data [359]. However, choosing one strategy over the other restricts the researcher's ability to benefit from strengths inherent in a variety of research methods [360]. Qualitative research as applied to health research, seeks to understand patterns of behaviour and how these patterns may influence and interact with health and health seeking behaviours. They may identify priorities and needs relevant to particular social contexts and/or groups of individuals and help make recommendations that are appropriate to these contexts and or groups of

individuals [361]. Qualitative methods were the main methods used in this study; however additional methods were used to triangulate the findings.

For research question 1 a legal and policy analysis was combined with qualitative Key Informant interviews. Data from FGDs and In-depth interviews collected for objective 2 was included in the analysis where appropriate.

For research question 2 a descriptive and interpretive situation analysis was conducted using a range of qualitative methods to explore the perceptions, experiences of intimate partner violence and the role of health care services in addressing violence in Blantyre, Mangochi and Lilongwe districts, Malawi. This was the largest part of the study.

For research question 3 qualitative findings about service uptake were triangulated by collecting quantitative data through a register review at one referral hospital.

Underpinning the study is the understanding that knowledge is socially constructed. To better understand the topic in-depth accounts of events, relationships, experiences or procedures occurring at a particular time are required. The researcher tends to examine the phenomena from the perspective of those experiencing it [362] and acknowledges the role of the researcher in the production of knowledge. In this study, the researcher did not provide participants with definitions of violence and IPV. Informed by chapter 3, the researcher was aware that the definitions of violence may vary but the researcher sought the local understandings of these terms. It was important for this study to have emic definitions because that's what would inform how they respond to violence. The definitions provided in chapter 2 were important to the researcher as a base of which local understandings were compared with understandings at international level. In doing so, the researcher allowed knowledge to be inductively generated throughout the research process [362]. Qualitative data collection methods and analysis are mainly used although mixed methods may be utilised in a way which support or expand upon qualitative data and effectively deepen the description. The study therefore uses primarily qualitative methods but sought to add quantitative methods in one referral hospital to triangulate the perceptions of participants with data that would deepen our understanding both of the potential for collecting data on magnitude and the potential limitations of this.

As discussed in Chapter 2, the researcher was also informed by a feminist perspective towards the topic of IPV. Qualitative methodology is a common method among feminist

researchers because it is more personal, interactive, open, contextual and phenomenological [363]. It is also the best methodology for researching sensitive issues or when researchers aim to capture the complexity of sensitive everyday life with the goal of understanding perspectives of those who live it [364, 365]. Research on IPV fits in the conceptualisation of sensitive research because the safety issues for those involved stem from the private or personal nature of the subject of IPV as well as the potential for embarrassment, offence and /or social censure on disclosure of associated attitudes and/or behaviours [366]. Puentes-Markides (1992) says qualitative research techniques have also been utilised to describe and assess the functionality and utility of systems, which includes a focus on both health providers and health recipients, and seeks to assess the perceptions and responsiveness to interventions [358]. Therefore, qualitative research methods are ideally suited for the topic under study, in which the critical insights into the perceptions and experiences of the respondents are essential to inform the development of context relevant and sustainable IPV preventive health interventions including screening programmes [367, 368]. The researcher did not approach the topic without prior knowledge: personal issues, practical and intellectual issues also impacted on the selection of the topic (see reflexivity 4.12.3) and largely seeks to answer the how and why questions, making constructivism the appropriate epistemological stance for the study.

4.2 Process of research design and development

The research design is based on existing concepts, assumptions, expectations, beliefs and theories formed by the researcher as an individual and through available data from elsewhere (expert opinion, literature review). The following figure represents the process of the research design and the development of the research process

Figure 4.3: The process of the research design and development

Data SYNTHESIS   Data COLLECTION

ESTABLISHING RIGOUR

FEEDBACK LOOPS

FGD's   IDI's

Legal and   Data Collection   Register Review

Data Reduction

Findings

Member checks/Validation workshop

FINAL REPORT

CONSTRUCTIVIST APPROACH

Own Prior   Expert Opinion   Literature Review

Concept
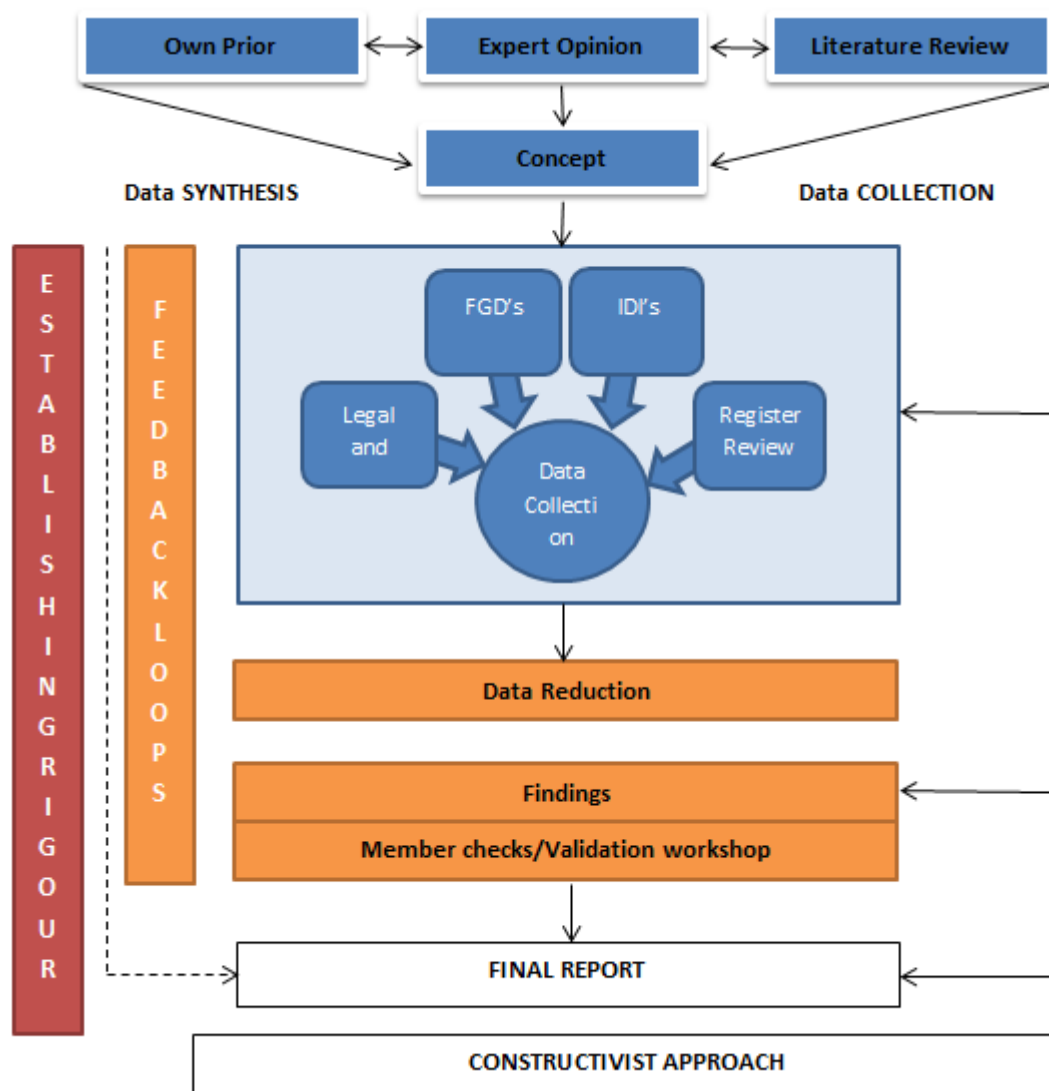
4.3 Study Timeline

The study timeline was from January 2010 to December 2012. Qualitative and quantitative data collection and analysis was carried out simultaneously as seen in Table 4.2. Analysis was an on-going process.

Table 4.2: Study timeline

Dates	Activities
Jan 2010 - Dec 2010	Development of research enquiry and tools Development of links with Domestic Violence service providers Obtaining ethics approval Policy and legal analysis
Jan 2011-October 2011	Health care providers' focus groups small groups and individual interviews. Focus groups with Village Health Committees
Apr 2011- July 2011	Register reviews and analysis
June 2011-Jan 2012	Key informant interviews with policy makers
May 2011- December 2011	Focus groups with community members, marriage counsellors and victim support units In-depth interviews with service users ('survivors') and Health Surveillance Assistants
Jan 2012-Dec 2012	Write up Updating of legal and policy analysis
July 2012	Dissemination workshop with stakeholders
February 2013	Submission

4.4 Study settings

The study was primarily conducted in Blantyre, Malawi. Some additional data from health care workers for objective 2 were collected in Mangochi and from health care workers and policy makers in Lilongwe. These were added subsequent to the initial study design based on recommendations from UNICEF Malawi, who provided supplementary funds in late 2011 to further investigate the health sector response.

Both rural and urban sites were included in the study, although these were difficult to differentiate clearly in the peri-urban setting as illustrated in the following photograph of Ndirande (figure 4.3)

Figure 4.4 Ndirande location, Blantyre, Malawi
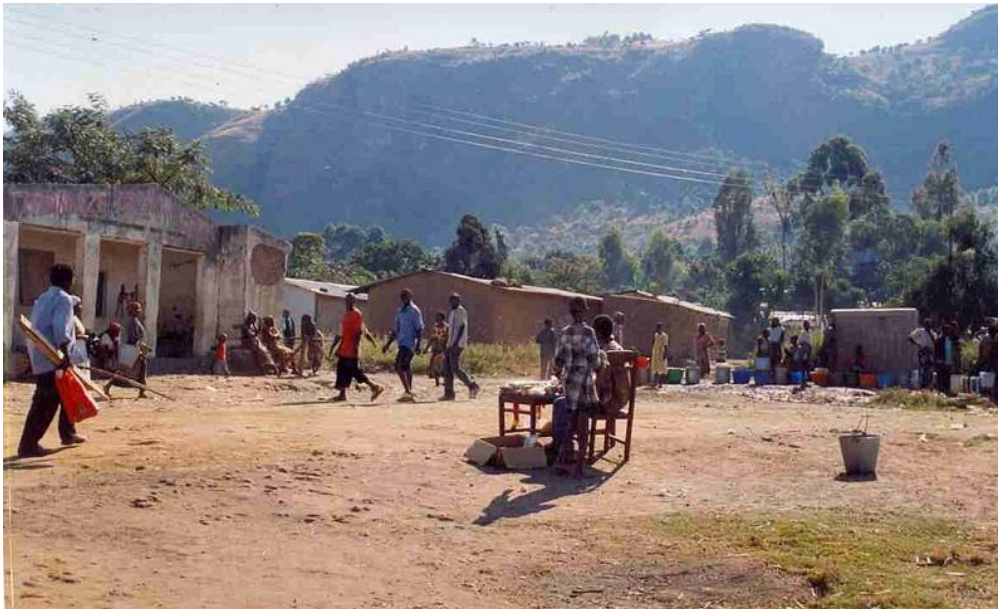
4.4.1 Blantyre District

Blantyre as a district has a population of 732,518 and is divided into Blantyre rural and Blantyre urban (Blantyre city), making it suitable for a study targeting both urban and rural populations with limited funding. Fighting Gender based violence(GBV) is also one of the priority areas for the district according to the gender needs assessment report released in 2010 [369] . Residents are more likely to have access to some domestic violence services compared to typical rural areas. The accessibility of these referral points was a key ethical consideration in district selection since the research has potential to raise issues that may require onward referral.

Blantyre district and city are divided into eight traditional authorities (see Figure 4.4). They cover a wide area and up to three health centres may be located within each traditional authority.

Figure 4.5 Traditional authorities in Blantyre District
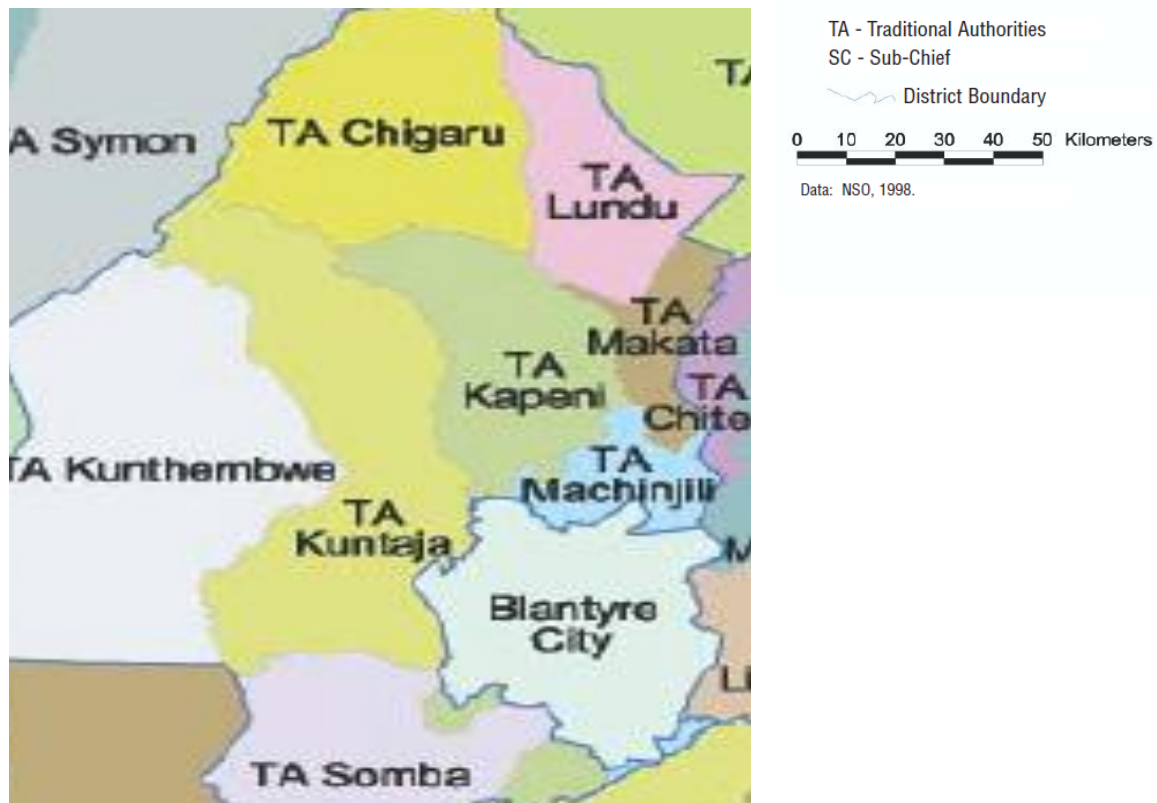
The district of Blantyre is home to the oldest city in Malawi and in Southern Africa. It was established in 1876 when Scottish missionaries, led by Dr. David Livingstone, passed through the area. Later more missionaries and traders followed to set up a church (the Blantyre Mission, which is still standing today) and businesses. Today, the City of Blantyre is the main industrial and commercial centre for Malawi. People of diverse socio-economic and ethnic backgrounds reside in this city. About 60% of this population lives in unplanned or squatter areas that are characterized by congestion of houses and poor infrastructure and social services. The city has a young population hence a high dependency rate with about 60% of the total population being below 25years. The population of Blantyre City is growing by 3.4% due to both natural growth and rural urban migration. The migrants are attracted to the city by economic activities, services and opportunities that are available in the city. Unemployment rate at the moment is 57%; illiteracy rate is at 27% while 82% are lacking formal skills. About 46% of all households in the city earn less than $50 a month. Poverty is pervasive in the city with 65% of the total households in the city living below the poverty line.

The health care delivery system in the district has both curative and preventive health care services, and this is provided through a network of hospitals and health centres/clinics which are distributed in different parts of the city. The government runs Queen Elizabeth Central Hospital (QECH), the biggest referral hospital in the country, which has a total of 1,000 hospital beds, and the three private hospitals, have a total of 122 hospital beds. The Queen Elizabeth Central Hospital (QECH) is the largest referral hospital in Malawi, a country with over 13,000,000 citizens. QECH has been selected because it is the largest referral hospital in Malawi and is a teaching hospital for the College of Medicine and Kamuzu College of Nursing, both constituency colleges of the University of Malawi. This is an added advantage as perceptions elicited at QECH may be reflective of some of the attitudes in the other hospitals since most of the health care providers in the country get their early professional socialisation through this hospital. The catchment area for QECH is large as it also serves as the district hospital for Blantyre district. As such it also acts as referral centre for all health centres in the district.

In addition to QECH five community locations within Blantyre's traditional authorities were selected based on willingness of the communities to take part and with consideration of geographical spread, presence of health centres, availability or absence of GBV services and previous recognised association with IPV. Dziwe, Limbe, Mdeka, Madziabango and Ndirande were selected for inclusion. Dziwe and Limbe have been previously identified as having a high prevalence of suicide cases, which has a recognised association with intimate partner violence [370].

4.4.2 Mangochi District

Due to a lack of a 'proper' district hospital in Blantyre, the researcher decided to explore perceptions of health care providers in a 'proper district hospital' (designated as such by MOH). Mangochi district, south of Lake Malawi and 150 kilometers north of Blantyre, was selected for this particular purpose. For this study health facilities under Mangochi DHO were purposefully selected taking into consideration the levels of service provision available: District hospital, rural hospital and health centres including village health committees. The following were included: Mangochi district hospital; Namwera rural hospital or health centre; Malukula Health Centre; Chipalamawamba village health committee

4.4.3 Lilongwe District

Lilongwe was selected because it is in the central region. Lilongwe is the capital city of Malawi. Lilongwe has a central and district hospital, unlike Blantyre where the referral hospital (Queens) doubles as a central and district hospital. For the interest of this research, Lilongwe is the only Central Hospital among the four that had not yet incorporated the One Stop Centre model in its provision of services to survivors of violence. This was of particular interest to the study. The following were included: Bwaila hospital; Kawale health centre; Mitundu health centre; Mitundu village health committee.

4.5 Methods for Legislative and policy document analysis

Legislation and policy documents governing the health sector responses to violence were reviewed with the aim of understanding responses at the Macro level. Documents were identified through internet searches using Google, through direct communication with policy makers and through obtaining   soft copies from lawyers and NGOs involved in GBV. Thirty-four documents were reviewed and seventeen met our inclusion criteria.

4.5.1 Legal review

Current Malawian laws according to an Act of Parliament that had sections or statutes that mentioned violence, sexual violence, child protection or abuse were included. Internationally ratified instruments that had not been domesticated (turned into Malawian law by an Act of Parliament) were excluded from the analysis as the lack of domestication limited the ability of Malawian citizens to invoke their provisions at national level [371]. Four legal documents were included in our analysis. In the analysis definitions of a child, of domestic and sexual violence and of outlined punishments were considered. Gaps and conflicts in the documents were outlined.

4.5.2 Strategy document review

Strategy documents were included if they mentioned health sector responses to violence. We included health policy documents that were in-date and in active use in the health sector. Four national strategic planning documents (one Ministry of Gender and three Ministry of Health) were included in the analysis.

4.5.3 Policy review

Policy statements, guidelines and protocols were included that outlined health sector roles or activities in relation to violence. Nine health sector policies, guidelines and protocols were

considered in our analysis.   In the critical analysis of the policy documents we considered their focus area, definitions and the roles and responsibilities of different sectors and different services providers as they are outlined in theory.

4.5.4 Triangulation with qualitative methods

Document critique was combined with qualitative methods with purposively sampled policy makers, service providers and other stakeholder, the details of which are covered in section 4.6.

4.6 Study populations for qualitative methods

The target study populations are outlined in Table 4.1 above. These are discussed in turn in the sections below.

4.6.1 Health care policy makers, non-health care policy makers, programme managers

The challenges of violence prevention demand an inter-sectoral approach [4].   This stems directly from the conceptual stand point of the public health approach which namely that working with and learning from other sectors and disciplines is essential in building the type of sustained , inter-sectoral response required to prevent violence [372]; and strengthening of referral networks with other IPV service providers is one of the five prongs for implementing a systemic response to IPV [373].

Populations of policy makers were therefore drawn from both the health sector and from outside the health sector. Health policy makers, domestic violence agencies or advocacy groups, government institutions and donor agencies were purposefully selected to participate in key informant interviews. In describing one of the characteristics of key informant interviews Kumar (1989) states that key informant interviews involve interviewing small number of informants, usually in the range of 15-35 individual participants as interviewing fewer than 15 participants may compromise the validity of the findings.   The study interviewed 26 Key informants (for details see table 4.3) by which point no new data was being gained by carrying out further interviews.

Table 4.3: Policy maker participants

District	Services	Organization Type	Method	Number of participants
Blantyre	GBV service providers	NGO/CBO	KIIs	6
	Police Services	Community Police	KIIs	
		Victim Support Units	Small Groups	3
	Social work services	City of Blantyre	KIIs	1
	Health policy makers	Ministry of Health	KIIs	2
		One Stop Centres	KIIs	2
Lilongwe	Government	Ministry of Gender	KIIs	1
		Ministry of Health; HIV, STIs, SRH,HMIS,SWAP,NCD and HE	KIIs	7
	Private	CHAM	KIIs	1
	Judiciary	Legal representative	KIIs	
	Training regulatory bodies	Health Professional Councils	KIIs	1
	International funding	Donor Agencies	KIIs	2
Total				**26**

4.6.2 Health care workers

Health service providers are assumed to be critically important in improving health sector responses to IPV. They can help to identify women experiencing violence and refer them to specialized services [7, 243]. However, their perceptions and attitudes towards intimate partner violence can present as opportunities (supportive attitudes) and barriers (judgemental attitudes or victim blaming) to integrating IPV prevention, care and supportive services into health services [374]. This made understanding of their conceptualization of IPV and the role of the health services; and their experiences with service provision important.

Participants included health care workers from the following departments at QECH: emergency departments, outpatient departments, obstetrics and gynaecology, psychiatric clinic, dental, family planning and antenatal clinics, STIs and ARV clinics, paediatric, surgical and medical departments. These departments were identified based on the literature from low and middle income countries describing them as entry points for IPV interventions [7]. Hospital based social workers were included as part of the health team because by the nature of their job, they were likely to be in contact with survivors of violence. In health centres, all types of health care providers were represented: medical assistants, clinical

officers, and midwives. Health care providers who spent at least 50% of their time in client service provision were included in the study.

Health care workers were who were recruited, participated in individual interviews (IIs), small group interviews or FGDs. This flexibility allowed views from all the target areas to be included since it was not always possible to convene FGDs. The researcher observed that urban health centres were better staffed than rural health centres where only two to three members of staff served the centres. In such centres it was very difficult to convene a FGD. Bringing HCWs in rural centres to one place for the sake of convening a FGD could have proved costly as these centres are far apart. More importantly it could have raised ethical issues removing them from their work station. In urban areas in Blantyre and all facilities in Lilongwe and Mangochi FGDs were convened by bringing staff of different cadres such as nurses, medical assistants and clinical officers together out of clinic hours so as not to compromise the provision of care. In rural centres in Blantyre only individual interviews were conducted.

Table 4.4: Health care worker participants

District	Location	Facility type	Rural Urban	Method	Number of participants
Blantyre	QECH Blantyre	Referral Hospital	Urban	FGD Small group IIs	17 3 7
	Limbe	Health Centre	Urban	FGD II	9 1
	Mdeka	Health Centre	Rural	IIs	3
	Madziabango	Health Centre	Rural	IIs	3
	Ndirande	Health Centre	Urban	FGD	8
Mangochi	Mangochi	District hospital	Urban	FGD	9
	Namwera	Health Centre	Rural	FGD	5
	Malukula	Health Centre	Rural	Small group	2
	Chipalamawamba	Village Health Committee	Rural	FGD	10
Lilongwe	Bwaila	Hospital	Urban	FGD	6
	Kawale	Health centre	Urban	FGD	7
	Mitundu	Rural hospital	Rural	FGD	8
	Mitundu	Village health committee	Rural	FGD	10
Grand total					**103**

Most of the FGDs were mixed genders dominated by female HCWs. The total numbers conducted are provided (see Table 4.4). Shortage of staff precluded the ability to recruit

homogenous groups (for example by gender and cadre). As such mixed gender and cadre groups were used. Linhorst observes that FGDs should be prohibited for improper mixed groups [375] (see above), but I argue that our grouping was a proper mixed focus group, following Kim and Motsei who successfully managed to conduct mixed FGDs in a study that explored attitudes and experiences of gender-based violence with primary health care nurses [269], although all their study participants were nurses. This study took extra care in selecting participants for the health professionals FGDs. Grades of these professionals and not gender acted as a leveling ground where equal discussion was built (nurses, medical assistants, and clinical officers, dental and environmental officers). Very senior staff members were excluded from FGDs. The lowest cadre (VHCs) had their FGDs conducted separately. Health Surveillance Assistants (HSAs) are a cadre of health care workers who reside in the communities and are familiar and trusted. These village level health care workers (see section 3.7) are covered in section 4.6.3 which deals with study populations at community level.

4.6.3 Community members

4.6.3.1 Individuals who had contacted IPV services

Both male and female 'survivors' who reported to have experienced IPV were included in the study. Recruitment strategies are discussed in section 4.7 (sampling). Only participants aged 18 years and above (or considered mature minors), had experienced IPV and had sought IPV-related services were recruited for community in-depth interviews (IDIs). The researcher gave preference, to survivors who were not currently in abusive relationships, who were therefore relatively safe and at relatively low risk of retaliation from their abusive partners, thus their safety would not be jeopardised by their participation in the study. However, some participants were in current abusive relationships and additional measures to ensure safety included ensuring no-one know about the interview locations and nature and recruitment materials that were non-specific to IPV. No couple's interviews were conducted and partners were not aware of interviews going on. Interviewing these individuals was critical to the study because interventions designed to improve health care providers' response to survivors of abusive relationships must be informed by service users perspectives on how health care providers can help them move toward safety and thus improve their health [376, 377].

The original sample size was 10 women and 5 men. However, only twelve survivors participated in the study: 7 women and 5 men (see Table 4.5). More men were interviewed relative to their representation in the total number of survivors reported nationally and the

original sample size was easily met. The total number of women was limited as few volunteered to share their stories due to the silence surrounding issues of IPV and concerns for   safety.

Table 4.5: Community participants

District	Location	Rural Urban	Method*	Number of women	Number of men
Blantyre	Blantyre City	Urban	IDI	7	4
	Dziwe	Rural	4 FGDs	27	N/A
	Limbe	Urban	4 FGDs	N/A	32
	Mdeka	Rural	4 FGDs 1Small group IDI	28 3 0	N/A 1
	Madziabango	Rural	4 FGDs	N/A	29
	Ndirande	Urban	2 FGDs	14	N/A
Grand total				79	67

* IDIs describe in-depth interviews with 'survivors'

4.6.3.2 General community

A purposive sample of men and women was drawn from the community to participate in FGDs. This was to ensure that all constituents relevant to the phenomenon were captured. Recruitment to FGDs was on the basis of similar age, sex, marital and parental status to create a relatively homogenous sample in each FGD where participants can be free to talk to each other because they share similar characteristics. These allowed for the opportunity to give voice to a wide range of perspectives. Saturation was reached rapidly in focus groups and members commonly talked about IPV as something that they all experienced. The number of FGDs conducted therefore exceeded saturation point but was required to meet the need for male and female participants to be drawn from separate locations for safety issues as recommended by WHO domestic violence ethical guidelines (see ethical issues section). Groups with older people included a large number who were also marriage counsellors. Four FGDs were conducted in each location to allow for disaggregated representation.

4.6.3.3 Community victim support units

Based at community level these trained volunteers are part of the community networks established by the police to support victims of crime. They also deal directly with survivors of violence and members were included in the general community focus groups alongside marriage counsellors. Unlike marriage counsellors, who were ubiquitous among the older population, the community victim support volunteers identified themselves and their role

within the group discussion. Each focus group had at least one member of the community victim support unit and some had two.

4.6.3.4 Health Surveillance Assistants

Health Surveillance Assistants (see section 3.7) were also included in the study. Individual health care worker interviews were conducted in the communities at the time of the FGDs.

4.7 Sampling strategies for qualitative methods

4.7.1 Purposive sampling

The major sampling approach used in the study was purposive – that is, information-rich cases were selected [228]. This is the most common approach to qualitative sampling whereby, the sampling units are not chosen in a random manner, but on the basis of some of their characteristics. The researcher's practical knowledge of the research area, information available in the literature and from the study itself was strategically used by the researcher to select information rich subjects. Use of purposive sampling strategy allowed the study to include a broad range of participants from service users to policy makers, including participants who have specific experiences (critical case sample of women and men who have experienced IPV) or participants with special expertise (key informant sample).

A subset of purposive sampling according to Paton is homogeneous samples, which involves selecting a small sample with similar attributes[228]. This strategy was specifically used in this study for community members FGDs. The point here is that sampling for focus groups typically involves bringing together people of similar backgrounds and experiences to participate in a group interview about major program issues that affect them.

The purposive sample of health care workers (including HSAs) were recruited in consultation with departmental managers of QECH and in-charges of the selected health centres (see section 4.3 study setting) and District Health Officers.

Snowball sampling was also used to identify individual interviewees in this thesis. Snowball sampling is defined simply as a method of identifying research subjects that has frequently been used in studies dealing with sensitive issues, possibly concerning a relatively private matter [275]. It is particularly useful in identifying social groups whose members tend to hide their identity for moral, legal, ideological and political reasons [228]; but may sometimes be used to locate the elite participants who maintain invisibility by choice. It can be both used as

an informal method and as a more formal methodology. When used as a more formal method inference about a population of hard to reach individuals can be drawn.

Snowball sampling involves identifying subjects for inclusion in the sample by referral from other subjects. The process begins by asking well-situated people: "Who knows a lot about this? Who should I talk to?" By asking a number of people who else to talk with, the snowball gets bigger and bigger as one accumulates new information-rich cases [228]. Some of the contacts and referrals can also be made fortuitously. This does not mean that participants are accessed by chance but tends to demonstrate the researchers increased sensitivity to the study and ability to maximise opportunities.

In this thesis snowball sampling was used to identify additional respondents among policy makers, non-governmental providers of services for IPV and survivors. For policy makers the snowballing sampling technique proved very effective. UNICEF Malawi played a significant role in helping the study identify key relevant health development partners and other policy makers within the Health Ministry. Once identified, key informants were requested by telephone or in person to participate in the interviews at their offices at a time and day that was convenient for them. Key informants were excluded from the study if they consistently failed to honour their appointments. This was the case with three identified key informants. They were also asked to identify other policy makers for interviews. Women and men were purposively selected for in-depth interview on the basis that they had experienced IPV. The challenges in recruitment and selection and potential limitations are discussed in the following section.

4.7.2 Selection of interviewees who had experienced violence

Achieving an adequate sample in sensitive research can be challenging, and recruiting 'survivors' of IPV is particularly challenging. Chakwana in the Malawi Demographic Health Survey states that women may not disclose issues of domestic violence as it is regarded as bringing shame to their family and society discourages women from talking about their experiences of domestic violence to maintain respect from the community [346]. The researcher used multiple methods of recruiting survivors purposively to maximise the chances of successful recruitment.

A major method of recruiting female 'survivors' who had used services was through referral from various services from which they had sought help. Five of the seven women interviewed were selected in this way: one was referred from police, one from non-health GBV services,

and three from STI clinics. Survivors who were recruited through the STI clinic were slightly different from the rest of the participants. Unlike the participants above who were approached as known survivors of IPV, those recruited from health services reported for services other than IPV. Based on knowledge gained through literature patients with repeated STIs and those who had problems with partner notification were asked for their experience of IPV. Some women revealed IPV as a problem in their family and agreed to take part in the study.. Two additional women were recruited: one following a community focus group discussion via an HSA; and one through snowballing/participant referrals. Of the five men interviewed, two were referred from non-health GBV services, one via police and 2 were identified through snowballing. Participant referral was not very easy as many of the interviewed participants reported that they did not know anyone else who was experiencing IPV. Those survivors who gave examples of other women who were experiencing violence in their relationships reported that the women they mentioned were divorced or they had gone to the village and some of them reported that those experiences were in the remote past. One survivor reported that she was to bring a friend who had sustained a fracture from IPV but later reported that the woman declined the invitation because she had reconciled with her abusive husband.

The two cases recruited through the police (one male and one female) were identified by the researcher on the basis of their high visibility since they were published in the local media. The researcher was able to trace the survivors through the police following the media reports.

Whilst recruiting participants in this way had its advantages such as facilitating recruitment of participants there were also some disadvantages. Many of the participants recruited had experienced closer to what would be categorised as severe form of violence, since their cases were either visible to other community members or to service providers. This means that voices of the survivors who may have experienced normalised forms of violence and never sought help from these sources were missing in the data. The ramifications of this are discussed further in chapter 8 under limitations of the study.

4.8 Qualitative data collection methods

A range of qualitative research methods, including focus group discussions (FGDs) and in-depth interviews were used for this study.

4.8.1 Key informant interviews (KIIs)

KIIs with key informants included policy makers; programme managers and donor community (see section 4.6.1). Those at policy level within the Ministry of Health centred on policies and strategies, coordination mechanisms, information systems and accountability mechanisms and whether violence was considered a priority, what they had done so far and challenges faced. Interviews with the donor agencies included exploration around the support offered to Ministry of Health to enable it to fulfil its mandate, whether they see violence as a priority issue for the Ministry of Health and what the challenges they were anticipating are. Interviews with non-health GBV service providers included their role in GBV, and linkages with Ministry of Health. Data were collected using a brief semi structured guide. The following are the thematic areas contained in the interview schedule:

Interviewees were asked about their role in violence prevention, including what their constraints were and their organisational budgetary allocation

Health care response: They were also asked to describe their collaboration with the health sector and other stake holders involved in violence prevention and to reflect on health services provision and the facilitators and barriers to effective responses within health services. Questions on health sector policies, guidelines and protocols were included and their perceptions of the current mechanisms in place for responding to IPV in the health sector, including on capacity building

IPV: Interviewees were asked what the term means to them; what the scale of the problem is as they perceive it and what factors may be driving it in Malawi. They were also asked about the consequences of violence and what motivated them to engage in violence prevention work. What can be done: interviewees were also asked what the health care services and/or their own organisations can do to improve responses to intimate partner violence

4.8.2 Focus group discussions

Focus groups is a qualitative research method in which a moderator interviews a small group of participants, typically 6 to 10 [375], and uses the group process to stimulate discussion and obtain information on the beliefs, attitudes, or motivations of participants on a specific topic [375, 378]. For many years FGDs were confined to market research but they have become an accepted method in health research [379]; and in feminist research as a critical method of inquiry with marginalized groups [380]. FGDs have the potential to empower participants, by raising the level of consciousness of participants about themselves and the focus group topic

[375]. FGDs have been found to be empowering in some research with vulnerable groups such as HIV-positive women[380], domestic workers [381, 382] and domestic violence survivors [381, 382].

FGDs have been used in formative and process evaluations, informing programme development [375], understanding decision making process of patients, identifying barriers to decision making and conditions required to participate in decision making [227, 375]. They can also be used to discuss sensitive topics because many people may be willing to share sensitive information through group support [223, 380]. They can be also be used in combination with other methods including quantitative research. A previous study in HIV case management concluded that combining chart reviews and FGDs in their study helped them to get a more accurate and richer picture of HIV/AIDS case management than what could have been captured if they only used information obtained from reviewing charts [383].

FGDs have the potential of generating ethically problematic issues such as problems with maintaining confidentiality due to the group situation; stress; feeling of powerlessness in some participants; expectation of action and consequent frustration and the transmission of wrong information [375]. An example of this is when people talk about issues that are not necessarily true but that they have strong opinions about or that are a common belief in the community. This phenomenon may include myths surrounding condoms or HIV prevention, stories about post abortion care and other IPV-related issues. The strength of feeling around issues could in turn convince other people of the truth of these myths and needs careful handling by facilitators. FGDs are not recommended for non-research purposes, when group discussions are inhibited by an improper mix of intended participants, when confidentiality cannot be assured when dealing with sensitive topics and statistics are required (detailed under ethical issues) [375].

FGDs were chosen to allow for exploration of IPV as they may enable discussions on these taboo topics because the less inhibited members of the group may break the ice for shyer participants[223]. FGDs were also an appropriate choice that fitted well in the Malawian context because a culture of silence is an obstacle to discussing violence experiences[328], but the oral culture is still strong [384] and lends itself to the discussion of sensitive topics [385, 386].

Permission for audio taping the interviews was obtained for each focus group discussions. All focus groups were moderated by the researcher and/or one assistant under direct mentorship. Either the researcher or the research assistant (depending on who was moderating) took notes and observed group dynamics. Health care worker participants were

informed that the research was seeking their work experiences and perceptions of IPV and not their personal experiences. FGDs lasted between 55 minutes to 2hrs.

4.8.2.1 Topic guide for discussions with health care workers

Discussions with health service providers centred on their perceptions of and attitudes towards the current health care services provided to survivors of violence. Exploration was carried out around the following thematic areas:

Knowledge/understanding of IPV and its relationship to health

Skills and needs of service providers

The role of health services in IPV prevention, care and support

Health policies, protocols and guidelines towards IPV in health services

Challenges and opportunities for implementing IPV prevention, care and support at the hospital

Collaboration with other sectors

Existing referral systems, how they are rated and their relationships with referral services in-terms of how comfortable they are to refer their clients to such services

Perceptions of the feasibility of screening for IPV and type of screening.

Perceptions of what type of injuries might reflect an underlying problem

Perceptions of options for improving health services response to IPV

Practices in terms of recording: what might be the potential indicators of violence that they might record in a register?

4.8.2.2 Community entry and consent issues for community interviews

FGDs were held in villages or townships which required negotiations for community entry with a wide range of gatekeepers. Introductory letters to access the villages were obtained from the District Commissioner, City of Blantyre officials and Southern Region Police. The Health Surveillance Assistants (HSAs) initiated discussions with community gatekeepers. Community leaders, who have administrative and moral obligations for the people in their respective villages, were also involved and meetings informed them of the purpose and

design of the study. Chiefs, who knew individual households well, approached participants through their helpers and HSAs about their potential interest to participate in the study. For young people consent was also obtained from parents to allow their adolescent children (aged over 18 or considered mature minors) to participate in the study. This applied for all young people who were still living with their parents at the time when the study was conducted. Consent was obtained directly from each participant, including the young people [75, 387].

4.8.2.3 Topic guide for discussion with general community members

The following areas were addressed: (see appendix 5)

Their understanding and perceptions of different types of violence that might be experienced within the family/relationships (with a focus on their understanding of IPV) and the potential causes of these

Their understanding of the relationship between IPV and health (e.g. health consequences)

Their perceptions of help seeking and sources of support for people experiencing IPV

Their perceptions of challenges and barriers to seeking and receiving help

Their perceptions of health services for people experiencing IPV and the quality and utility of these

Their perceptions of referral services for people experiencing IPV

Their perceptions of how existing health and other support services could be improved

4.8.3 Semi structured individual interviews with health care workers (IIs)

To maximise opportunities for presentation in areas where FGDs could not be held due to staff shortages and other constraints (see section 4.6.2) additional IIs were conducted with health care providers (see annex 3). These one on one interviews were carried out to uncover individual perceptions, experiences and practice. Either the researcher and/or one research assistant conducted the interviews [388].

One member of staff from each department (where possible) who had not taken part in the focus group discussions was invited to participate in the individual interview (II). Using IIs helped to triangulate the findings from the FGDs. Individual interviews allow the interviewer

to deeply explore the respondent's feelings and perspectives on a subject. The confidential atmosphere in which informants can share sensitive information provide for the opportunity to gather detailed information about their personal experiences, opinions, feelings and experiences without the influence of peers [389]. The IIs revealed different information from the FGDs despite an almost identical topic guide. For example there was reference to personal experiences, to friends and family members and more freely expressed opinions.

4.8.4 In-depth individual interviews with service users 'survivors' (IDIs)

The critical incident technique was used for these IDIs. Critical incidences concentrate on asking the respondent about a key event in their past (in this case help seeking for intimate partner violence) to describe in detail their actions in response to the event or episode including all forms of help used or sought [390]. The following areas were addressed (see annex 4):

> IPV: Interviewees were asked about what their understanding of what was happening to them, what they think might be the cause and what are the consequences of this.

> Help-seeking behaviours: Interviewees were asked whether they sought help following abuse. What made them seek care? Where did they seek help? How satisfied were they with the help they received? If they sought help from the health care workers: which specific services, where did they present first, who were informed? How was disclosure done, how did they perceive the care they received? What made it more satisfying? What made it worse? What was the attitude of the health care providers? What would encourage them to disclose abuse to health care providers? What would make it difficult? How did they cope? What were their experiences of being referred to other services? What was the impact of care seeking on their situation?

> What can be done: interviewees were also asked what the health care services can do to improve their response to intimate partner violence, and what priority interventions should the health care providers engage in to prevent intimate partner violence.

4.9 Quantitative Data Collection Methods – register reviews

The aim of collecting register data was to collect data that could be used to estimate the potential burden for health services of a selective screening tool (i.e. to be used only when violence is suspected) by measuring the occurrence of proxy indicators of violence that might

be used in such a tool. The study was conducted at Queen Elizabeth Central Hospital (QECH) in Blantyre as this has a large number of admissions and is the site of the first fully functioning One Stop Centre. No additional sites were included in this register review. Data were collected in the month of January 2011 because it was expected that more cases of IPV would be seen during the festive season. The potential implications of surveying routine data and for only one month are presented in chapter 8 under limitations of the study

A total of 3567 Patient register records of adult admissions to gynaecology ward, attendances at outpatient departments, , reproductive health services, sexually transmitted clinics, ART clinics and PEP for post rape were retrospectively reviewed using a standardised tool containing socio-demographic, clinical and outcome indicators. This included variables on the demographic characteristics of the survivors excluding the name of the survivor. Other element to include in the tool was based on positive indicators identified by Morrison and Bolt (2007) and health consequences of IPV and sexual violence by Krug (2002) (tool appended see annex 1). This tool was amended based on the feedback from health care providers.

Data from the One Stop Centre located at QECH and police registers covering the Blantyre district were used to triangulate the findings through establishing the burden of referral to the health sector from the police and direct attendances to the One Stop Centre. Data were entered and analysed in Epi Info [391]

4.10 Data management and analysis

4.10.1 Qualitative data analysis

The interpretive and subjective nature of qualitative research requires the researcher to be intimately engaged with the data [392], and there are no 'quick fixes' in qualitative analysis since qualitative research techniques generate a mass of words that need to be described and summarised[393]. This research uses a thematic approach to data analysis and in particular the 'framework' approach for the reasons outlined in the following section.

The framework analysis approach developed by Ritchie and Spencer (1994) and some concepts in Krueger's (1994) framework of analysis have been chosen to guide the analysis of the data. The framework approach seemed most appropriate because the study had specified its objective, pre-designed the sample (e.g. health care providers) as well as prior issues to be explicitly addressed (intimate partner violence and the role of health care

services) [393]. The framework approach can also be used in analysing both the in-depth interview and focus group discussions data [379, 394]. Apart from being transparent, the stages provided by framework simplified the complex process of qualitative data analysis [394]. Also, although to some extent it uses a deductive approach, the framework approach allowed themes to develop from both the research questions and from narratives of the participants [393, 394]. Ritchie and Spencer (1994) describe five stages for data analysis [393, 394].

Familiarisation (principle researcher, research assistants):

> This stage of data analysis involved listening to tapes, transcribing the data, reading transcripts in their entirety over and over, and studying observational notes taken during the interviews to make sense of the data as a whole before breaking it into parts.

Identification of a thematic framework (principle researcher, independent researchers/supervisors):

> The researcher drew on a priori issues identified in the literature (e.g. perceptions of IPV, perceived burden of IPV, reporting of IPV, health consequences and feasibility of IPV screening), the aim and objectives of the study, as well as issues raised by the respondents themselves and views or experiences that recur in the data. The aim was to identify key issues, concepts and themes to produce an initial coding framework, which was subsequently refined as analysis progressed.

The next two stages of coding or indexing and charting are seen as data management stages as they lead to reduction of the data [394]. Krueger advocates for either a long table or a computer based approach for cutting, pasting, sorting, arranging and re-arranging data through comparing and contrasting relevant information[395]. In this study, key emerging themes were indexed and data were managed with the assistance of computer-aided qualitative data analysis software (CAQDAS) NVIVO 9.

Coding or indexing (principle researcher and supervisors):
During this stage the researcher applied the thematic framework developed in the previous stage. Textual codes were used to identify specific pieces of data which corresponded to differing themes. The NVIVO output below shows how a framework for reporting violence played out during the analysis of data from health care provider interviews. For detailed framework see annex 7.

Table 4.6 an example of NVIVO node output on reporting violence

Name	Sources
Nodes	
reporting violence	11
shame	4
fear of arrest	6
endurance	8
Dependence	7
recording	3
identification of survivors	5
provider characteristics	2
judgemental attitude	4
normalisation	10

Charting: (principle researcher):

Charting of the data involved creating a four column table in Ms Word consisting of the following column headings: coded data, dimensions identified and analytical categories, copying headings from the thematic framework or "tree node" in NVIVO9, and pasting the coded data accordingly for easy view of the data.

Mapping and interpretation of the data (principle researcher, independent researchers, stakeholders attending feedback workshop, supervisors):

The researcher looked for patterns, associations, concepts and explanations in the data aided by visual displays and plots [393]. The whole process was driven by the original purpose of the study and emergent themes. In interpreting the coded data the researcher used : words, context, internal consistency, frequency and extensiveness of comments, specificity of the comments, intensity of the comments and big ideas to make sense of the data [394].

Table 4.7: an example of charting

Analytical category	Level one coding	Level two coding Dimension identified	Coded data
Reporting violence	Individual	Shame	*You find that a patient comes with a wound near the eye suggestive that she has been hit by an object. They come here to seek medical attention without disclosing the cause of the injury. They feel so ashamed to disclose that my husband has beaten me. (HCW FGD, Urban*
	Relationship	Dependence	*Like in our area here most women are economically dependent on men. The women find it hard to report violence to appropriate or relevant organizations because they fear for their children as to who is going to feed them once divorced.(VHC MAN)*
	Community/cultural	Endurance	*What I see on the part of the women is that they say I should continue to endure because he is my husband may be tomorrow he will change.(HCW SWO, hospital)*
		Normalisation	*Just as an example, in marriage, when a married person is hurt by the other partner, the victim of this violence accepts it and move on while if a stranger hits you, you will take it to be violence straight away because there is no association between you.(HCW FGD, Hospital)*
	Institutional factors	*Identification of survivors*	*Some people voluntarily disclose violence like I have been beaten by my husband. But most cases seen at this hospital are voluntary although some do not but we still realize.*
		Judgemental attitude	*The other factor is what P1 has already alluded. Attitude of health workers that's why they don't want to access health services.(HCW FGD, urban)*
		Provider characteristics	*If a woman meets a male clinician disclosure becomes a problem. The same applies if the clinician is young. Let's say if she meets our doctor here she is very young. She can't be free because she will think that what this girl know about marriage.(HCW FGD, urban)*
		Recording	*When a patient comes here with history of being beaten. Her diagnosis will not be beaten but we document the injury that she has sustained. May be what we could suggest is that let them create some indicators in the HMIS that are specific to violence.(HCW FGD, rural*
		fear of arrest	*When they come to the hospital they don't disclose because we will tell them to go and get police report. That scares them, should my husband be imprisoned, they think their husband will be jailed that's why they choose to say I fell or I hit the wall. (HCW II, rural)*

4.10.2 Quantitative data analysis

Data was checked, entered with the help of a data entry clerk, cleaned and analysed using EPI info. Statistical analyses included quantitative descriptive analysis and summary statistics (means, percentages and standard deviations etc). Pearson's chi-square was used to compare categorical variables and Fishers exact test were used for variables with few entries using two by two tables. A p-value of less than 0.05 was considered as statistically significant.

4.11 Ethical considerations

4.11.1 Ethical approval

The research proposal was approved by the Liverpool School of Tropical Medicine Research Ethics Committee, the Kamuzu College of Nursing Research and Publications Committee (KCNRPC) and the Malawi College of Medicine Research and Ethics Committee (COMREC) for ethical review and approval. Permission to conduct the study was also obtained from the Hospital Director of Queen Elizabeth Central Hospital, Blantyre District Health Office, in charges of respective health centres, service organisations and community leaders in various communities and individual participations.

4.11.2. Informed consent

Consent was sought from all participants and participating organisations. This discussion was in Chichewa where appropriate and thumbprints were used to obtain consent from illiterate participants. A standardised information sheet and consent form was used**.** The information sheet explained that participation was voluntary; participants had the right to withdraw from the study at any time, or refuse to answer any questions. Issues of confidentiality and anonymity were also discussed. Additional consent to use tape-recorders was also obtained.

> For policy makers consent to participate in the study was obtained in one or two phases depending on individual participant situation: if the director of the organisation participated in the study then consent was obtained only once. Participants also provided a written consent
>
> For HCWs consent to participate in the study was obtained in two phases: from the participating hospital and health centres and from individual participants.
>
> For community members IDIs, prior contact was made with potential participants to explain the study purposes and obtain full informed consent. Those who agreed to be interviewed were then offered the choice whether to continue with the interview immediately or to schedule it for a later date to enable them to think carefully about their decision.
>
> For the community FGDs, health workers and other stakeholder interviews, full informed consent was obtained at the beginning of each FGD and interview.

4.11.3. Anonymity

Transcripts were coded by numbers. No names were written on all the documents produced as a result of the interviews except for the consent forms. However, for community IDIs the

interview code was also indicated on the consent form so that there was a way of following them because the researcher expected that she would conduct repeated interviews with them. This was also necessary for proper referral if required. In the conduct of this study, repeated interviews were conducted with some and not all participants for the following reasons: 1) in some cases the researcher discovered that the first interview was able to produce rich data such that the contributions from the repeated interviews were very minimal, 2) it was easier it secure an appointment with women who were divorced or separated at the time of study than those living with their abusive partners, 3) and the repeat interview was dependent on voluntary turn up of the participant and we could not follow them up by phone for safety reasons. Contributions from participants are anonymised to avoid recognition.

4.11.4 Data storage

The details of interviewees were stored securely and separately from transcripts and tapes. Tapes and hard copies of transcripts were stored in a locked cupboard and transcripts were protected by a password only accessible to the researchers.

4.11.5 Confidentiality

There are some confidentiality issues that are specific to FGDs as participation may involve some loss of privacy and confidentiality due to over disclosure. In addition, maintenance of confidentiality usually falls outside the jurisdiction of the researchers as some participants may go out and gossip about the things that have been said in the group [396, 397]. In spite of the inherent weakness of FGDs highlighted, the researchers were strict to observe ethical principles to minimise the harm participants would have experienced by volunteering to participate in this study. At the beginning of the FGDs, the moderator together with participants agreed on norms that would enhance confidentiality. Participants were informed to treat focus group discussions as a public meeting and say the only things that they were comfortable to say. The moderator actively discouraged over disclosure in the focus group discussions by reminding participants from time to time that discussions are meant for general discussions, and gave opportunity for participants to be listened to as individuals through arranging IDIs at a future date. In one of the rural FGDs with women, a participant gave the researcher her phone number so she could be contacted following the FGD. Debriefing meetings were held with participants and referrals for counselling were offered but none in the FGDs required those services.

4.11.6 Revelations of child abuse

Participants were also informed that confidentiality would be breached in two exceptional cases. First, if a case of current or ongoing child sexual abuse was reported on the basis of evidence or first-hand experience. This was because the law requires mandatory reporting of abuse cases of children under the age of 13. Second, if an interviewee reports a serious and credible threat to their own life or the life of others, these cases were to be reported to police. In the conduct of this research there was one reported case of child abuse: a girl with learning difficulties, who was aged above 13 had been abused and made pregnant by her uncle and most recently by her step -father. The researcher was not obliged to report the case because it had already been brought to the attention of the police. The researcher followed the issue with police to find out what they were doing since there seemed to be some a lack of action from police.

A second case where children were affected, involved a young girl aged ten with two other siblings. These children, especially the young girl, showed signs of Post-Traumatic Stress Disorder (PTSD) resulting from physical abuse and psychological trauma resulting from rejection by her father. The perpetrator was serving a prison sentence for severe domestic violence abuse of his wife. The researcher engaged the services of a registered psychiatric nurse trained at master's level with trauma and PTSD counselling skills to assist the family. All the children and their mother attended five sessions. The mother initially had refused to attend services for herself because she felt that she had received enough support from various people including her church leadership but accepted to enter into counselling for the sake of her daughter who she felt was severely traumatized by her father's actions. She felt that she had greatly benefited because the counselling sessions were different from what she had been exposed to previously.

4.11.7 Risks of harm to researchers

Hearing distressing stories about abuse can result in increased distress and burn out in the researchers. Frequent meetings were held between researchers for debriefing and also for providing support to the researchers. The main researchers also maintained frequent contact with the local and main supervisors for support. A supervisor also visited the main researcher in the field to offer support.

4.11.8 Risks of harm and distress to participants

Researching domestic violence poses extra safety issues in addition to those inherent in research dealing with human subjects. Participants together with researchers are at risk of both physical and psychological harm from retaliatory actions from the perpetrator and/or judgemental attitudes by other social actors such as other family members or community members, and exposure to or re-living traumatic experiences. To ensure that the risk of exposing participants to harm was reduced, the study adopted the WHO guidelines [398]. The study was known as "family conflict and health study" to gate-keepers in the community for obvious safety reasons of the participants. The name "family conflict" closely reflected the issues of concern in the study. Gate keepers were informed that only one person in a household can be eligible to participate in the focus group discussions. In addition, male focus group discussions were conducted from different communities to women focus group discussions. However, the real contents of the study were communicated to participants at the time of obtaining an individual informed consent. This was important as telling the truth about the study is an important aspect of getting an informed consent from the client.

A dummy topic guide was formulated so that the researcher can switch to it if somebody interrupts them during the data collection process. Researchers were trained to stop the interview if interrupted and leave the scene if the situation appears risky. The researchers worked in pairs and had a vehicle and driver on visits to communities. Security was also considered in choosing a location for interviews with survivors (e.g. a private room in the researcher's workplace was used when acceptable to participants) and private place for FGDs in the community selected by community leaders. In one incident, a female survivor sent a message that she failed to come because somebody had reported to her husband that she saw her with a research nurse. She did not report any violence but felt it was safer for her not to be seen again.

In IPV research there is a risk of 're-traumatisation' of respondents and traumatisation of researchers as violent experiences are recounted. The interview may cause an interviewee to relive painful and frightening events, and this in itself can be distressing. The researcher had made contacts with GBV service providers in Blantyre prior to data collection from survivors and community members. She established relationships with these organisations and assessed their willingness to receive and assist women referred to their agencies. Where services were not readily available a concerted effort was made to provide temporary counselling services for women who needed such services, including paying for trained psychological support

from nurses. An assessment of the immediacy of the need was made by the researcher and services were organised with urgency where necessary. No referrals were made from FGDs. Referrals from IDIs are discussed below.

The researcher used a research assistant with counselling skills and experienced psychiatric health nurses for confidentiality purposes but also for their skills. Researchers were trained to observe for signs of emotional upset (such as crying, withdrawal, silences etc) and when to stop the interview and give time for the participants to recover. Then participants were given an opportunity to choose whether they would like to continue, postpone or stop the interview. The interview continued only when the participants were willing to do so. Basic counselling skills were used to support clients. In addition, a contingency plan was built into the budget to cater for return visits for uncompleted interviews. Researchers routinely encouraged supportive reflection on the impact of the interview at the end of each interview. Researchers also made themselves available to be approached after FGDs and one woman approached in this situation.

Apart from measures taken by the researcher to ensure the safety of the participants, the participants were also informed of the need to keep the contents of the interview secret for their own safety. Information was given to all participants about counselling services available and contact details of the researcher for further details. Participants were also told of their freedom to decline to answer any questions that make them feel uncomfortable. All survivors were offered the opportunity for counselling. None of the male survivors accepted the offer. Five of the seven female survivors received some form of support. Three of the survivors attended one session each with psychiatric nurses. One failed to report for the second session because a neighbour reported to her husband that she had seen her with a research nurse but no violent incident was reported. The remaining two said they were comfortable because they had received spiritual counselling and were relying on prayer. One of the women survivors had received five sessions together with her children who were also traumatised. The remaining two met with the researcher on several occasions and difficulties arose over the delineation of role as the sessions became more involved and required professional counselling support. See section on reflexivity (section 4.12.3).

4.11.9 Training of research team

In addition to the training on distress the research assistants were trained on gender and GBV, in addition to ethical issues in domestic violence research and basic qualitative skills. This

was done over three days to help research assistants better understand the field under study and also to appreciate the nature of the study. The training included field testing. Negative attitudes towards IPV were emphasised to help them to deal with their own prejudices as these may have impacted on the quality of data collected. The lead researcher made a careful selection of the research assistants such that only those passionate about the topic were picked. The potential risks involved in the study for both the participant as well as for their own risk were discussed.

4.11.10 Compensation for participant's time and costs

Apart from gaining approval from ethical review bodies, feminist researchers have argued that an ethically sound research should include some token of appreciation for participants time and taking part in the research [399]. From this viewpoint, tokens are viewed as benign in themselves [400], as they are seen as a way of overcoming some of the power imbalance between the researcher and the researched so that the former isn't the only one in the relationship to benefit directly [399]. The researcher shared a common view with the above. However, the tokens for participants for both in-depth and focus groups were those deemed appropriate in the Malawian context, sufficiently small as not to raise unsustainable expectations in future research activities, for example, refreshments (soft drink and a snack) and transport reimbursement where applicable. In our first interviews women requested that instead of giving them a drink and a snack we should give them an equivalent so they can buy *(matemba)* small fish and eat with their children. We felt that their cause was justified so we opted for giving them money as a reimbursement for their time.

4.12 Trustworthiness of the data

Several frameworks for ensuring trustworthiness in qualitative research exist but Guba's constructs of credibility, transferability, dependability and confirmability [401] form a framework for this study. Credibility is critical to establishing trustworthiness in qualitative research, and deals with the question "How congruent are the findings with reality?" It is closely linked to the other methods of ensuring trustworthiness[402].

4.12.1. Steps taken to ensure trustworthiness

Several steps were taken to ensure trustworthiness.

Focus groups were audio-taped with participant consent and conducted in the vernacular (Chichewa). Audiotapes were transcribed in Chichewa by whoever moderated the session and translated into English by the main researcher. A sub-sample of translated transcripts were

translated back into Chichewa by an independent translator and compared with the originals to check for any problems in translation.

The study used FGDS and IDIs, which are both well-established methods in qualitative research and have been used to investigate issues related to IPV and other sensitive topics (see methods). Community FGDs were carefully disaggregated into participant types and separated in time and place. For HCW FGDs there were no observed differences between mixed and non-mixed FGDs in terms of group dynamics. HCWS were able to interact well during the discussions despite the sensitivity of the topic.

The study used triangulation through multiple data collection methods and data sources (types of respondents) – for example by including both young men and women in the study as well as older community members and health care workers in separate groups. This was a deliberate strategy of incorporating multiple different sources to increase validity and reduce inherent biases [403, 404].

The study was led and conducted by experienced Malawian researchers, conversant with cultural norms and probing for more information.

The insights from peer debriefing with research assistants and review of transcripts by independent researchers and supervisors in Malawi and UK familiar with gender and IPV issues were incorporated in analysis.

Findings were presented, discussed and validated at a multi-sectoral stakeholder workshop where additional feedback was incorporated into the analysis.

4.12.2 Addressing possible constraints to trustworthiness

Research on IPV raises specific potential constraints to trustworthiness. The potential for non-disclosure of violence is generally recognised as a greater risk factor affecting validity in domestic violence research than the potential for over-reporting. This is not unique to violence research but applies almost too all research studies that deal with sensitive issues. There are several factors identified in literature that affect disclosure and these include the contexts in which research is being conducted, the time the interview is taking place and also the absence or presence of other people. Privacy is very important and as well as the attitude of the researcher and the sex of the interviewer [405].

The study facilitated open discussion by: establishing rapport through multiple interviews; by being sensitive to the gender issues (the research team were comprised of both male and female researchers so that the sex of interviewers and interviewees/FGD participants were matched to facilitate open discussion). This was adhered to during the fieldwork except for health care provider's interviews, which involved mixed groups and were facilitated by female researchers. All female community interviews were conducted by female researchers, but three of the five male survivors opted to be interviewed by the female researcher. They said, they recognised that the gender violence agenda in Malawi is driven to a larger extent by women and do not take into account the concerns of men so they wanted to talk to a woman so she can hear what men are experiencing from the hands of fellow women. It was hard for the researcher to envision the type of conversation and there was a potential concern about ethics. However, considering the principle of autonomy, the researcher proceeded and interviewed them; the interviews were successful and elicited rich information.

Training of the research assistants and particular ethical developments was discussed in section 4.11 above. Additionally repeated interviews were offered to some survivors to overcome constraints around trustworthiness, provide a more supportive environment promoting disclosure and minimise any distress of prolonged interviewing.

4.12.3 Reflexivity

Reflexivity is particularly valuable to qualitative research because it brings honesty to the fore, asking us not to feign objectivity or reach post hoc conclusions but to acknowledge that multiple factors, including our personal narratives, shape the data we produce and our interpretations [406]. The researcher as an instrument in qualitative research needs to recognise that they bring their own values, beliefs, knowledge and experiences into the research process to help level the playing field [406]. Maxwell identifies three kinds of goals for doing a study: personal goals, practical goals, and intellectual goals. Personal goals are those that motivate the researcher to do the study; they can include a desire to change some existing situation, a curiosity about a specific phenomenon or event, or simply the need to advance your career. These personal goals often overlap with practical or research goals, but they may also include deeply rooted individual desires and needs that bear little relationship to "official" reasons for doing the study. Maxwell emphasise the importance of reflecting on these and to take account of the personal goals that drive and inform the research. This does not mean eradicating or submerging the personal goals and concerns, as attempting to do so is unnecessary. He calls upon qualitative researchers to think about the best way of dealing with their consequences as

they may have profound influence in the selection of the research topic issue or question and over the selection of the qualitative method as a mode of enquiry[359].

This then brings me to the genesis of my study. In the rest of this chapter I have used the term 'the researcher' to refer to myself, but for the purposes of this section I will revert to the first person since this seems most appropriate term for a reflexive discussion of positionality. The idea for the present study can be traced back to 2006, when I wanted to explore the link between HIV and violence. I had just finished a module on health effects on domestic violence in my masters of women's health programme. It was the first time that it emerged in me that the effects of Domestic Violence (DV) are often neglected. I expressed my interest to conduct the study. One of the senior lecturers, who had just returned from a WHO expert meeting on gender, supported the proposal highlighting the paucity of information in sub-Saharan Africa. Unfortunately, my supervisor then did not support the idea fearing non-disclosure. In the end the HIV component of my study was retained. This did not quench my personal goal of wanting to know more about the subject. First because I had encountered women with miscarriages disclosing abuse but did not know how to deal with them apart from listening and feeling sorry for them. Secondly, I would consider myself as an insider because I grew up with my grandparents and my grandfather used to be aggressive once he got drunk. I could not understand why my grandmother got stuck with this man when all his children including us (grandchildren) were fed up and wanted him chased out of our grandmother's village (I was brought up within the matrilineal family structure). I wanted to know why men abuse the very same women they professed to love. At this point my personal and practical goals converged. However, the practical and intellectual goals superseded the personal goals because I wanted to explore the link between HIV and Violence based on gaps identified in the literature.

An opportunity to pursue my goals were realised when I was given a scholarship to study for a PhD. I consulted a senior member of staff with regards to government priorities. They had just finished revising the National Sexual Health and Reproductive Rights policy and told me that they have identified a big gap in terms of gender violence issues in health. There was no research or publications on the topic. I was convinced it was confirmation for me to do the study. I went back and checked whether this was a thematic area for my potential funders and realised it was so I developed a concept note. My topic evolved as the research progressed and informed by literature I ended up with an intellectual goal of exploring health care service responses. I returned to Malawi in December geared to start fieldwork in

January but the main fieldwork did not begin until April 2011 due to logistical problems. Reactions from informal talks with colleagues over the research topic revealed attitudes that created uncertainty about the outcome of my study and reactions I was likely to meet during field work. In one conversation a colleague sarcastically in local language said "ee!! *Nkhanza zomwezi,"* meaning "why bother, is this an issue?". A senior member of staff asked, *"are you sure this is an MoH priority?"* This sounded like an intellectual question, reminding me to reflect on the goal behind my research. On the other, I felt this could also have been a polite way of saying IPV is a non- health issue. Some asked, *"do you intend to continue working with the nursing college after your study? You will need to start a Non-governmental Organisation to help these people better".* During one of the interviews a health provider asked, *"why are you asking about violence that happens in the home, why not study violence in health services?"* (she then narrated a story of abuse in the hospital). Engaging with different people made me aware of what to expect in the field, and prepared me to devise means of overcoming potential obstacles in my study.

My previous knowledge of researching sensitive issues, my experience of conducting qualitative research and my background as Malawian served as a foundation for collecting rich data. I was well versed with the protocols required for community entry, and the appropriate mode of dressing that would reduce power differences between the participant and the researcher. Prior experience in dealing with community members increased my sensitivity towards the research participants and prevented me from making premature judgements, imposing my personal views and opinions on the responses made. I was able to encourage the participants to realise that they were experts in the production of knowledge and that the role of the researcher was to learn from them. I am an introvert, but highly respectful of other people and their opinions. Although being an introvert may appear on the outset as a disadvantage in engaging with people it has proved to be a very helpful characteristic for a qualitative researcher. As an introvert, I am a very active listener and talk only where necessary. This worked to the advantage because participants were allowed to express themselves fully without much disturbance from me as a moderator. This is illustrated by the richness of the data generated in FGDs with young people.

My listening skills also caused challenges for me as many of the women (in particular) interviewed wanted to come back for more interviews, which they perceived as counselling sessions. Even after finishing the audio-taping they would continue to share counselling issues, make requests for help and referral risks becoming dependant in some instances. It

was very difficult knowing how and when to set boundaries (see section 4.11 on ethical issues).

My own experience as a mother of teenage girls proved to be an asset in understanding some of the language young people use in describing their relationships. In addition, my involvement in the Student Christian Organisation facilitated easy communication with young people. The potential negative influence of hierarchy and my position as nurse may have influenced the support I received from nurses as they perceived the research as their own. Some of the nurses commented during the FGDs that, *"this is what we would like to see continued, having nurses doing their own research"*. The study had very few doctors participating because it was difficult to fix appointments with them due to tremendous shortage of personnel. No health centre is run by doctors; however, I do not rule out the influence of the gender dynamics prevalent in health services on my ability to recruit male doctors. Nonetheless, doctors, and directors of central hospitals contributed to the validation workshop (see section 4.12.1). Interviewing policy makers at National level was made easier with the collaboration with UNICEF (who had come in part way through the study and funded an expansion of its scope in assessing health sector responses) and the letters of introduction provided by the MoH NCD.

Both 'insider' and 'outsider' views can be helpful in understanding data in different ways. In this study I generally considered myself as an insider from the perspective that I am Malawian conducting my study in Malawi. I was also an outsider geographically, based on my educational level and income. I also consider my supervisors as outsiders. What shocked me from the data was not what shocked my supervisors. For example, I was concerned with the most severe forms of IPV manifested in the study, yet they were disturbed by the widespread normalisation of violence. Having my supervisors read some of the transcripts helped to bring in a balanced analysis to the problem under investigation.

4.13 Summary

This chapter has presented the research design, theoretical perspective guiding the study, research methodologies, sampling methods and selection procedures, analysis, ethical considerations, and trustworthiness. The chapter also highlighted the positionality of the researcher as the 'research instrument'. The study employed a descriptive interpretive situation analysis to explore perspectives on IPV and health care services with multiple sources of data. The study was largely qualitative with a limited, small-scale quantitative

sub-study that involved reviewing hospital registers. The results are presented in the following three chapters.

Chapter 5: Analysis of the legislation and policy environment governing health sector responses to violence

Introduction

This chapter presents a critical analysis of the legislative and policy environment and frameworks governing the health sector's response to violence against women and children. The critical analysis considered the documents in terms of their area of focus, definitions and the roles and responsibilities of different sectors as they are outlined in theory. Some potential gaps and areas of conflict were identified. This assessment combines the analysis of the gaps within the legal and policy documents with qualitative research findings drawn from interviews conducted with communities, key informants, health care workers (HCWs) and other stakeholders. The whole range of qualitative data collected (see chapter 4) was included in the analysis if discussion was coded as being relevant to the legal and policy analysis. Participants in community FGDs, HCW interviews and FGDs and KIIs with policy makers were all asked whether they were aware of the documents and whether they found them to be useful, user-friendly and relevant to the problems of violence against women and children they encounter as part of their work (see chapter 4). For clarity the findings are presented as:

> The legal framework: international conventions and Malawian law
>
> Health sector policies including guidelines and protocols
>
> Current health sector strategies including national plans, frameworks and sector wide approaches

In the qualitative analysis findings are presented on the perceptions of stakeholders from different levels and sectors of the system (beyond the health sector) to give a comprehensive assessment of the perceived utility of the documents from a variety of perspectives.

5.1 The legal framework: international conventions and Malawian law

Malawi has ratified several major international, regional, and sub-regional human rights instruments that protect the human rights of women, children and of persons living with HIV [326]. See table 5.1.

Table 5.1 International and regional treaties and conventions ratified by Malawi

Convention/treaty (references in brackets)	Description	Year ratified
The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), 1979.	The Convention requires that countries take all appropriate steps to end discrimination against women in all forms and to incorporate the principle of equality of men and women in their legal system [407].	1987
	Optional Protocol to the CEDAW. By ratifying this, Malawi recognizes the competence of the Committee on the Elimination of Discrimination against Women to receive and consider complaints from individuals or groups within its jurisdiction [408].	2000
UN Convention on the Rights of the Child (CRC), (1989)	A comprehensive human rights convention on child rights which is supplemented by the International Covenant on Civil and Political rights (ICCPR) (1966) and the African Charter on the Rights and Welfare of the Child	1991
Human Rights Conference in Vienna [409].	States that Gender-based violence and all forms of sexual harassment and exploitation, including those resulting from cultural prejudice and international trafficking, are incompatible with the dignity and worth of the human person, and must be eliminated. This can be achieved by legal measures and through national action and international cooperation in such fields as economic and social development, education, safe maternity and health care, and social support	1993
International conference on Population and Development –[410]	Aims at empowering women and improvement of their status and for the state governments to develop policies and laws that better support the family, contribute to its stability and take into account its plurality of forms	1994
African Charter on Human and Peoples' Rights. [411].	The protocol includes articles on the rights of women in Africa: the rights to life, integrity and security of the person, elimination of harmful practices such as FGM, and health and reproductive rights	1989.
SADC protocol on gender and development (1997) and its addendum on women and children rights (1998) [412]	States that all countries shall enact and enforce laws against all forms of GBV by 2015; all perpetrators shall be tried by court of competent jurisdiction and be offered social and psychological rehabilitation. Accessible, effective and responsive police and specialized legal and health services among others	1997
United Nations Convention against Transnational Organised Crime.	Is a protocol to prevent, suppress and punish trafficking in persons, especially women and children	2000
Rome statute of the [413]	The statute defines rape, sexual slavery, enforced prostitution, forced pregnancy, enforced sterilisation or any other form of sexual violence of comparable gravity as a crime against humanity	2002
International Covenant on Civil and Political Rights[414].	Clarifies that no marriage shall be entered into without the free and full consent of the intending spouses. States Parties shall take appropriate steps to ensure equality of rights and responsibilities of spouses as to marriage, during marriage and at its dissolution. In the case of dissolution, provision shall be made for the necessary protection of any children	1993
International Covenant on Economic, Social and Cultural Rights [415]	This states that it is the right of everyone to the enjoyment of the highest attainable standard of physical and mental health	1993
SADC Protocol on Health [416]	This states that member states shall co-operate to promote a public health approach to the prevention of violence, particularly domestic violence, and road traffic accidents	2000

5.1.1 Domestication of international instruments

For citizens to use the international instruments once they have been ratified there is need by the Malawi government, through Parliament, to re-enact them into local law (domestication) and this remains a challenge in Malawi [371]. For example, Malawi has failed to increase the minimum age for marriage to the age of 18 as recommended by both the Committee on the Rights of the Child (CRC) and the Committee on the Elimination of Discrimination against women (CEDAW) [371]. Thus only some aspects of the international human rights obligations are reflected locally. The two most important pieces of domestic legislation in relation to violence and human rights are the Constitution and the Penal Code. The Constitution offers broad protection against the violation of the rights of women and children whereas the Penal Code criminalises conduct that undermines or infringes those rights.

The Malawi Constitution (1995) as amended by the Constitution (Amendment) Act, 2009 is the supreme law of the land. Section 12 (1) (d) and (e) recognizes the inherent dignity and worth of each human being and gives equal status to each person before the law. The specific rights of women are addressed in section 24. Women in Malawi have the right to full and equal protection by the law, and have the right not to be discriminated against on the basis of their gender or marital status. Policies on domestic violence, maternity benefits, economic exploitation, rights to property and security are addressed under section 13 (a).   The Constitution also provides under section 22(8) that the State shall actively discourage marriage between persons where either of them is under the age of 15 years. Marriage is allowed with parental consent from the age of 15 and without parental consent for individuals who are 18 and above (section 22 (7) of the Constitution).

The Penal Code (1930) as amended by the Penal Code (Amendment) Act, 2009 is an Act of Parliament that establishes a code of criminal law, setting out offences and punishments and reflecting the values of the Constitution. Under the section which outlines offences against morality, the following crimes are defined:

Crimes against women and girls defined in the Penal Code

1. Rape and indecent assault 'Any person who has unlawful carnal knowledge of a woman or girl, without her consent, or with her consent if the consent is obtained by force ...shall be guilty of the felony termed rape'. Indecent assault of females is the term for sexual assault that does not involve vaginal penetration and 'any person who unlawfully and indecently assaults any woman or girl shall be guilty of a felony.

2. Defilement of girls under sixteen years of age. 'Any person who unlawfully and carnally knows any girl under the age of sixteen years shall be guilty of a felony'... 'it shall be a sufficient defence to any charge under this section …that the person so charged had reasonable cause to believe and did in fact believe that the girl was of or above the age of sixteen years.'

3. Incest in Malawi applies only to the abuse of girls. It states 'Any male person who has carnal knowledge of a female person, who is to his knowledge his grand-daughter, daughter, sister, mother or grandmother, shall be guilty of a felony and shall be liable to imprisonment for five years: Provided that if it is alleged in the information or charge and proved that the female person is under the age of sixteen years, the offender shall be liable to imprisonment for life.' Once above the age of 16 the girl or woman involved in incest is also considered a perpetrator: 'Any female person of or above the age of sixteen years who with consent permits her grandfather, father, brother, son or grandson to have carnal knowledge of her (knowing him to be her grandfather, father, brother, son or grandson, as the case may be), shall be guilty of a felony and shall be liable to imprisonment for five years.'

Crimes against boys and men defined in the Penal Code

1. Indecent assault of boys under 14 states that 'any person who unlawfully and indecently assaults a boy under the age of fourteen years shall be guilty of a felony and shall be liable to imprisonment for seven years, '

2. Indecent practices between males are described as 'acts of gross indecency' and considered felonies. These are not further defined.

Statutory protection for women in Malawi is further outlined in a relatively recent Act of Parliament: The Prevention of Domestic Violence Act (PDVA 2006). . The purpose of this Act is to ensure the commitment of the state to eliminate GBV occurring within domestic relationships, and to provide for effective remedies and other social services. There is no Sexual Violence Act in Malawi which brings all these issues together into one coherent and consistent document and the PDVA does not detail sexual offences.

The national laws, including the Constitution, do not have a consistent definition of a child. A child can get married at the age of 15 years with parental consent. yet is defined in the Constitution as being a person less than 16 years. Defilement, rape, and incest are defined as crimes in the Penal Code as crimes against girls and women with defilement being sexual

abuse of a girl child under 16 years. Indecent assault is not defined in detail but covers girls and women as well as boys less than 14 years.

Domestic violence is defined as any criminal offence arising out of physical, sexual, emotional, psychological, social, economic or financial abuse committed by a person against another person within a domestic relationship. *Physical abuse* means any act or omission which causes or is intended to cause physical injury or reasonable apprehension of physical injury. *Sexual abuse* includes sexual contact of any kind that is made by force or threat and the commission of, or an attempt to commit, any of the offences under Chapter XV of the Penal Code. The other forms of violence are not defined. A *domestic relationship* is defined as being between two persons who are family members and share a household or residence, or depend on each other socially or financially, and includes a husband and wife; a person who has a child in common with the respondent; a parent and child or dependent; and individuals who have been in a visiting relationship for a period exceeding twelve months. Thus domestic violence is defined by the intimacy of the relationship between individuals (including sexual partners and dependants).   Former partners are not included in the definition.

5.1.2 The theoretical duties of care that are enshrined in law

The PDVA outlines the duties for different sectors and stakeholders in relation to domestic violence. It states that every member of the society has a responsibility to report committed or suspected acts of domestic violence to relevant officers. It defines a service provider as *"any person or body of persons approved to provide assistance to survivors of domestic violence, and includes the police, community policing forums, faith-based organizations, Government institutions, non-governmental, voluntary or charitable organizations"*.   However, it stipulates only the duties of police officers (section 34) and of enforcement officers who are public officers from Ministry of Gender Affairs (section 32). Every police officer has the responsibility of responding to every complaint of alleged domestic violence regardless of who the complainant is and to complete a domestic violence report for the national register. The duties of Enforcement Officers are: *according proper treatment* and providing necessary assistance to survivors of domestic violence; *assisting victims* as dictated by their circumstances in finding temporary accommodation and medical services; providing *access to information* about services and support and *informing* the victim of the right to available legal remedies.

Health services are briefly mentioned in section 33 (2b) of the PVDA where upon the judgment of the enforcement officers a victim of domestic violence may be taken to the nearest health facility or hospital for medical assistance, giving the duty of arranging for medical assistance to enforcing officers. The duties of health service providers in domestic violence prevention, care, support and documentation are not clearly defined in the PDVA which is biased towards adults and towards the provision of legal remedies. In particular, the potential psychological effects of domestic violence are not given attention.

5.1.4 Conflicts and gaps in legislation

The definitions of rape, indecent assault and defilement are open to some interpretation, particularly in the case of married individuals, girls over 13 years of age and boys over 14 years of age. These gaps hinge around the interpretation of consent to sex. Firstly, marital rape does not exist in Malawian law as marriage is *de facto* considered consent to sex. Stated differently, husbands are at law deemed to enjoy perpetual consent from the time of marriage. Secondly, while age has been used to define a child for child protection issues various inconsistencies exist. In the Constitution a child is defined as under the age of 16; the PDVA defines the child as under the age of 18. Yet in the Penal Code defilement for the girl child is considered to be possible only if a girl is under the age of 16. A girl aged above 16 is considered by the law to be competent of giving consent for sex whilst incompetent for consenting for marriage, and a girl of 15 years cannot consent to sex but can be married with parental consent.

The Penal Code is also not gender balanced. For boys indecent assault covers up to age 14 so there is no offence of sexual assault or rape for boys and men over 14, beyond which the boy themselves could be considered as taking part in homosexual activity, the punishment for which is outlined as a separate offence.

A final gap is that in giving the power of arranging for medical assistance to enforcing officers it has implicitly meant that survivors need evidence of recommendation from these officers to show to health services. This gap creates a procedural and bureaucratic barrier for survivors wanting to access health care. Although the Ministry of Health has taken steps to highlight the importance of attending to clients who seek health services without police referral in some of its documents, such actions are not currently enshrined in law.

5.1.5 Stakeholders' knowledge of legislation and perceptions of its utility

Our policy maker, NGO and health care worker interviews revealed that knowledge of existing laws on violence in Malawi varied greatly. On the one hand a minority of stakeholders from NGOs, especially those dealing with human rights issues; those involved in lobbying government and those with a law background had comprehensive knowledge and were articulate regarding legal provisions and challenges of implementing the law. On the other hand the majority of participants could hardly say what the laws were about as this quote illustrates:

> *"Eh! Ha! (Sighs) there was a document concerning that but I don't real know what it says. There is a document on GBV but I am not sure of what it says" (City of Blantyre, KII)*

The degree of legal dissemination, awareness and implementation was found to be limited. Community members, public officials and stakeholders working in gender services all agreed that accessibility to the law is limited due to lack of awareness. This did not only apply to women living in the rural areas but also among the city dwellers. Limited gender violence activities and assumptions that the city are more educated and have many sources of information was perceived to be one reason why dissemination of the law in the city was low.

Even service providers who are supposed to be in the fore front advising people regarding the law seemed to have limited knowledge and reference material

> *"We haven't had a chance to scrutinize it properly (laughs). They told us we are going to receive one but we haven't ... we are just told in workshops. It has not been issued to us but from what we have been told in workshops there was no mention to that effect" (Small group, police)*

Stakeholder interviews revealed that the PDVA was perceived to be a useful piece of legislation by those who were aware of it, although difficult to apply. One participant indicated that the PDVA has helped to clarify the role of police in domestic violence issues. The police were now attending to domestic violence cases yet previously they were refusing to handle domestic violence cases because they claimed that the penal code referred only to criminal and not domestic violence cases. The provider also illustrated how the PDVA is helping in curbing violence by giving the following example:

"The prevention of domestic violence law has had some impact. We have seen abusers stopping violence. For example a medical doctor prominent in society was abusing the wife. He was served with the protection order and stopped the abuse. Later on he kept on asking the wife who is your lawyers? It has some impact."
(Female GBV service provider, KII)

However, the degree of implementation and the challenges associated with implementation as well as the level of accountability were thought to be low and instances of enforcement rare. Protection orders were felt to be difficult to enforce, often leaving women and children in vulnerable positions. The tenancy occupation clause would see men leaving marital homes only to move in with a new partner and leave the family destitute. Obtaining financial support from estranged partners was also seen to be unenforceable.

A number of practical challenges were mentioned and service providers were left feeling they were filling the gaps themselves. For adults the response was felt to be piecemeal and capacity to implement the legislation limited.

"There is no professional attention given to survivors of violence nor is psychosocial counselling, financial or education support provided to the survivors. Most organizations work on assumptions because there is lack of skills in most stakeholders. There is need for a fully fledged programme to deal with trauma."
(Male GBV service provider, KII)

Some participants explained that the prevention of domestic violence law is limited to guiding people on how to prevent domestic violence and not dealing with violence which has already occurred. Participants felt that the law is somehow silent on what assistance would be given to somebody who has received domestic violence, especially, where the survivor has been disabled due to violence.

Those more familiar with the legislation indicated that the issue of marital rape has not been captured in the law. Some providers who participated in forums lobbying for marital rape to be legislated explained that this was and still is one topic that sparks high level debate, and even, divisions or arguments within the circle of NGOs involved in human rights promotion. Some noted that even female parliamentarians did not support the idea of criminalising marital rape. Others felt that failure to include marital rape was a result of wide consultative process conducted by the Law Commission. Most of these arguments were based on the

understanding that Malawi is a Christian nation. However, some noted that there is a toning down when such marital rape issues are being discussed these days. More people including men are realising that rape does occur in families but they don't agree with criminalising the act.

There was a general feeling among interviewees that the Malawi government has shown intent to end violence in Malawi by ratifying different human rights instruments and stipulating specific issues in relation to protection of children and women against violence. Service providers rely on the definitions provided by different documents be it international human rights conventions even local laws to determine what form of violence a survivor has experienced or determine whether the issue brought before them could be categorized as violence or not . However, the major challenge is to ensure that the various conflicting aspects in law in Malawi are harmonised and translated into practice.

> *"But at the same time the confusion comes in because the laws are conflicting. Because this law says the child can get married at the age of 15 years. The other law says no; any child below the age of sixteen years when they engage in sexual activity with a man then that's defilement. So it's also because our own laws are conflicting. At the end of the day it's not clear what law is protecting who" (Female GBV service provider, KII)*

Mixed responses were also obtained in community interviews regarding the laws addressing rape in Malawi demonstrating a lack of knowledge on the part of the participants, although all agreed that there is no law about marital rape in Malawi. They explained that rape in marriage is not discussed outside the house.

> *"Aah! I can say that may be there can still be differences... For instance, in case of marriage you may rape and you may discuss and it ends there in the house but if you rape a person whom you did not marry the issue can reach far." (Older men FGD, urban)*

Some community members, particularly male, were of the opinion that violence laws are biased towards women. They said they have never heard a woman being arrested for raping a man, yet women do rape boys. Some participants felt that the major challenge with woman – boy rape is that a lot of men do not take this form of coercion seriously so they remain silent

but acknowledged that if such cases were to be reported then it was likely that the women would also be prosecuted.

The PDVA was said to be hated for making women stubborn

> *"To be honest I am against the law of Malawi because our laws favour women very much. Women are deliberately becoming disrespectful in the family, or having extra marital partners with the view that if you slap her she will report about violence against women, the man will be put in custody." (Older men FGD, urban)*

Community members felt that the problem is that the government has not come in the open to inform people about the laws regarding violence. One participant said the government is not enlightening people with regards to rape laws. People do not know whether forcing a wife to sleep with her husband is rape or whether refusing to sleep with a husband is violence. This was perceived to be a burden among people in the rural areas where most of them are ignorant about the laws.

> *"We have not been reached, we have not been told in the open. If the laws are there they have not been told to us people in the villages that we should know that when a woman refuses, or a woman should also see that when I refuse my husband I have acted violently against him." (Older men FGD, rural)*

5.1.6 Summary

This review and interviews with various stakeholders has highlighted gaps and inconsistencies in the legislative pieces meant to fight violence which may lead to on-going vulnerability of women and girls to abuse and violence. A number of conflicts and gaps can be identified in the legislative environment that undermines efforts to address violence against women and children in Malawi. While there is increasing political support, there remains limited research and experience to guide service provision and inform advocacy campaigns.

5.2 Health sector policies including guidelines and protocols

This section includes an analysis of the relevant formal policies, guidelines, services delivery protocols and training curricula that have MoH recognition. Documents that relate to violence, sexual abuse and reproductive health (including HIV, STIs and family planning) are included. The documents described below are presented in chronological order of the latest version of policy or guideline. Where guidance is lacking this is stated. Where guidance

conflicts this is highlighted. In some instances there may be training manuals but no up-to-date guidance or policy available and these are taken into consideration as the most up-to-date protocols.

5.2.1 Outline and analysis of relevant policies

The overall national health policy in Malawi aims to raise the health status of all Malawians by reducing the incidence of illness and death through developing a sound delivery system capable of promoting health; preventing, reducing and curing disease; protecting life and fostering general well-being and increased productivity. Since violence against women and children threatens life, well-being and decreases productivity this policy provides over-arching support for addressing violence issues. The many health sector and child protection policy documents, guidelines and protocols vary in their target audiences, level of detail and focus area as regards to violence against women and children. Included in this analysis are 7 health policies and one from policing services.

HIV/AIDS Policy (2003) Chapter 5 *the Protection, Participation and Empowerment of Vulnerable Populations* outlines policy in relation to women and girls (section 5.2) and specifies a commitment to protect women and girls from violence and sexual abuse. It states that government, through the NAC undertakes to: (1) protect the rights of women to have control over and to decide responsibly, free of discrimination or coercive violence, on matters related to their sexuality, including sexual and reproductive health and (2) ensure that women and girls are protected against violence, including sexual violence, rape and other forms of coerced sex, as well as against traditional practices that may negatively affect their health. This document also includes an appendix with proposals for legislative reform to improve the rights of people living with HIV and reduce the risk of HIV in vulnerable populations. It proposes changes to criminal laws including the decriminalization of same sex practices and prostitution; the revision of the Penal Code to remove the defence of genuine belief in higher age in order to protect children from sexual abuse and to make marital sexual abuse a criminal offence;

HIV Counselling and Testing Guidelines are not a single unified document. Malawi has separate guidelines for Voluntary Counselling and Testing (VCT) (2003), for Prevention of Mother-to-Child-Transmission (PMTCT) (second edition 2008) and for Provider-Initiated Testing and Counselling in Clinical settings (PITC) the guidance is captured in the 2011 Guidelines for the Clinical Management of HIV in Children and Adults. Couples

Counselling and Testing Training Manuals are based on generic Centre for Disease Control (CDC) couples counselling and testing training modules. They have information on counselling skills, on follow up counselling and state that disclosure may lead to violence in a minority of cases. They veer deliberately away from HIV couples counselling being seen as marital or violence counselling but include an annex with questions to help counsellors screen for intimate partner violence and how HIV Testing and Counselling (HTC) counsellors can identify it although information on what to do next is lacking.

Sexual Abuse Guidelines (2005) provide a practical handbook with a focus on health care workers. The guidelines focus on sexual assault in adults (primarily women) and children. They aim to provide the information on managing survivors, set standards for the provision of health care and forensic evidence to survivors of sexual assault and provide guidance on the establishment of services for survivors. They provide a lay summary of the duty of care of HCWs in relation to violence. There are practical suggestions on dealing with survivors, including history taking, examination, treatment and follow up. The appendices have flowcharts, checklists and examination records. The guidelines are being updated to include a focus on One Stop Centres (see section 5.2.3).

Malawi Police Service Community Policing Services Victim Support and Child Protection Guidelines (no date on this document) provide guidance on the support and care of survivors of GBV, HIV and AIDs related abuses and other human rights violations. These were developed as guiding instruments to victim support unit (VSU) officers and other interested parties on how to: provide care and support to survivors of GBV, HIV and AIDs related abuses, and other human rights violations; to minimize further trauma and distress to survivors and maximize efficiency.

Management of Sexually Transmitted Infections using Syndromic Management Approach (third edition 2007) states that one objective of STI services should be to prevent and provide support to survivors of domestic violence and abuse. They affirm the guiding principle that all individuals have the right to a sexual life that is free of discrimination, coercion or violence. There is a section in these guidelines that explains how health care worker attitudes can be a barrier to good STI services. This is not extended to reporting of violence. The guidelines have a distinct policy (Policy 3.6) on sexual and domestic violence that states that 'All victims of domestic and sexual violence shall have access to legal entitlement under the course of the law, HIV testing, counselling and other support services'.

The guidelines give no further practical guidance on how this can be achieved and no mention of screening for or reporting of either violence or any suggested referral points.

National Sexual and Reproductive Health and Rights (SRHR) Policy (2009) builds on international agreements and development frameworks. It has 'harmful practices and domestic violence' as one of ten policy themes and gives an overall stated goal of reducing the incidence of these. Harmful practices include domestic and sexual violence as well as wife inheritance, initiation, dry sex, death rituals and genital mutilation. It does not spell out the details of the SRHR standards and guidelines, but states its close relationship to the HIV Policy, the Gender Policy, the STI and Family planning guidance. The SRH policy aims to reduce domestic violence and mentions strengthening human resource capacity to provide screening, treatment and follow-up care for victims of violence, including provision of Post Exposure Prophylaxis (PEP). It also encourages research on the magnitude of domestic violence. The policy outlines roles and responsibilities within each Ministry in the government with respect to Sexual Reproductive Health and Rights (SRHR) and clarifies the importance of multi-sectoral working. With respect to violence the responsibilities are:

> Ministry of Health – disseminate relevant guidelines and standards
>
> Ministry of Education – empower boys and girls to make informed decisions about their SRHR
>
> Ministry of Information and Tourism – raise community awareness of SRHR services including harmful practices/domestic violence
>
> Ministry of Local Government and Rural Development – assist community dispel misconceptions and eliminate harmful practices
>
> Ministry of Women and Child Development – support empowerment of women to make informed sexual choices; support advocacy against harmful practices that affect women and girls reproductive health; GBV prevention
>
> Ministry of Youth Development and Sports – raise awareness on cultural practice that expose youth, especially girls, to HIV
>
> Parliamentary Committee on Health – supports enactment of appropriate legislation including age of marriage and on violence against women.

Pre-service Education Family Planning Reference Guide (2010) has been developed to assist pre-service health institutions in Malawi in creating, updating, or adapting the family planning content of their curricula and individual courses. Included in this document are

materials that institutions and individual tutors can use to develop technically accurate and pedagogically sound lessons on family planning. This document includes a comprehensive unit (unit 2) on gender-sensitive family planning service with training exercises and sessions on gender-based violence and its impact on family planning choices[417].

Guidelines for Provision of Comprehensive services for survivors of physical and sexual violence (One-Stop Centres) in Malawi (2012). These have recently been finalised and provide a detailed operational manual for future establishment of One Stop Centres focusing on the sexual abuse of women and children. They build on the 2005 Sexual Abuse Guidelines They outline steps for examination, treatment and support for women and children presenting to the centres and provide guidance on documentation and reporting[418].

5.2.2 Conflicts and gaps in policy

While all the policies share a commitment to addressing sexual and domestic violence, details and suggestions of how this will be done in practice are scant. There is no clear outline of referral systems and no details of how screening, reporting or Monitoring and Evaluation should be undertaken for cases of violence that present to the health sector. Instead many of the policies appear to have been developed by separate vertical programmes with insufficient attention to overlap, conflicts and relationship to the national strategy documents and frameworks policy. Since the documents on the whole make limited cross reference it seems likely that awareness of the documents that have a definitive protocol and lay out duties in relation to the law (such as the sexual abuse guidelines) is limited. The majority of the documents reviewed pre-date the current Malawi health sector strategic plan (HSSP). The delineation between policy and strategy or between policy, guideline and protocol is not always clear. In addition the documents raise areas of conflict with Malawian law. In the 2005 sexual abuse guidelines (see item 4, Useful Resources, Appendix 1) the definitions of rape and sexual assault in adults are based on WHO definitions not Malawian law, whereas the definitions for children are based on Malawian law. The HIV policy has since 2003 recognised that Malawian law has the potential to increase vulnerability to HIV through violence and it is in recognition of this that it calls for extensive legislative change.

A major cross-cutting policy gap is the lack of indicators for the health sector's response to violence to be measured in a concrete fashion. Difficulties faced by service providers in documenting the evidence are explored in more detail in Chapter 7. In terms of Monitoring and Evaluation (M&E), there is a general need for the health sector to focus on measurement

of impact and outcomes, ensuring that hospital statistics are added to the routine HMIS and made available, extending the M&E system to monitor quality of care, to complement DHS. In the SRH policy the indicators are vague, particularly in reference to domestic violence and focus on responding to victims' physical and HIV prevention needs. Furthermore, there is no specific milestone on prevention of domestic violence as part of health promotion. The lumping together of harmful practices and domestic violence in this policy means potential interventions are less able to focus on root cause prevention and there is a tendency for the measurable outcomes to focus on harmful practices to the detriment of domestic violence. It outlines multi-sectoral roles and responsibilities but fails to show how these sectors will coordinate responses and work together.

A major concern is the lack of clarity on the roles and responsibilities outlined in policy. Taken together these factors make it difficult for service providers to see how they relate to each other and what the policy is on violence in these different clinical settings and what their particular role is in which settings and who may be accountable for what.

Some of the confusion over legislative responsibilities in response to rape was clarified in the 2005 Sexual Assault Guidelines that state that it is not the responsibility of health care workers to determine if someone has been raped. It states that is a legal determination. The health care workers' responsibility is to provide appropriate care, to record the history and other relevant information which can be provided to the police and used in their investigations if the survivor requests this. In many settings it has been routine to request a letter from the police before a survivor can be attended to. The guidelines underline that this is **not required by law** and that insisting on a police letter will cause a burden to survivors and unnecessary delays. It refers this responsibility instead to the Victim Support Unit at the police and the Criminal Investigations Department (CID).

5.2.3 New policy directions and evolution of One Stop Centres
At the time data were collected for this thesis there was a lack of clarity on the coordination of policy development on violence and adisconnect between the theory and practice of new policy. Responsibilities are multi-sectoral and involve several Ministries. The two main areas of focus are the strengthening of a network of 300 Victim Support Units (VSUs) and the development of One Stop Centres (OSCs).The former are intended to provide support at police stations for women and children reporting violence and are coordinated by the Malawi Police Service. The latter are coordinated by the Ministry of Health and are intended to

provide comprehensive health, social and police services under one roof, including post exposure prophylaxis post rape. OSCs are described in detail in Section 3.7 and are an evolving service and policy area that currently has a very limited reach. Reorganisation within the Ministry of Health has seen violence issues become the remit of the Non-Communicable Disease Directorate and this in conjunction with the current HSSP is the current focus of new policy directions on violence and is intended to cover the whole country response.

5.2.4 Stakeholders perceptions

Policy and guidelines development is regarded by stakeholders as a sign of commitment of the government to taking action on violence and there was a lot of support expressed for the concept and practice of One Stop Centres. However others expressed concern that new policy and guidelines face challenges in their implementation particularly at district and community levels.

Overall stakeholders and service providers outside of One Stop Centres found it difficult to see how the policies relate to each other and what the current policy is on responding to violence against women and children in these different clinical settings.

Dissemination, awareness and implementation of policy

The degree of policy dissemination, awareness and implementation was found to be extremely limited. The sexual abuse guidelines and protocols from 2005 were found to disseminated and used as a reference document in larger hospitals yet, reporting rates varied widely as upward reporting was not requested and people were uncertain what to do with available data. Stakeholders also noted that only self-presentations of rape are captured and recorded in these records, so even this was likely to represent only a small proportion of the burden of disease. Pre-service training materials for family planning were considered well thought through in the area of GBV. In most health facilities, family planning health providers were able to indicate that they keep a lot of health passports for clients who are afraid of violence if their husbands realise that she is using family planning methods. Again reporting was not implemented in most settings and awareness was patchy outside of larger hospitals.

The couples HIV testing and counselling participant's manual encourages screening for partner violence if the provider suspects that they might be dealing with abusive relationships. However, this was found to be poorly disseminated and rarely implemented

and the ability of the providers to identify abusive situations was limited as the screening tool was neither covered in the training on couples HTC nor linked to a functioning referral mechanism or to skilled counselling support. Interviews with policy makers suggested that further dissemination of the guidelines for violence outlined in the HSSP is required. A number of the interviewees were unaware that the HSSP contains details about screening for violence in the health services. Some also were unaware that tackling violence had become the remit of the Non communicable Diseases Unit which may suggest that health care workers at the implementation level also lack knowledge of the guidelines.

In one of the in-depth interviews, a health care worker demonstrates how trivialised cases of violence are in the health care services by explaining how a call for an ambulance from the district hospital (for a rape case) would be received.

> *If we are to call for an ambulance that we have somebody that has been raped will the ambulance come? Everybody will laugh. No ambulance can come. (Male HCW II, health centre)*

Other stakeholders indicated that policy documents do not necessarily translate into policy action

> *"Putting in place a policy doesn't mean that something's is going to be done or is being done. We can have a policy stating what we would like to achieve but by the end of the day you find that the things that were mentioned are just for the decoration of the document to make it look nice". (City of Blantyre, KII)*

This chimes with the finding that all available policies were limited in practice by poor dissemination, awareness and implementation.

5.3 Current health sector strategies including national plans, frameworks and multi-sectoral working

This section outlines three areas where significant linkages and gaps exist between the health sector, government and non-government organisations and agencies and other service providers working on violence issues:

At the national level: policy makers, agencies and donors leading action on GBV (macro-level);

At the district level: One-Stop Centres, district hospital and health centres (meso level)

At the community level: Health Surveillance Assistants (HSAs) and Village Health Committees (VHCs) who work with communities on the ground (micro-level).

5.3.1 Macro-level

At the macro (national) level, there is evidence that inter-sectoral linkages are being developed between the health sector and other agencies, under the nominal leadership of the MoH but with assistance from key stakeholders. The recent legislative and policy developments (section 5.1) are welcomed but much confusion still remains about who exactly should work with whom, how a multi-sectoral approach might work, who is responsible and who has accountability for the process. This confusion appeared to result from a combination of conflicting documents and limited dissemination of policy.

Interviews with Ministry of Health policy makers suggest satisfaction among policy makers with the fact that the MOH has recently embarked on initiatives to improve its responses to violence. Concrete examples of areas of progress mentioned included the development of strategy and policy documents. Their very existence was seen as a sign of commitment and progress. Participants also felt positive about the development of One Stop Centres. In interviews, UNICEF was specifically associated with the establishment and scale-up of One-stop Centres:

> *"Through UNICEF there are a few One Stop Centres that have been established. One is at QECH. Concurrently UNICEF is arranging to come up seven more centres. We hope to adopt that and also learn from other countries as well." (Male policy maker, KII)*

However, it was also revealed in some interviews that national level coordination is currently focused mainly on One Stop Centres and is not linked well with the national planning structure to ensure that issues of violence against children are main streamed in health sector planning and budgeting. There are opportunities for broader collaboration within directorates in the Ministry of Health, for example with reproductive health unit for sexual violence, HIV and AIDs for PEP and HMIS for reporting. There also needs to be more clarity about where responsibility lies for coordinating issues around SGBV.

The Non-communicable Diseases and Mental Health Unit

The Ministry of Health in July 2011 established the Non-Communicable Disease and Mental Health (NCD) Unit within the Clinical Services Directorate. The intention was to cover cancer, diabetes, cardiovascular diseases, other chronic illnesses such as epilepsy and a broad range of mental health issues including violence and trauma Part of the mandate of this NCD Unit (under the mental health section) is to act as a focal office for dealing with issues of violence. Interviews conducted however, revealed that a number of policy makers within the Ministry of Health but outside of the NCD Unit were not yet aware that there is now a Unit responsible for sexual and gender-based violence (SGBV) issues. While the Unit was established in July 2011 the interviews were conducted in November and other directorates were provided with information on its role.

Health Sector Wide Approach

Interviews with key informants highlighted some of the challenges about the implementation of the Health Sector Wide approach (SWAp) in relation to responding to violence. First, the health SWAp primarily funds the Essential Health Package (EHP) and violence against women and children are not among the conditions covered by it. Second, not all donor agencies fund the health ministry through SWAp and as such SWAp is in turn limited in what it can and cannot fund. Third, budgets are prepared by responsible directorates in response to burden of disease as documented by upward reporting and SWAp funds activities according to what has been budgeted. Lack of both a directorate responsible for VAW and VAC and of credible reports meant there has until recently been no funding allocated for these.

> *"SWAp does not provide funding for violence against women and children. SWAp is a coordinating unit coming from various departments and then SWAp consolidates. So you do not expect much from SWAp to say SWAp will take this on board, no...Who is going to take it forward or budget if there is no specific department?" (Male, policy maker, KII)*

> *As a unit we have seen the budget dropping instead of increasing. (Male policy maker, KII)*

However, there is an expectation that the establishment of the Non- Communicable Disease directorate and the implementation of the HSSP may lead to funding for violence as the former takes up its remit.

Violence as a national priority

Despite the overwhelming acknowledgement that violence is a public health problem in almost all critical documents governing the health sector in Malawi; it was not regarded as a priority public health problem. Interviewees explained that health services prioritise other 'major health issues' such as HIV, Malaria and Tuberculosis rather than violence. Interviews also revealed that some health care workers regarded violence issues, particularly physical and domestic violence; to be under the jurisdiction of the Ministry of Gender. Others felt that it was the duty of the police Victim Support Units and non-governmental organisations. The following narratives illustrate typical comments:

> "*Indeed we were supposed to be active in these issues but to be honest with you we are not very active. I feel it's because of people's mentality. There are issues like these which people think that they are concerns of the ministry of gender, these cases are for gender activists, these are for women activists who advocate for women issues or violence issues are for school children. We haven't reached the stage where we have to recognize that we are in the fore front. I feel these are inadequately addressed.*" (Female policy maker, KII)

> "*MOH especially this unit prioritizes maternal mortality. Others can come as complementary to this. So if we say VAW and VAC [violence against women and violence against children] is a priority I think I am not being honest.*" (Male, policy maker, KII)

Focus areas of development partners

Apart from supporting UNICEF initiatives in the health services, the extent to which major health developmental partners were supporting the various Ministries in their duty of care for survivors is limited. Interviews with some donors working in violence-related areas revealed that they were more involved with the justice and community organisations than they were with the Ministry of Health. It was also revealed in the interviews that various donor initiatives work with different departments of the Ministry of Health yet without proper coordination. For example, the nursing department coordinated the prevention of child maltreatment programme and the HIV/AIDS unit worked on the One Stop Centres.

Whilst health care workers articulated their mandate in terms of treating or responding to violence, the health developmental partners were focusing on reducing violence. One of the developmental partners explained why their organisation prioritises prevention of violence.

> *"Our primary focus is prevention of violence using the public health Approach (PHA). We emphasise on prevention rather than reacting to incidences. Reacting to violence which has already occurred is an expensive intervention although prevention may have a long term health impact." (Male health developmental partner, KII)*

Another health developmental partner indicated that it had occurred to them for the first time during this interview to realise that health services have the potential for working in violence prevention and that this is a gap that has not been covered by anyone.

> *"We are on the side of support. I don't think we have been involved in any area of prevention through primary health care. This should be an interesting area to look at. Counselling couples who are going to have a baby. Often violence occurs during pregnancy isn't it? Actually seeing you sitting there this is the first time that it has occurred that there is a gap that I don't think is covered by anyone." (Female health developmental partner, KII)*

Some stakeholders also highlight the missed opportunities for tackling issues of violence within the Ministry of Health.

5.3.2 Meso-level

The "meso" level refers to referral hospitals (where One Stop Centres are operating), district hospitals and health centres, police, social welfare department and NGOs. One Stop Centres offer opportunities for multi-sectoral linkages as well as for linkages within and between health departments at the referral hospitals they are based in. Interviewees point to the importance of links with the police, with other government bodies such as the social welfare department and with specific non-government agencies that are outlined in policy documents. However, the extent to which these links function effectively at this level with the exception of One Stop Centres is not always clear.

Linkages with the police

The most consistent link mentioned was with the police; however, health care workers felt that this needed to be strengthened.

"There is need for proper networking between us and the police and these other organisations that deal with violence. In this network if we could give each other feedback, this can help to make this work effective. I would summarise that collaboration, networking and skill acquisition would help very much." (HCW, FGD, rural)

One-Stop Centres create linkages

The narratives also revealed that services required by survivors were offered in largely disparate locations within and outside the health facility. One Stop Centres offer opportunities for multi-sectoral linkages as well as for linkages within and between health departments at the referral hospitals they are based in. Focusing on specialised centres which function within hospitals is appropriate given the low reporting of cases of violence at health departments. A visible One Stop Centre can contribute to higher reporting and more streamlined referral mechanisms where health workers are aware of the existence of a specialised unit for violence issues. NGO staff however pointed out that lines of communication between One Stop Centres and non-government organisations are not always effective and can exclude NGOs from contributing to work on violence. One staff member of an NGO working on violence gave the following example pointing to the report circulated by the OSC unit:

"The report circulated by the social welfare office at the one stop centre is only circulated to government offices. NGOs are sidelined. This limits participation." (Male GBV service provider, KII)

It is also important to take into account that the visibility of such a centre could, in some cases, prevent reporting where people are uncomfortable with being seen reporting to a known 'violence' unit.

Referral mechanisms

There was some evidence of functioning referral pathways when dealing with child abuse or assisting orphans. The same was not found for the response to IPV among adults. Even health care workers interviewed who had confidently indicated that they refer their clients to Non Governmental Organisations or community based organisations, had little idea of whether any of the services they told their clients to access actually existed. This is illustrated by the following interview where the interviewee was asked how confident she was that such services existed in the communities and admitted referring clients on.

"We are not sure but we are certain that they will find assistance in the community because in some communities there are child protection workers who care for children and we know they will be assisted. " (HCW II, hospital)

Outside of the limited network of OSCs the referral mechanisms for rape and domestic violence cases described often relied on informal communication between health workers in different sections and departments. Participants also described problems with follow up. Referral mechanisms for rape and domestic violence cases described often were between police and health care services or vice versa.

"The first thing that the victims of domestic violence go to is police, get report and come to the hospital. The current guidelines are saying that they can come directly to the hospital and they shouldn't be sent back. We have been sending them back. In fact we didn't know we are hearing it here for the first time" (HCW FGD, hospital).

The potential for Social Welfare Officers as referral point persons

In relation to referral mechanisms for women experiencing violence there was evidence that referral pathways exist between the Social Welfare Officers (SWOs) working in the hospital and various departments. There was some evidence of productive referrals within the health system:

"So what we have started here is a multidisciplinary model with the social worker.... this is somehow the first Malawian child protection officer. His job is this one stop shop and we have a couple of a team of volunteers...from fountains of life rape counselling centre. Again speak to them and police around the area and also including the department of public prosecutions and the people from the juvenile justice court." (Policy maker, KII)

Social welfare officers mentioned receiving referrals from staff working in the gynaecology department and other general staff. They also described reciprocal referral pathways with staff from Psychiatric wards. SWOs also discussed referring to marriage counsellors beyond the hospital. These were considered to be a useful point of contact. Since they are already providing referrals and making use of linkages beyond the health system, SWOs could be useful point persons in the development of a referral system. However, apart from those SWOs working in the hospital, social workers were generally perceived as ineffective:

"Also go to social welfare have you put them as part for your interviewees? Just find out from them because they are not effective but they could be. Just find out. They are rubbish you know they are not doing anything...but it doesn't mean that they are to be ignored. I think you need to find out how best they can be useful and why are they not useful, what is the problem because nobody knows what the problem with those people is." (Female GBV service provider, KII)

5.3.3 Micro-level

At community level, there are Community Victim Support Units (300 of them) at police stations. One of the members of the Community Victim Support Unit core team are Health Surveillance Assistants. The Community Victims Support Unit generally undertakes prevention activities, mediation in case of violence and referral to health facility, police or traditional chief.

Interviews were carried out with Health Surveillance Assistants (HSAs) and members of Village Health Committees (VHCs) who work with communities to address specific health issues. In view of their role is important that they are linked to services addressing violence against women and that they are able to assist community members in negotiating linkages between the health sector, the police and NGOs working on violence, in particular.

However the VHC members described having difficulties in knowing where to refer cases of violence or how to proceed with such cases. Participants described a lack of a referral system between them and the hospital; that they do not share issues on GBV such as number of cases and how to handle them, though they meet to discuss other issues such as malaria and cholera prevention. They also said that they are not trained in prevention of violence and sometimes when they assist victims they are threatened by their partners (the perpetrators).

"Although sometimes we refer survivors of violence to the health facility, health care workers at the facility do not refer them back to us after discharging them from the hospital." (VHC FGD, rural)

Another issue that arose was in relation to the role that community and religious leaders play in providing counselling, in particular to women experiencing violence. While a number of the interviewees mentioned that it was common for HSAs, VHC members, health workers and SWOs, to recommend that women access such leaders for advice, there is no protocol

established for such referrals and it is not known whether religious or community leaders would in turn refer women and children to health or social services.

5.4 Summary

This chapter has presented an assessment of the legislative and policy environment and frameworks governing the health sector's response to violence against women and children with qualitative research findings summarising a wide range of perspectives. Interviews were conducted with community members, with key informants, with health care workers and with a range of other stakeholders to elicit their perceptions of the various documents including of the multi-sectoral response to violence.

Section 5.1 involves the analysis of the legal framework. The analysis revealed that the Malawi government has shown intent to end violence in Malawi by ratifying different human rights instruments and stipulating specific issues in relation to protection of children and women and against violence in its various laws and policies governing the affairs of women and children. However, the major challenge now is that these instruments cannot be relied upon by women and children in national courts because, with the exception of some of the provisions in them, the instruments have not been domesticated. The other challenge is to ensure that the various conflicting aspects in law in Malawi are harmonised and translated into practice.

Section 5.2 presented an analysis of the relevant formal policies, guidelines, services delivery protocols and training curricula that have MoH recognition. There were a large number of policies, guidelines and training materials that touch on the health sectors response to violence. The most useful of these are the specific guidelines for sexual violence, guidelines for One Stop Centres and the family planning and couples counselling curricula. Pre-service training materials for family planning were found to be well thought through and detailed on GBV. However all available policies were limited in practice by poor dissemination, awareness and implementation with conflicts between documents, lack of funding prioritisation and lack of coordinated reporting being cited as key challenges.

Finally section 5.3 presented the perceptions of linkages between the health sector, government and non-government organisations and agencies and other service providers working on violence issues. There is evidence at national level that inter-sectoral linkages are being developed between the health sector and other key stakeholders but mechanisms for coordination, accountability and reporting need strengthening in order to effectively address

violence. At the district level there was some evidence of functioning referral pathways in the districts where One Stop Centres are operational and awareness of the role of One Stop Centres and of linkages with police and NGOs. However, service users were very sceptical about the link between police and health services in general and about the response to violence in the majority of districts without OSCs in particular.

Having analysed the legal and policy framework and its perceived utility it is important to link this to a better understanding of perceptions and experiences of intimate partner violence from the perspectives of survivors, community members and service providers. This is critical in understanding not only how legislation, policy and strategy can be improved but also to understanding under what circumstance and why people access and implement the services in practice. Laws and policies will never become living useful documents without a deeper understanding of intimacy and of violence in intimate relationships and how this plays out in the communities that the health sector is serving. Chapter 6 explores perceptions of IPV in Malawi.

Chapter 6:   Malawian Perspectives on Intimate Partner Violence

6.0 Introduction

This chapter presents part of the findings of the situation analysis conducted with various stakeholders in Blantyre, Malawi. It seeks to describe the perceptions and experiences of IPV as obtained from interviews conducted with policy makers and other stakeholders (see section 4.6.1), HCWs (4.6.2), with selected individuals referred from IPV services (section 4.6. 3) and FGDs conducted with community members (section 4.6.3). HCWs were included on the understanding that they come from same communities as the community participants and share the same cultural backgrounds. Their understandings and perspectives are important in getting a deeper understanding of IPV at community level and starting to build a picture of the concepts, values and attitudes they may carry to work with them. Sub-sections present data organised along the themes generated. Only heterosexual relationships are included since these were the only ones described. This was due in part to the topic guide and study design and in part due to the stigmatised nature of homosexuality in Malawi. Pre-marital, marital and extra-marital relationships were described. While there are overlapping issues these have been presented separately in some sections in order to draw out similarities and differences. Section 6.1 presents types and perceptions of intimate relationships, 6.2 presents definitions and perceptions of violence in relationships, 6.3 outlines the perceived magnitude of IPV, 6.4 the range of forms of violence, 6.5 presents perceptions of the causes of violence, and 6.6 perspectives on violence and health.

6.1 Types and Perceptions Of Intimate Relationships

Participants from all methods (interviews and FGDs) described various forms of intimate heterosexual relationships in Malawian society. They also talked about what the cultural or personal reasons were for engaging in these relationships and how they might be perceived, including negative perceptions and possible links to violence. Young people, in particular, used a range of language in discussions, which evoked both modern and traditional concepts. Words used to describe certain aspects of their relationships demonstrated clearly that language is evolving and advancing. For example, language that was used to justify pre-marital sexual relationships tended to portray modernity as a driving force; using metaphors such as computer passwords and contrasting their attitudes with 'old fashioned' ones. This communicated that they as youth are living in a different world from their ancestors and as such they have new ways of understanding and conducting their relationships. However,

they are not completely divorced from the past. Words like 'go-betweens' *'mtumiki'* or '*mkhalapakati*' refer to established traditions in pre-marital courtship.

Furthermore, the language used is suffused with traditional cultural gendered scripts; for example the importance of ensuring women's fidelity and the passivity of women's sexuality underlie the metaphors of 'locking' women's sexual availability. Language used to describe pre-marital pregnancy ('bush' pregnancy), teen abortions or childbirth out of wedlock and cohabiting relationships tended to be derogatory, most often conveying a meaning of lost value. For example young people in this study used the words '*zape*' or '*zapezeka*' ('readily available') to describe girls who had experienced pre-marital pregnancy, denoting them as 'easy' or unworthy of effort. Laughter was used in various ways in the discussions. Laughter, in many cases demonstrated a shared or common understanding. It was also a sign of hesitancy or discomfort. This was commonly observed in cases where the perceived 'ideal' response (e.g. in the eyes of the moderator or other participants) seemed to be in conflict with the value of the speaker. In some cases, it was used where the response was unexpectedly frank, such as the girl explaining the dilemma around HIV testing following rape. In general, a sense of humour generated by the discussions helped to propel the discussions of this rather difficult topic forward, and signalled young people's enjoyment of the discussions, as expressed in the following quote:

> *"When people come, like the way we are discussing today, in this house (privacy), they shouldn't stop. They need to come frequently so that we can continue conversations (need to be heard)." (Young women FGD, urban).*

Types of intimate relationships described are summarised in Table 6.1.

Table 6.1: Characteristics of intimate relationships as described in the interviews

Type of relationships	Drivers for engaging in these relationships	Status of relationship in society/how sanctioned	Perceptions and links to violence
Pre-marital relationships			
Boy-girl intimate relationships ('chibwenzi')	Desire to establish a long term relationship Identity Fashionable Sense of manhood	Gives status among peers Not sanctioned by wider society Very common (fashion) among young people	Empowering (right to choose partner) Linked to coercive sex and sexual initiation
Student-teacher relationships (Inter-generational)	Desire for good marks Teachers initiate them Girls may give a green light	Perceived to be increasing in certain areas and not others	Abusive and disturbing especially for school girls Abuse of power by teachers
Ritual/cultural relationships ('*Kusatsa fumbi'*)	Cultural tradition Sexual training for young people	Perceived to be declining in some areas; Sanctioned by older people	Abusive High risk for HIV
Marital relationships			
Ideal marriages	Maturity Children	Society sanction these Have *nkhoswe*s Maybe wedded in church or traditionally	Peaceful, loving, caring and respectful; Privacy Described as non-abusive Long term Marriage is endurance
Non-ideal marriages Eloped or cohabiting marriages	Presence of pregnancy Associated with declining morals Society does not sanction these but recognises them	No parental or God's blessing No nkhoswe Commonly occurring To be formalised in the proposed new wills and inheritance law	Described by participants as 'high motion' 'hurried marriages', 'Road marriages' Lack proper marital arrangements Not established on love High level of violence High level of abandonment Unstable
Extramarital relationships	Desire for newness Lack of partner satisfaction Denial to have sex with partner Peer pressure Weak morals Wealth Masculinity Challenge to partner	Sign of heroism for the man Associated more with men than women	Source of problems in marital relationships Form of violence in itself High risk of sexually transmitted infection

6.1.1 Young People's Premarital Intimate Relationships

Most narratives about pre-marital intimate relationships concerned boy-girl relationships, but other relationships were also described. Boy –girl relationships were described in the young people's community FGDs as being initiated between peers at a young age (between 10-14 years), are unsanctioned by parents and are held secretly and as such rarely recognised as intimate relationships by society and helping organisations   Both female and male youth agreed that sexual activity, either consensual or forced, is an inherent characteristic of these relationships and an important part of adolescent social identity. Participants used terms such as 'fashion', (as opposed to 'old fashioned') and 'habit' to illustrate widespread sexual activity. Go-betweens (mostly close friends) play an important coordinating role and are

trusted with secret information. The following typically demonstrates that sexual activity is wide widespread and accepted as a norm within pre marital intimate relationships

> *"The youth have turned sleeping with each other as their fashion. He will ask you that when you were accepting me to become your boyfriend, what you were consenting to. Are you my sister? I thought you wanted this. " (Young women FGD, urban)*

The gendered nature of the perceptions of sex came out strongly. Male participants felt that being in a relationship without sexual activity left them vulnerable as some girls would go around 'spreading news', questioning the potency of their boyfriend. Sexual activity was viewed as an important strategy for asserting manhood.

> *"If you just chat and laugh with her, she tells her friends, he runs away from me, 'he is not a man'. To stop that story you would want to do a good job on her and let her say eh! He is a real man (laughing)." (Young men FGD, urban).*

Others explained that having sex with their girlfriend helped them to secure their position against competition with other young men - a way of staking a claim and ensuring a girl's loyalty. They described it as equivalent to a computer password:

> *"Without having sex with a girl, she cannot say that I have a partner. She may invite other people to entertain her... But when you strike your password you are done... Even in your personal computer you load in a password that means you have launched it (laughing)." (Young male FGD, urban).*

Both boys and girls said that boys dominated decisions to initiate sex. This did not necessarily mean that girls had no desire for sex but felt they could not be seen to initiate it.

> *"To say the truth in a relationship you are not forced you also deep down want to have sex (all of them laugh). At that time you are deeply in love so the issue of force doesn't exist. It is in your heart so you agree to it (all laughing)" (Young women FGD, urban)*

> *"Most of the times it is because we are shy. We feel that he is going to think that I am a prostitute. This is why girls do not start asking for sexual intercourse. We wait for the boys to start." (Young men FGD, rural).*

The power differences between boys and girls and perceptions of pre-marital relationships were linked to violence and this is discussed further in the sections on physical and sexual violence (see 6.4.1 and 6.4.2).

These boy-girl relationships were described by young people against a background of other experiences of sex - between students and teachers (see Table 6.1) - which were also mentioned in the wider community FGDs. Participants felt that some girls made advances to their teachers because they sought favours. However, they reported that harassment by teachers was a common problem, which they perceived as violence. Girls explained that some teachers abuse their power by punishing students for rejecting male teacher's advances, although ostensibly for other reasons, which can extend to suspensions from school. Some girls take the initiative to leave school to avoid the harassment. Young girls in the rural areas were concerned with increased risk for violence in self boarding schools(refers to boarding schools where the children look after themselves) and questioned why in the first place the government thought of creating such schools where girls as young 12 or 13 years of age would live alone without proper security.

Cultural relationships mentioned in table 6.1 referred primarily to an initiation practice called *'kusatsa fumbi'* (removing dust). Arranged by older family members at menarche, this practice introduces young girls to sexual activity, either through arranging for them to have sex with older men or suggesting that they experiment with their peers. Girls indicated that the practice was still prevalent, particularly in the remote areas. They linked this with violence via the subsequent adoption of high risk sexual behaviour, teen pregnancy and HIV infection.

> *"You find that when they come back from the initiation ceremony they start behaving badly. It's like they have introduced the girl to certain things before her time. You find that she starts moving with many boys and sooner or later you discover the girl is pregnant. You start wondering why somebody who supposedly went for advice ends up with pregnancy. It's all because they introduced her to wrong things"(Young women FGD, urban).*

6.1.2 Marital Relationships

Two distinct forms of marriages emerged in most narratives describing marital relationships: the ideal and 'eloped' (cohabiting) marriages.

Ideal marital relationships: were described as caring, loving, happy, peaceful, respectful, faithful, free, non-abusive and by the ability of the married couple to mutually co-exist and consult on all matters with regards to decision making. Some participants explained that ideal marriages are supposed to be lifelong. One of the recently married female in-depth interviewees explains her observations regarding what a harmonious relationship ought to look like:

Although I am young but I have observed that people who are married have a cordial relationship. They agree on everything and are able to care for one another during illness. They help one another; they are free and live happily. It's not that only one party enjoys at the expense of the other (female IDI 11, urban area)

Overall, an ideal marriage was described as one in which the marital contractual agreement goes beyond the couple as marriage is negotiated between families. Selected family members represent the family in their role as *'nkhoswes'*. Descriptions of how the *'nkhoswe'* system operates were also provided in some of the FGDs and In-depth interviews. Details on their roles are provided in chapter 3. Participants described that the *nkhoswe* system operates in such a way that every marriage is supposed to have two marriage counsellors from each side [in some settings they may have one representative each] selected based on their level of seniority in the extended family structure. The first set of 'marriage counsellors' is referred to as *"Nkupamame's"* or dew removers. The couple is expected to first approach this set of marriage counsellors in the event of conflict. These counsellors are expected to help the couple resolve the conflict but if they fail to resolve the conflict for other reasons, they are supposed to refer the case to *'mkokowogona'* the great uncle sometimes referred to as ['*Mwinimbumba*']. Religious leaders become active players for marriages that are blessed in church.

Cohabitating marital relationships: were described as a non-ideal form of marital relationships. They were perceived as hurried relationships which lacked parental or God's blessing and were associated with high levels of violence compared to 'ideal marriages' Some of the participants used the words 'high motion' or 'eloped' to describe these relationships and they were blamed on excessive children's rights and democracy. Some participant's - mainly older women - commented that increased human rights for children are making it hard for parents to raise the girl child properly. They said many young girls engage

in sex early, get "bush pregnancy" [pregnant before getting married]; are forced to marry because of the pregnancy without proper love.

Cohabiting marriages are perceived as problems of the current generation.

In this generation many marriages do not have marriage counsellors... they have two children they will tell you that we just picked each other... the major problem which we come across are marriages without marriage counsellors in this generation. (Older men FGD, urban)

One of the GBV service providers felt that in Malawi cohabitation is driven by men who do not want to take responsibility for their actions; and that legalisation of these marriages will just do that.

Marriage implies perpetual consent to sex The general consensus among participants was that marriage is a long-term cordial relationship that exists between adult males and females to meet the sexual needs of each other. Consent to sex in any form of marital relationship was perceived to be an inherent part of marriage. It was said in both the interviews and FGDs that sex was essential for the sustenance of marriage. Many participants mentioned this is what tradition tells them. A participant in a FGD made the following statement, comparing the situation in Malawi with what he had heard was the situation in other countries where forced sex in marriage is illegal

> *"Here at home [Malawi] as black people we culturally teach that the man did not want your face but he came for your private parts (nudity), so whenever he wants give him... So we keep the custom that we are not supposed to deny each other"* (Older men FGDs, urban).

Women shared similar views about the place of sex in marriage with their male counterparts. Sex was also perceived as a sign of happiness in a marital relationship.

> *"Marriage is sex. If we say a man and a woman are happy in marriage we mean they are having sex"* [Female IDI, 1]

Marital relationships are hierarchical in nature The marital relationship itself was perceived to be hierarchical in nature with clearly defined decision-making and gender roles. In all the FGDs, IDIs, IIs and KIIs with indigenous Malawians, the male partner was perceived to hold a superior position to that of his female partner. The husband was described as the head of the family, breadwinner and a lead decision maker on family

matters. The wife was expected to act in subordination to her husband, and to respect the position of her husband as the head.

> *"There is a mentality among Malawians, something that our parents established and it's grounded in us that the husband is the head of the family. So people think the man is always right. This spirit is well established in us Malawians but the bible says the same thing." [Female IDI, 1]*

Pre-marital counselling given to the brides-to-be emphasises on gender roles, the headship of the man and the subservient position of the woman. Differences between men and women emerged in the way they described ideal marriages - men tended to emphasise the headship and the subordinate position of the woman, while women tended to focus on egalitarian decision making, care for one another and love for each other, all reflecting on the gender roles ascribed to men and women. This withstanding some men and more women in both FGDs and interviews recognised egalitarian decision-making, amicable resolution of couple conflict between partners and mutual existence of the couple as the original plan:

> *I mean what God intended marriage to be. I would say in the beginning God created a man and a woman. He took his rib to create a woman. This rib was taken out of his heart. This means that a woman is supposed to be at heart of the man and he said these are no longer two but one. So if people are one, you cannot allow your own body to suffer or allow your own hand to fight your own body. In fact in married people are not supposed to suffer; this is a creation that God designed... He wanted the man to truly love the person that he is staying with. It should be true love. (Female IDI, 4)*

Marital issues should be kept secret Both men and women agreed that the ability to keep marital issues secretive is an inherent characteristic of marital relationships (regardless of whether an 'ideal or an 'eloped' marriage). Secrecy was seen as a way of maintaining family respect. This culture of silence was associated with endurance. There was also the expectation for women and girls to 'endure' violence, as a part of life and relationships. In many cases, participants reported that they are told that marriage is endurance. This was also mentioned in relation to violence against men as some participants felt that this was a growing problem which men would be unlikely to report due to cultural expectations of strength and authority as part of their 'masculinity'.

"We are taught that marriage is endurance. When they say marriage is endurance it means hiding whatever is happening in the home. "(Older women FGD, rural)

Women FGDs revealed that although IPV is considered a private matter it is not that 'private' in the communities where data was collected especially moderate to severe forms. Women agreed on many examples of violent families during the interviews.

6.1.3 Extramarital Relationships

Extramarital relationships were discussed alongside marital relationships in all the FGDs and interviews. They were seen as problematic to the marital relationships and were themselves seen as a form of violence. There was a general consensus among participants that these are common, and that more men than women engaged in these for various reasons indicated in table 6.1 and are discussed further in the sections below. Participants explained that married men leave their wives, marrying other women, having sex with them and at the same time abandoning their families. They explained that some married men believe they cannot stay with one woman just as they can't live on one type of food. The desire for change or newness was perceived as one reason driving men into extramarital relationships. Associating with 'bad friends' was the other factor women identified as responsible for extramarital relationships. Some women said that men who love and stay close with their families are described by others as not real men, so some men take alcohol and propose to many women to prove their masculinity to others.

The majority of men and some women, in both urban and rural areas blamed women for driving men into extramarital relationships. Several reasons were given including: refusing to have sex with husband and lack of openness of sexual matters. Male participants summed it this way:

> *"In many places you hear that men have extramarital relationships. Those extramarital relationships are the ones causing violence in families because of women who refuse to sleep [to have sex] with their husbands". (Older men FGD, urban)*

6.2. Definitions and Perceptions of Violence in Relationships

Having looked at different forms of intimate relationships in the previous section, this section aims to present understandings of violence in relationships in general, and IPV in particular as understood by study participants.

Violence was broadly defined in all FGDs and interviews as being forced to do something against one's will. Many explained that violence is painful such that perpetrators of violence would not feel comfortable if the same was committed against them or their relatives. Violence was also associated with shame and a general expectation that violence must be hidden. In many instances violence was equated to beating, torture, oppression, slavery and a form of imprisonment leading to deprivation of peace, especially peace of mind. There was a general feeling among many participants, both men and women that perpetrators use violence as a means of punishment, a way of taking revenge, a mode of silencing or controlling the other, and a tool in resolving conflicts. When participants were asked how they differentiate violence from misunderstandings, most of them identified lack of consent or agreement and use of force or threats as common characteristics that distinguished violence from misunderstandings. The majority said misunderstandings are a cause of violence. Others felt that occasional violence is misunderstanding and distinguished it from 'violence' which was seen as usually repeated behaviour. Lack of consent was seen as a marker in violent behaviours.

Behaviours that constituted violence ranged from failure to cook for husband to killing of a partner. A general consensus was that violence is wrong and violates one's rights, but is expected in marital relationships. Violence was seen as a manifestation of both love and of lack of love.

Local understandings of IPV differed from IPV definitions in legal documents (chapter 5) and demographic health surveys. Participants felt the need for an inclusive definition of IPV that goes beyond physical and sexual violence. Interviews and FGDs described other behaviours which they felt qualified to be named as acts of violence (These are detailed in section 6.4 on forms of violence).

> *"Violence is not only about being beaten (other women nodding their heads)... Yes, violence is not only about being beaten. There are many forms of violence. It is not beating alone." (Older women FGD, rural)*

Similar sentiments were shared by some of the GBV service providers:

> *"Intimate partner violence it's not only having forced you to have sex with them. It's when you get genital warts and these other things people contract from their partner when they are just sitting its violence! Its violence! And then they should be telling*

you have Warts, you have this disease when you were not involved in anything somebody has transmitted that disease to you it's not on. Yaah! So I think this thing needs to be sorted." (Female GBV service provide KII, urban)

The following quote is typical of participant attempts to provide a definition of IPV:

"Violence means depriving the other of peace particularly peace of mind because peace of mind contributes to good health. Therefore I can say that deprivation of peace or beating is some form of violence." (Female IDI 1, urban)

6.3 Perceptions of the magnitude of IPV

Participants were unequivocal in describing the magnitude of IPV in both pre-marital and marital relationships. One of the service providers sums up the debate on the perceived magnitude by acknowledging that despite a lack of reliable epidemiological studies on IPV in Malawi it is widely perceived as a problem:

"Unfortunately we do not have credible statistics and I don't know if there is a sole study which they did on IPV... All I know is from my 15-16 years of work on domestic violence; IPV is a huge problem" (Female GBV service provider KII, urban)

6.3.1 Perceived magnitude and understandings of IPV in pre-marital relationships

Young people identified violence in their relationships as a huge problem. Gender differences in the experiences of violence were prominent in the narratives of the participants. More girls than boys were thought to experience violence and boys were perceived by participants as naturally more powerful than girls. Narratives from young people in all five communities indicated forced sex in particular was perceived as very prevalent, in contrast to the perceptions of the wider community FGDs, who felt that violence was mostly found in marriage, not in pre-marital relationships.

"What I know is that forcing us to sleep with the boys is very common. This is very common and it has happened to most of us, if we are to be honest with you. (Overlapping agreeing responses in the background)." (Young women FGD, rural)

"Ah! Indeed boys are forcing girls to sleep with them, forcing her in a car, they take their car and park in the wrong place, it is happening". (Young men FGD, urban)

A lack of recognition of IPV among adolescents by the wider society was supported by data from older community members and health care workers:

"I feel it is infrequent, because the love relationship is like a new relationship. The man loves that person because it's a new thing but for the married woman you have stayed with him over four years this is why I am saying that in a relationship violence may be present but it's reduced." (Female IDI 6, urban)

The following quote, illustrates the struggles some of the HCWs have to believe that rape can occur in a boy and girlfriend relationship.

"As for me, when a girl gives history of being raped by a boyfriend as stated by P1 I don't really understand. When somebody says I was with my boyfriend what come to my mind is that these people had agreed. So we think like... she had agreed but after sleeping with her boyfriend she fears being impregnated by him and because she knows that we give them emergency contraceptives that's why they come here reporting that she has been raped" (HCW FGD, Urban)

Violence occurring within pre-marital relationships was often discounted

"We don't consider boy-girl relationships as intimate partners. Intimate partners are those that have stayed together for a long time... It should be the kind of relationship that is known to other people and not the one that is not well known." (Small group, police)

6.3.2 Perceived magnitude of IPV in marital relationships

Both men and women believed that IPV in marital relationships, whether 'ideal' or cohabiting, was a huge problem in their communities. The majority of participants in the FGDs and interviews felt that there are no geographical, class or religious differences in the experience of IPV. They explained that violence in marriage was equally experienced among urban and rural populations including among Christians and non-Christian families, the rich and the poor. Some participants in urban Blantyre felt that IPV was concentrated in poor and densely populated areas of Blantyre.

The following typical quotes from two FGDs illustrate the picture many women painted regarding the widespread nature of IPV:

"I can say that almost everybody has experienced violence. I can say that almost in every family there is that form of violence called domestic violence" (HCW FGD, urban health centre)

169

"If we are to expand on the violence women are experiencing we will end up with volumes and volumes of books." (Elderly women FGD, rural)

It was clear from interviews and FGDs that IPV was highly prevalent, but perceptions of the magnitude IPV experienced by different subgroups were diverse and often inconclusive. Men and women were similar on this issue in that both started off by saying it is mostly women and then agreeing men were also affected. Narratives comparing magnitude of intimate partner violence against men (IPVAM) and intimate partner violence against women (IPVAW) revealed mixed feelings. The majority felt that more women than men experienced IPV. While acknowledging the presence of IPVAM, participants still felt that there are fewer men than women who experience violence from their partners. In some of the interviews and FGDs participants estimated about 90% of women and 10% of men experience for IPV in their communities. Some argued that for the men who are experiencing violence it is as retaliation from their wives:

"Men face little violence because when men get abused by a woman it means the man has triggered that violence. For example he leaves no food at home and goes drinking. When he comes back around 10:00 pm, we lock them out and we don't leave food for them since he left nothing. The woman has struggled to get that food by picking sand and bricks. Yet the man has used his money on beer. So this is more or less like reciprocated." (Mixed gender HCW FGD, urban health centre)

Few felt that IPVAM and IPVAW are equally experienced. Some noted that IPVAM is a growing, but possibly neglected, problem. These participants argued that IPV appears to affect more women if taken on face value but a critical examination may reveal more IPVAM. Men in particular, blamed organisations dealing with GBV issues for placing more emphasis on violence against women and were responsible for popularising reporting of VAW.

"Men are experiencing more violence than women. Women have several channels where they rush to complain. They can go to police and they are assisted. Men are threatened by police that if they continue violating women they are going to be imprisoned. This forces men to retract from further abuse but that is not the case for men. In fact, such an approach has given more power to women to abuse their men. "(Male IDI 5, urban)

Participants who felt that IPV was equally experienced also contested the gender perspective to violence. A minority of participants (mostly men) argued violence does not need to be distinguished from a gender perspective. They said an act of violence remains as such regardless of whom it has been directed to.

> *"Violence is violence although they call it gender-based violence; there are no different degrees to violence" (Older men FGD, urban)*

6.4 Forms of intimate partner violence

The following section describes types of IPV as perceived and experienced by participants of the study. There were many overlapping forms of violence described in the interviews and FGDs. Different examples included: physical and sexual violence (including rape, unwanted demands for sex and coerced sex), emotional violence and neglect and abandonment. Marked gender differences in the perceptions and experiences of violence were prominent in the narratives of the participants and these are described in the results.

6.4.1. Physical violence a form of IPV in Malawi

Discussions on the perceptions of physical IPV generated mixed responses within FGDs. The majority perceived IPV to be high in spite of the observations made by some of the participants that physical IPV was reducing in certain areas. Participants who perceived that physical violence had reduced explained that they rarely saw couples beat each other publicly as used to be in the past. Participants explained how public awareness of the evils of violence and human rights had led to reduced incidences of public fighting in their area:

> *"Ah! But this time around we have had gatherings/meetings organized by different organizations and because of this I have observed that cases of violence are reducing in this area. Previously we used to see husband and wife fights... but now it's not very common in this area. Such things are rare occurrences". (Older women small group, rural)*

These sentiments echoed the claim made by one of the GBV service provider who claimed that one of their achievements and greater contribution to the reduction of domestic violence was through awareness and stigmatisation of physical IPV.

> *"The real thing that we have achieved is to make wife beating look like a stigma so that a man who engages in acts of domestic violence should find it a shameful thing and therefore should desist from it. Before it was like it was expected but now people*

look down upon men or partners whom they know actually engages in physical acts. " (Female GBV service provider, KII)

In contrast, participants who were involved in solving family violence issues in their communities ascertained that IPV remained a problem. The shame and secrecy surrounding IPV were perceived to be responsible for making violence hidden. Participants explained that IPV is hardly discussed outside of the four walls except for extreme cases. A member of the chief's council in one of the communities said:

"I am one of the people who are responsible for my area. To say the truth violence here is too much. The kind of violence which we meet in the house where we meet, are very big such that if we are to expose it here, can make everybody's head confused... So what I want to say is that for you to hear about violence you should go and talk to leaders in the villages... violence is there mister, seriously" (Elderly men FGD, urban)

FGDs with women revealed that men have normalised the use of physical violence as a conflict resolution in relationships. In fact some women described wife beating as more or less like one of their husband's habits.

"Many men love beating their wives even if the offence committed is very minor. Even of the woman may respond with respect, the man appears as if the woman is rude. Immediately, they resolve to beat their wives all the time. (Older women FGD, rural)"

Interviews and FGDs with men confirmed that men use physical violence to assert power and impose behaviour change. Words like 'straighten things,' 'let her learn' and 'show her who the man is', were used by some men. Three of the five self-reported male 'survivors' of violence also reported having perpetrated physical violence against spouses in the past, although they all claimed to have stopped this. Reasons for beating their wives included fear that the wife would be attracted to other men she was chatting with, differences over handling of money and farm produce, leaving the home without informing husband, questioning husband over an alleged extramarital affair and a reaction to verbal insults from the wife. In describing their experiences of perpetrating violence, they tended to use language that minimised the acts of physical violence such as a slap or "touching" instead of "beating".

P: I have told you already that previously we used to live a violent life. That was long time ago...Uh!! Hu! Especially when she was blocking me from getting the things that I wanted to sell, sometimes I could touch her...

I: Touching or beating her?

P: (Laughing) no beating her. (Male IDI 10, rural)

Some of the interview narratives implied that at times violence against women and violence against men co-occurred

"It may happen that we quarrel and then she starts saying bad words. We fight... Sometimes she picks an instrument and throws it to me (cooking sticks, pots, plates, hoes or axe). She uses virtually everything that is around her. And then I give her a slap or two, she rushes to police". (Male IDI 5, urban)

Examples of isolated cases of severe physical violence against male partners were cited during the FGDs with both men and women. In one community, women made reference to some men who they perceived to have been exposed to physical violence. Interviews with men revealed that one of the participants experienced severe physical violence from his wife. He had many marks on his body as a result of biting and at the time of the interview he was still recovering from a recent injury to his reproductive organ. He gave history of several incidents of IPV in his relationship such that his relatives had advised him to exit the relationship but he refused because he loved his wife and wanted to take care of his children. Quarrels over suspected extramarital relationship triggered the violence:

"At first it happened that I left for my home village to assist my mother with gardening for two days. When I came back she accused me of visiting other ladies...she pushed me and bit my private parts. Blood gushed. (Male IDI 8, urban)

In contrast to this isolated case description experiences of physical violence were common among females interviewed. Four of the seven interviewed revealed physical violence. A range of physical violence was described including slapping, punching, beating, cutting, binding. On many occasions, the acts resulted in injuries requiring police and medical attention. For many of them physical violence began early in their relationships, they felt it was abnormal marital behaviour but that certain forms of IPV could be endured. Physical IPV was only considered more problematic when it was witnessed by others, resulted in

injury and co-existed with other forms of IPV such as reduced family support. Examples of injuries included fractures, genital injuries, eye and face injuries, bleeding, cuts, bruises, swollen face.

> *"I think my husband was violent to me from some time back but I didn't recognise the behaviour as violence. I used to treat violence as part of the normal married life because people had said that such things sometimes do happen in marriage…. However, the violent episode grew worse in 2008 following the death of our son. It became evident. This is the time that he was binding me and doing all sorts of bad things to me."* (Female IDI 1, urban)

Physical violence began early in her relationship and spanned over a period of close to ten years before she left and her husband was arrested by police on charges of domestic violence. She recalled that the first episode of violence happened when she questioned him over an extramarital relationship. From then onwards physical violence became routine, turning her into a punching bag. She reported physical violence even when she was pregnant and at times this co-occurred with emotional violence. The pattern of her story represents the form in which the stories of the remaining female survivors were told. The stories of these women may not fully represent the stories of the other women who had similar experiences for different reasons at different stages of their married life but they give a picture of forms of violence women are exposed to. The violence experienced by these women was particularly severe. In contrast the experiences of the other women were discussed in community and HCW FGDs and revolved around 'educational beating for love', controlling behaviours, sex at times when it was not wanted and other 'normative' forms of violence that were often not described as such. Common triggers were described as alcohol and financial control and this kind of violence was described as extremely frequent.

6.4.2. Sexual Violence

Participants described a spectrum of experience of sexual violence in both pre-marital and marital relationships which ranged from difficulties refusing sex (implicit coercion) to outright coercion that was only sometimes understood as rape.

6.4.2.1 Difficulties refusing sex in relationships

Both married and unmarried participants described difficulties in refusing sex as common occurrences in their relationships. Among young unmarried women and men, the gender norms suffusing the language and conceptualisation of negotiating sex led to apparent

174

confusion for both about how to signal and interpret desire, consent and refusal. Boys described a wide range of behaviours that are used to 'trick' or pressurise girls into sex; these ranged from buying of gifts to the use of pornographic materials. Most female participants explained that boyfriends provided them with gifts and money, and girls thus feel obliged to have unwanted sex. Again, threats of violence may be present.

"These days boys keep pornographic movies. When you take your girlfriend you already have the intention that I will do such a thing. As you are chatting you say let's watch a movie then you play a porno movie. In the end she is influenced yet it was not her intention." (Young men FGD, urban).

"Sometimes we agree to sex because they say you are going to give back my things, if you fail to give back, I will hit you. We give in out of fear." (Young women FGD, rural).

Girls described negotiation of and consent to sexual activity in a context of threatened physical violence; for example refusing to sleep with a boyfriend, proposing to or ending a relationship with a boy who demands sex, could result in physical violence against girls: The refusal of partners to go for HIV tests or use condoms in this context was described as a form of sexual violence and concurred with interviews with community members and health care workers:

"Sometimes you may decide that before we start sleeping with each other we need to test for HIV and use condoms but you find that the boy is refusing to go for an HIV test and is forcing you to sleep with him without condoms." (Young women FGD, urban).

When discussing difficulties in refusing sex in marriage the prevailing assumption was that sex was a given and that marriage gives the partners the perpetual right to sex. It was reported in the FGDs that married men do not accept any excuses for refusing sex. Men claim that they left their villages because they wanted the woman [sex] and not the food or beauty. Sex was described as a right in the family. Many men and some women felt that men had the right to have sex with their wives anytime they wanted to. They associated demands for sex with lack of appreciation of the very many jobs women engage in; in a day. However, demanding sex from a tired husband also results in threats. One interviewee described the different expectations for women and men:

"The bodies get tired. For a man you might tell him I want to have sex but he can say I am tired but if a woman says I am tired the man doesn't want to listen, he will still do it."(Female IDI 6, urban)

Refusing to have sex with a husband was accompanied with threats of extra marital affairs by the husband. Some women revealed that they are 'slapped' [physical violence] for refusing sex. Forcing a tired wife to have sex was perceived as a form of rape by only some participants.

In the marital context, demands to have sex with a wife with 'excessive' frequency were seen as sexual violence. Both men and women explained that there are some men with excessive demand for sex. Similarly demands for sex during culturally proscribed periods such as her menstrual period, in the immediate post partum and miscarriage period (less than six months post event) and when the wife is nursing a sick child were perceived to be a form of sexual violence. This discussion was generated among females; no male groups made reference to these. Menstrual flow and post-partum bleeding were both perceived as diseases that contaminate the woman. The bad blood was responsible for blocking blood flow in the male organ resulting in hydrocele. The post abortion period was perceived to be extremely dangerous as sleeping with a man during this period was associated with sudden death of the male partner locally named as *"chitayo"*.

"Sleeping with a man during menstruation and early postpartum period was associated with hydrocele formation in men." (Elderly women FGD, rural)

Women explained that during this period they are advised against 'provoking' a man into demanding sex and they used several methods to avoid this, including sleeping in a different place to the husband, and going to bed dressed. Women who slept on the same bed with their husband during menstruation were described as "bad" women, women with hyper libido or 'killers'. In one of the FGDs a participant narrated a story of her sister-in-law who was accused of killing her husband with '*chitayo'* after it was discovered that they slept together three months after abortion. The participant's relatives' perpetrated violence against the wife by falsely accusing the wife of killing her husband.

6.4.2.2 Coerced sex

Most participants acknowledged that coerced sex did occur within marriages. In all the FGDs and interviews participants mentioned that coercive sex in marriage is common and

perceived it to be on the rise. Some women said there seems to be no differences between coercive sex experiences for newlyweds and old couples. Overall it was perceived to be wrong, including by men, and participants tended to emphasise on the need for reaching out to each other on sexual matters. Both men and women recognised the need for consent to sex.

Others reported that husbands rape their wives 'as if they are dealing with a stranger' if they refuse to have sex with them, using what they saw as excessive force. In one case a survivor narrated her husband using extreme violence to rape her, including the insertion of a range of objects, which caused her internal injury:

"I got surprised when I felt something strange in my private part. It was strange. I knew it was not him. I asked what this you're inserting is. He answered silly what do you think this could be? He had trouble inserting it but kept on pushing it in until he forcefully managed. In the morning I had a lot of pains. I could hardly walk, I was in great pain and I was even afraid to go and urinate....When he inserted the thing he also forced his penis such that the penis was below the thing. He managed with great force. He used to appear angrier during such acts to create fear in me so that I remain silent... One day he told me, today I am going to see the place which you are using for prostitution. He took a certain bottle, inserted it into my private part allegedly trying to close the place I was using for prostituting. He forced the bottle in until he inserted it. It was a big bottle; he did not use the bottle mouth but the wider part and inserted it into the vagina." (Female IDI 3, urban)

Some individual interviewees were convinced that coerced sex was a problem in marriages after experiencing it in their relationships. However, they felt that it is grossly underreported. They said many women treat sexual violence as a private and shameful thing, as such most sexual violence issues are not discussed outside the home. One of the survivors who experienced several forms of sexual violence from her husband blamed the silence surrounding marital sexual violence on the closed nature of women:

"Uh it's a big problem. For me it's a very big problem because I have experienced this. So I see this as a very big problem.... the problem is we are not free. We women treat it as a private issue. It's not openly discussed. We say these are marriage issues, they end there. If you get angry you discuss it within and then it ends there. When it's something that has occurred outside marriage that's when you rush to tell

177

people and go to the police. It's us women it's us women hide such issues we don't bring them into the open" (Female IDI 3, urban)

Narratives from all young unmarried people indicated the incidence of forced sex was perceived as high, in contrast to the perceptions of the wider community FGDs, who felt that violence was mostly found in marriage, not in pre-marital relationships.

"What I know is that forcing us to sleep with the boys is very common. This is very common and it has happened to most of us, if we are to be honest with you. (Overlapping agreeing responses in the back ground)." (Young women FGD, rural).

"Ah! Indeed boys are forcing girls to sleep with them, forcing her in a car, they take their car and park in the wrong place, it is happening". (Young men FGD, urban)

Group/gang rape was reported by girls in one township, where an organised group of young men were proposing sex to girls individually with the intention of forcing them to engage in group sex.

"In this village we have groups of young men who convince each other to propose a girl. They may send one of them to start a relationship with a girl, after sometime he invites you to his home. The moment you agree to have sex, you see his friends coming. You ask what they are looking for... you find that all those boys sleep with you." (Young women FGD, urban).

There was some disagreement and confusion about whether forced sex within intimate relationships could be considered as rape, as contrasted with 'stranger rape' and the rape of children; there was a widespread view that a relationship inherently included consent to sex especially among young people, men and a few married women. The majority of women and some men clearly perceived intimate partner rape as such but felt that the wider society did not acknowledge this, whilst others were not convinced themselves.

"We understand rape as in the case of a man raping a child, that is rape but for a boyfriend that is not rape... There are some people who are raped when they don't have any idea or anticipation that such a thing could happen to them. She bumps into a man and he rapes her. This case is straight forward. You don't fear telling your parents and they can't even beat you. This is a criminal offence of rape but in a relationship ah (laugh) it's not rape". (Young women, FGD, urban).

The lack of recognition of intimate partner rape in wider society was supported by data from healthcare workers and older community members:

> *"As for me, when a girl gives history of being raped by a boyfriend I don't really understand... what comes to my mind is that these people had agreed..." (HCW FGD, urban).*

Its lack of recognition in Malawian law was also discussed.

> *"We don't have such a law at the moment. As Malawians we look at this thing as a shameful thing; to report such a thing to relatives or other relevant authorities that my husband has raped me. ...Even if you wanted to report such a thing to your marriage advocates they will ask you when you accepted him I thought you were consenting to the very same thing. In the end you still look stupid as if you have extramarital relationships. So there is no law." Older men FGD, rural)*

It was clear in some of the male FGDs and interviews that participants acknowledged the presence of forced sex but were uncomfortable with labelling forced sex in intimate relationships as rape.

> *"There is no rape in marriage. It doesn't happen...it's not rape. It's inside the house. In the bedroom there is no rape but may be forcing each other(laugh)yes, we call it forcing each other to do what God intended us to do...we have to force each other to do what is right to be done, do what I vowed I will do with her...there is a difference" (Male IDI 9, urban).*

Interviews with GBV service providers revealed that they felt most of the parliamentarians, male and female, were against the idea of labelling coerced sex in marriage as marital rape. They feared criminalisation of coerced sex in marriage would result in increased marriage break down. The interviewee felt that this was why the government decided to remove the clause on marital rape in the prevention of domestic violence act. Marital rape was also regarded one of the controversial topics even within the circle of human rights activists.

> *"We have indeed tried to lobby government that there is this thing called marital rape but Oh!Oh! Oh!Oh! In fact, they would say it's impossible to rape your own wife. What are you trying to say? But by and by men are now coming to terms with it that there are times really when a woman is forced into such a thing, and if you are forced*

what do you call it? They say yes, but it can't be criminalised" (Female GBV service provider, KII)

This is at odds with our findings from in-depth interview with women and community FGDs who asserted that forced sex in marriage is rape on the basis of lack of mutual consent. All the female interviewees, except one, in IDIs had experienced this and some alluded to it in FGDs and in FGDs with young people. Older women talked about being 'raped' when they were supposed to be abstaining culturally or when they had sick children to look after in the house.

6.4.3 Psychological and emotional violence

Psychological violence was reported primarily in marital relationships and was described very differently by men and women. For men it included failure to cook and warm bathing water for husband, blame, name calling and isolation. For women the focus was more on controlling behaviours and threats from their husbands.

All of the male in-depth interviewees explained that refusing to cook for husband and denying him food was a form of violence against men and almost all experienced this form of violence to varying degrees. Survivors explained that their wives were no longer sticking to meal times; some wives left the cooking to children, others were serving their husbands ill-cooked food and cold meals. One of the men interviewed perceived refusing to provide warm water for bathing to husband to be the most painful form of violence in the home; another said that denying him food as 'worse than killing'. The other common forms of violence described by men included emotional violence and verbal abuse. Men cited withdrawal of care, reduced respect, being talked down to in front of others and lack of sexual intimacy as examples of some of the forms of violence they experienced. Verbal abuse was the most common form of violence male survivors experienced from their spouses and was cited by all most all of the men who participated in in-depth interviews. In the following quote one of the survivors of emotional violence explains how his wife could shout at him using offensive language in the presence of strangers, children and his son –in-laws:

> *"She counts my body parts in the presence of my son-in-law and she does this mostly in the morning... Oh! I tell you, when she starts eh! I ask her are you telling your son-in-law about me." (Male IDI 10, rural area)*

Men living at their wives villages reported that they were threatened with divorce, and told to return to their home villages. Also, those who are financially challenged are threatened with extra marital affairs.

> *"She keeps on telling me go back to my village... she threatens quite a lot...One day she gave money to my grandchild. Give this money to your grandfather and tell him to use it for transport back to his village... my children say let our father stay, he built the house we don't want him to go and suffer in his village" (Male IDI 10, rural area)*

Women too described a range of behaviours that they perceived as emotional or psychological violence, some of which they saw as particularly severe. In many of the FGDs conducted with women, they felt that violence turns marital relationships into a kind of slavery, prison or boss to servant relationships where the female partner becomes a servant to the husband.

> *"When your partner always acts violently towards you, it's like you are imprisoned...you live unhappily all the time. You are like a slave as such you are not free because of violence." (Elderly women FGD, rural)*

Women explained that some husbands are very controlling. Controlling behaviour included a range of aspects. It often included demanding that women seek permission for every activity. In some cases men's control was exerted particularly around food preparation and consumption in the household. Women explained that in some families men control when food is to be eaten and women and children are not allowed to eat in the absence of the husband; some men write on the cooking flour to make sure that their wife doesn't prepare food in their absence. Women said they are questioned for serving children and sometimes husbands tell them to prepare only vegetables for the children, which women felt was hard to implement, unfair and associated with poor child health outcomes.

Controlling behaviour was also associated by women with sexual jealousy. Specific manifestations included husbands inserting objects into the vagina: health care providers gave examples of cases where they had to dig out mud from the vagina because the husband was trying to seal the orifice; in another case, pepper was sprinkled into the vagina and the woman came to the hospital screaming with pain. In one FGD women reported that husbands in their community commonly demanded to insert fingers into their wives vaginas to check if their wives haven't had sex with other men if they delayed coming from the market,

borehole, from fetching firewood or if they had travelled away from home. Wives were beaten if they resisted this. Some women concluded that jealousy was the driving force for some of the forms of violence women were experiencing in their families.

Women also described isolation as a form of emotional control. They explained that they are not allowed to go out of the home without permission and are stopped from chatting with certain types of friends. One of the female survivors who was HIV positive was isolated in her own house. She reported that her husband would not eat the food she prepared, refused their children to eat with her and made her sleep in her own bedroom. Denying women access to children was experienced by women who were separated from their husbands and women felt it was a great injustice to them and a painful experience. In a different interview, an interviewee who spoke courageously about her experience of violence suddenly broke into tears when she started narrating her concerns over the welfare of her children.

> *"Giving birth to children is also a big job it's a matter of life and death... I have three children... What is more painful is that he chased me out of the home; my property is still with him and my children too. I don't talk to my children anymore, and I don't see them; the reason being that I will kill my husband. This is very painful that ah!"* *(Silence wipes tears) (Female IDI 7, urban)*

6.4.4 Family neglect or wife abandonment and extramarital relationships

Participants reported that neglect was linked to extramarital relationships and was associated with misery and suffering for women and children. They also described the threat of HIV infection as a form of violence linked with extramarital relationships. Community FGDs revealed that many men are leaving the responsibility of caring for the family to wives alone whilst they spent money on women and beer. In the absence of the husband, women are forced to do piece work to fend for their children. Participants also indicated that some engage in extramarital relationships to supplement their sources of income and to meet their sexual desires if their husbands are unable. KIIs with police and GBV service providers revealed more cases of wife abandonment in Southern (where this study was conducted) compared to the Northern and Central regions. They attributed the differences to the different family system.

> *"This is common in the southern region. I feel like because of the marriage procedures. It doesn't take days, somebody can propose a woman in the morning you find that in the evening it's a family that's what happens here in the south so because*

they feel I can leave this one and marry the same day they don't find it as a problem… end result is that we have seen women having 3-4 children from different fathers… I wanted to add the element dowry (bride price). Here in the southern region there is no dowry like what is paid in the central and northern regions" (small group interview, police)

Community focus groups shared similar sentiments:

"What I have observed is that men are abandoning women one after the other. He leaves the first wife, proposes another woman, ditches that one and proposes another. Now you discover that in this chain of women that he has established everyone is pregnant but when it comes to caring he may only support his wife (first) and leaves the others non-attended. So we feel eh! Eh! This is also great violence because just impregnating you without giving you any support not even buying you a wrapper eh!"(Elderly female FGD, rural)

Having extramarital relationships was categorised as a special form of emotional intimate partner violence that disproportionately affects women. However, women perceived that only a small proportion of women may engage in extramarital relationships because it is culturally inappropriate behaviour for women. In the following quotes survivors explained that learning about your partner's unfaithfulness is a very painful experience, the worst form of violence and a violation of the loved human rights

"The man has the responsibility to love the woman. This is their responsibility but may be because of this they end up loving everywhere (laugh), loves everybody, every person in a skirt; let me love her (laugh). Forgetting that loving the other skirts means they are violating the rights of their loved ones. And this very painful to realize that your husband has slept here or he is going out with this one. It's very painful" (Female IDI 7, urban)

Infecting a partner with an incurable infectious disease was perceived by some to be the worst form of violence women are experiencing. FGDs with women and interviews with female survivors felt that this form of violence disproportionately affects women and was also linked to extramarital affairs. In one of the interviews, a survivor who had recently been diagnosed with HIV infection commented:

"Giving you diseases is worse than beating you. He can beat you; you may cry and stop but this violence of bringing you diseases especially this current disease [HIV] that we have here, when you get it means it's going to remain in you forever. This disease does not end, year in and year out you have to suffer from it. It's like he has brought a huge oppression on your life. This is the worst form of violence men are perpetrating against their wives. " (Female IDI 6, urban)

6.4.5 Use of love potions

Community FGDs revealed that there is a secret form of violence largely used by women against their male partners. Participants described the use of traditional medicine commonly known as '*konda ine'* [love me] used to cement or strengthen relationships. They felt it was secret form violence because its victim may not be aware this was done to him or her. They explained that these drugs may make a man's penis fail to erect if he meets another woman. It was also said that men may use similar type of drugs to make the man 'lock' the wife so that whoever attempts to sleep with her should die or get stuck during sexual intercourse. They noted that sometimes these drugs may result in exaggerated behaviours such that the partner becomes possessive, controlling, physically abusive and 'stupid'.

"I have seen some men who it is alleged they became stupid because of love potion. People say have you seen that man, he used to love his wife very much and the wife did not want him to give such love to another woman. She went to an herbalist, got love potion, fed him and now he is stupid. I consider this as violence somehow although it's not visible. "(Older men FGD, urban)

6.5 Perceived causes of violence

Overall there was a feeling among participants that IPV was a manifestation of failure to amicably resolve misunderstandings between the couple. The major reason given by participants was that of gender differences existing between men and women that intersect with religious and cultural factors to increase vulnerability of women towards IPV.

6.5.1. Power differences between male and female

The concept of power differences between men and women dominated the explanations of why violence against female intimate partners is greater than violence against male partners. These power differences were described mainly, but not only, in narratives. Both men and women saw it as a problem and men saw it as a cause of both violence against women and

against men, referring to shifts in power leading to shifts in abuse patterns when 'women become men'.

In spite of the IPV gender parity and disparity debates in our findings overall the majority of both men and women believed that few women had the ability or power to fight back against their men and most women just agree to what their men say.

> *"It's a question of who is in power. Who has more control and our society women are still very subordinate to men and as long as that still remains you will find that issues of violence will always be against women but it's right to say some men do complain of violence perpetrated against them by their wives" (Female GBV service provider, KII)*

Several sources of male power were acknowledged. Men were always perceived to be physically stronger than women. Religiously, men were perceived to be more powerful than women because biblically they were created first, the woman was created out of them and that they are the head of families. Culturally they are the head of the family and have the power to propose marriage. This was perceived as another source of power that increased men's decision-making power.

> *"If we look at the family, the head is the man. If a man tells his wife about a plan and the woman seems to be wise she refuses, so if this happens we tend to think that the woman is underrating us." (Elderly men FGD, rural)*

The mentality of regarding women as tails and men as heads was described in one FGD as a seed upon which IPV flourishes.

> *"The seed upon which violence between two people stand on is: many were born with a life that when they marry, a woman is a tail and the man is the head; he is the head in everything, she should listen...if she does not listen to me it means she is undermining me... Even many organisations are ruined because of such conduct" (Older men FGD, rural)*

Many men and women blamed IPV on the hierarchical positioning of men and women in marriage. Participants explained that the problem is that the men are seen as the head of the family and are expected to lead on many matters concerning the family. If the wife appears to be much wiser, rejecting some of the decisions made by her husband, this is easily

185

interpreted as undermining husband's authority. Some participants felt that it is not the power difference that is problematic but the abuse of power that is responsible for IPV in the country:

> *"Men just abuse this position to oppress women of course they are heads of the family, but that position does not allow them to oppress the wife". (Female IDI 7, urban)*

Structural sources of inequality focused on education between men and women. FGDs and some of the interviews associated inequity in education levels between men and women at society level with increased IPV. Participants explained that lack of women's education translated to inequities in resource distribution at the family level and increased dependency of women on the male partners, thus increasing women's vulnerability to violence. Interviews with gender service providers revealed that education alone may inadequately prevent women from abuse but education may empower women to resist abuse.

> *"You and I have a greater opportunity to resist it than my maid and the difference between you and I and my maid is that she has lesser education." (Female GBV service provider, KII)*

6.5.2 Poverty

The other structural factor associated with IPV during the interviews and FGDs was poverty. There appeared a general consensus in urban interviews and FGDs that violence was concentrated in poor disadvantages areas of the city locations. Interviews with police, GBV service providers and health service providers revealed that many of their clients come from Mbayani, Chilobwe, Bangwe and Ndirande. Women reported that they are beaten by their husbands for asking him for money to buy salt, food and clothing. Providers felt that the issues of poverty entangle with the issues of gender roles, where men are expected to provide for the family; such that when men are not able to provide, it can cause stress in them and they can resort to violence. IPV was perceived as a means of silencing an insisting woman. One of the service providers talks about a case of IPV she came across in the hospital

> *"One day I went to the hospital for other things, a minibus came carrying a woman who was completely unconscious with the man the husband sitting next to the community who had arrested him... I asked why you beat your wife to this extent. He*

said she was being rude to me. She was requesting money for food and yet I had no money. This made us quarrel; she is very rude. "(Female GBV service provider, KII)

Against the background of poverty the accumulation of some wealth was associated with IPV against women. Women in particular said that wealth made their husband feel more important and led to extramarital relationships.

"Domestic violence is caused mostly by at least for those in town it's a matter of a man that has moved on in status and feels that the wife is no longer capable to look after his status you find that they start mistreating the woman to the extent that the woman is going to decide to leave" (Female GBV service providers, KII).

One woman in urban Blantyre explained that she was convinced that poor people in the village love one another better than people who have wealth.

"I can give you an example of the village life you find that the woman is using a wrapper as a blanket and has to put it on again during the day, they eat vegetables every day. I feel that such people rarely abuse each other... when such people start getting money, that money makes somebody to appear to be cleverer... Now the man says I am the head of the family... money starts to control him" (female IDI 7, urban area)

A man who was not employed and reported getting very little from piece works at the time of interview felt that violence in his relationships started because his wife was getting more money through the selling of *Kachasu* beer than himself. This made the wife feel that the husband had less power and as such she started abusing him

"She was getting money and I don't have money. She starts ruling over me because I am depending on her resources. She started thinking that she is a man and I am a woman. I can't do anything freely". (Male IDI 5, urban)

6.5.3 Alcohol and drug abuse

There was a general consensus on the role of alcohol and drug abuse in IPV. In both interviews and FGDs alcohol and drug use were perceived to be significant causes of violence, particularly the more severe forms. During interviews women who were married to men who were both abusive and alcoholics reported severe forms of IPV, which some of them equated to forms of human torture. They explained that substance abuse makes them

arrogant such that they do not listen to advice when they are under the influence of the drug; and they have more energy making it difficult for them to be restrained. One female survivor reported to have experienced abuse only when her husband was intoxicated. In the FGDs, women talked about women and children in abusive relationships running away from home for safety when their abuser gets intoxicated. In the narrative that follows a survivor talks about how her abusive events are well calculated and that alcohol intake was used to justify violence:

> *"When he is drunk..., he will beat me. If I ask anything from him whilst he is sober, he doesn't respond..., he waits until he is drunk. He drinks to beat me. It doesn't matter when that issue was raised... morning or afternoon..., he will just keep the issue, goes drinking and comes back to confront me or beat me. So this is how my husband behaves." (Female IDI 11, urban)*

Drug abusers were perceived to be worse abusers than alcoholics only   One of the survivors whose husband abused Indian hemp *'Chamba'* made this contrast:

Most of the violent men are smoking Marijuana ('chamba'), some drink but the Chamba smokers are worse... When they smoke... They feel like they have all the power, they are much stronger than anyone else. When they smoke Chamba they feel more energetic, they are not afraid, and they can do anything that comes to their mind at that particular time. (Female IDI 3, urban)

6.5.4 Family planning and desire for children were linked to violence

Use of family planning methods was a recurrent theme related to violence among female survivors, health care workers and in community FGDs with women. Participants explained that many men do not support the use of family planning and most men who oppose family planning are abusive. Interviews and FGDs with health care workers revealed that many women access family planning methods without the knowledge of their husbands. Many would request that their appointment cards be kept by family planning providers at the clinic and would cheat that they were going to the market yet they were going for family planning. Several reasons for men's lack of support for family planning methods were given during the FGDs and interviews with women. Participants explained that some men refuse their wives to use family planning because of associated complications such as lack of menstruation, prolonged menstruation, making husband sick and consequent loss of the male sexual desire. Women explained that prolonged bleeding is stressful to men because culturally they are not

supposed to sleep with a menstruating woman. Lack of menstruation was also perceived problematic as it was associated with accumulation of diseases; as menstruation is associated with removing bad things from the female body. Other women in the FGDs felt that jealousy was the driving force. Participants said that many women on family planning methods look good because their bodies look healthy; therefore men feel threatened and jealous because the woman appears much younger whilst the man feels he is ageing. Denying a woman access to family planning and consequently abandoning her was perceived as a form of violence among women. Examples of marriages that ended in divorce because women were not menstruating or had prolonged bleeding following injectable contraceptives were given by several participants including this survivor.

> *"With injections many women do not menstruate… Men feel there is something missing in the wife… some men will accuse their wives of witch craft, claiming that they feel sick when they sleep with her…many women on injection who are not menstruating experience some form of violence… I received one shot and menstruated daily for 8 months. It was hell, my marriage nearly ended that time, in fact we separated, he told me pack and go to continue practicing your things in your village, the doctor gave me some medications and I stopped. When I stopped bleeding he called me back and warned me that if I continue that will be the end of our marriage…my friend was divorced" (Female IDI 1, urban)*

Three of the seven interviewed female IDIs could trace the origin or exacerbation of violence in their relationships to issues around use of family planning and desire for more children. Two were on permanent methods and one was on long-term temporary method. One of the two on a permanent method reported being coerced by her husband to have a tubal ligation only for him to turn around and started demanding for a male baby. The second case involved a woman who consented to a tubal ligation following difficulty delivery and an HIV-positive diagnosis. Following the death of their only boy child, her husband demanded that he wanted to have another baby boy. She reported having consulted gynaecologists who advised them against on medical grounds and also on poor chances of reversing fertility. Her husband then impregnated their house maid. Another woman recalled this episode focused on her Norplant (long lasting contraceptive implant).

> *"In 2011 he started saying that he would like to have another baby. I was unable to refuse because I feared violence. I told him I had Norplant. He said let's go to the*

hospital they should remove it… he stayed outside the consultation room… I told the sister [nurse] I am here to have the Norplant removed. She asked when it expired. Why then are you removing it? I told her my husband has ordered it to be removed... She told me to invite him in …. He said that's rubbish, he turned and immediately walked away… When we arrived at home that's when the battle began. I was beaten until he got tired of beating me. He then took a knife and tried to remove the Norplant. Unfortunately it was a blunt knife. He went ahead and took a razor blade. He cut the edge of first stick [participant removed her top and showed the interviewer the upper left hand where the husband had cut open to remove Norplant] he squeezed it so that it should come out from the opening that he made He tried all he could, I was crying and blood was flowing" (Female IDI 3, urban area)

Childlessness was also associated with violence, especially in the form of neglect, wife abandonment and divorce. Women who declared themselves childless explained that they faced violence from their husbands some of which was instigated by mother in-laws. Women reported that men abandoned them for other women in the quest for children. One woman interviewee (IDI) who had been married for some time without having a child reported that her husband was refusing to buy her food because there was no child to eat that food

"It may happen that you are not able to have children so he may say that you are not giving birth. It is better for me to go and find children. This is a very big problem resulting in total separation, total separation. When he comes home he does his own things and you also do your own things." (Older women small group, rural)

Some participants explained that childlessness may expose a woman to a form of cultural practice where *'fisi'* hyena (human hyena) is introduced into the family. The Human hyena's (man's) role is to father a child for the family in the case of a woman who is childless, failing to carry pregnancy to term or having her babies die prematurely. While both parents and the couple may be involved it's a process that is perceived to be engineered by parents

"They may hire this man to sleep with the woman until the child is born to this family. The child may survive, the owners may know who the father is but the secret is kept in the family. Outsiders may think that the man is the biological father yet the family knows." (Young women FGD, urban)

6.5.5 'Democracy' and 'human rights' as a cause of violence

Narratives from interviews and FGDs revealed that the introduction of democracy and increased observance of human rights in the country was blamed by participants (particularly male and elderly female participants) for increased IPV in the country. Democracy and human rights were perceived as a new social order, a kind of departure from old ways of living and characterised by ungoverned behaviours, selfish ideologies and introduction of new technologies such as condoms. Elderly women in particular were concerned with the unruly behaviours of both young girls and boys which they attributed to excessive human rights. Other women felt that many men are not seriously committed to marriage, but to enjoy pleasure. They aim to bring shame to women and that they do this in the name of democracy and human rights with the realisation that they can get away with so many wrong behaviours. Human rights have led to increased unstable marriages which are dangerous to the girls because of increased violence:

> *"These days' girls are only listening to what they want because of excessive rights. The same applies to the boys (participants agree). Our parents used to discourage us from staying together with boys (having sex) but nowadays they tell us that does not concern you, leave us alone it's our rights.... They marry hurriedly without knowing the character of the husband. Two to three years down the line violence erupts in the family. Now in this, their rights our children are giving us a lot of burden because they are not getting into stable relationships/marriages, they leave us to suffer with bringing up grandchildren" (all participants agree in a chorus). (Elderly women FGD, rural area)*

There was also a realisation that the problem is not democracy but that people are hiding behind democracy to abuse others

> *"Like these days people talk about democracy... People are now getting used to doing things in the name of democracy; I don't think its democracy but people deliberately choosing to act violently towards women." (Older women FGD, rural)*

Organisations dealing with gender issues were particularly blamed for turning women into men. Similarly the attitude of some of the health workers towards IPV survivors demonstrate that women are beaten by their partners for advancing gender issues in their relationships.

6.5.6 Witnessing violence in the family of origin

Participants in interviews and FGDs felt people who grew up in violent homes tend themselves to be violent as grownups. Women FGDs revealed that children imitate the bad behaviour from their parents. Thus, children growing in violent environments; watching their parents fight grow up thinking that fighting is what makes marriage. Men had similar explanations. They said boys growing in violent homes believe that they were born violent, they have less regard for others and they may hit anyone without feeling remorse. This behaviour may later translate into wife beating because they will have no regard for her. Both male and female participants in in-depth interviews associated violence in their relationships with poor upbringing in the family of origin of their spouses.

> *"I may say that he must have inherited some of the violent behaviour from his family because that was not the first time for his mother to shout at me. I don't think it was because of the child we lost. I think my husband was violent to me from some time back but I didn't recognise the behaviour as violence". (Female IDI 1, urban)*

Similar sentiments came from FGDs

> *"The male children grow up thinking like marriage is fighting taking after what their father and their mother were doing. They feel like fighting is a good game that's what marriage is all about". (Young women FGD, urban).*

6.5.7 HIV infection

Participants in the FGDs and interviews felt that violence is quite big because of the HIV pandemic. They described HIV transmission as a form of IPV (see section 6.4) but also described HIV acquisition as a cause of it. Participants explained that many spouses, especially men, do not want to stay with a sick wife. They said that men who are caring for their sick wives are relatively few compared to women. Interviews with service providers revealed stories of deliberate transmission:

> *"We had some cases coming to the organization, husband and wife are on separation and the husband knows that he is HIV positive. He will come back to the wife and forcing himself on the wife and then the wife discovers that she has been infected with HIV later after the man has forced himself on her….what the husband did was rape because he forced himself on the wife and it was intentional what he wanted was actually to infect her" (Female GBV service provider, KII)*

Interviews with some of the male and female survivors who were HIV positive revealed that violence existed in their relationships prior to the diagnosis but it exacerbated the abuse

> *"Violence came to my life because of my HIV-positive status. My healthy could not have deteriorated if he had taken good care of me but violence, lack of proper food and worries has facilitated the deterioration of my health. Imagine with a low CD4 count I was supposed to take drugs. My husband hated the idea of having someone who is on treatment on daily basis. He wanted me to stay without treatment. Sometimes he used to tell me that when are you going to die? Your friends are dying, such a friend of yours is dead she was healthier than yourself. Why are healthy people dying and leaving you behind? Such talks contributed to the weakening of my body"* *(Female IDI 1, urban)*

6.6 Perspectives on violence and health

The data reveal a number of perceived links between violence and health. Violence was said to adversely affect the HIV status, the reproductive, emotional, psychological and physical, health of men and women, and to both directly and indirectly affect the health of children and family and national development. When discussing the health effects of violence one of the participants in a FGD described health and violence as opposing forces that are involved in a fierce battle and envisaged that health loses the battle to violence.

> *"There is a big battle between health and violence and violence wins destroying the whole health of a person"* *(Older men FGD, rural)*

The major themes occurring in the data are presented below.

6.6.1 A strong perception of the link between violence and HIV

The link between HIV and violence against women and girls was a consistent theme in all FGDs, IDIs and KIIs. Forced sex in marriages was perceived as exposing women to the risk of HIV, whilst HIV/AIDS infection was also a widely feared impact of rape. The refusal of partners to go for HIV tests or use condoms in this context was described as a form of sexual violence across interviews with survivors, community members and health care workers and came out most strongly among young people. There was a high prevalence of self -reported HIV infections among those interviewed individually. Five of the seven women and two of the five men disclosed that they were diagnosed with HIV infection. Most of the female survivors attributed their HIV risk to marriage. The emotional burden that resulted from

193

contracting infectious diseases and thoughts of the aftermath of such infections was great among the survivors. Participants felt damaged and regretted getting married in the first place. Narratives from the participants displayed the sense of hopelessness.

> *"I am meeting various kinds of hardships yet I am still young and moreover I have not given birth yet he has started giving me such diseases like Bubo (Lymphogranuloma venereum), gonorrhoea, syphilis. He is somebody that I might divorce. I may want to marry another man and that other man may need a child but he has destroyed me. Imagine I went for testing and I have been found HIV positive. This is making me to have so many thoughts. Sometimes I ask myself what made me get married. If I had not married I wouldn't have contracted such diseases" (Female IDI 11, urban).*

Disclosure of HIV-status was perceived to be particularly problematic within intimate relationships. Health care workers felt that a large proportion of HIV-positive people do not disclose their HIV status to their partners. Some of the health care workers felt that this constitutes a human right violation. The following examples were given by some of the health workers based on reflections of dealing with HIV-positive people in health services:

> *"When women are found HIV- positive and when we ask who they are going to tell, very few mention their husbands. The majority mention their parents or other relatives. This is how we know that once they tell their husband it means that will be the end of the marriage." (HCW FGD, health centre)*

Typical examples of non-disclosure of HIV status to partners by both women and men were drawn from individual interviews

> *"Her grandmother took her to the hospital and got her tested for HIV. When she came back from the hospital she started taking Bactrim secretly. I was just surprised with what was going on. No child revealed this to me... When I enquired from her about the drugs that's when she opened up to explain about the drugs and she even sent me to collect the drugs for her" (Male IDI 5, urban)*

> *"My son-in-law asked me why I frequently visited the hospital. I decided to let him know. I said for how long will I manage to hide this information? I told him I take ARVs... But my wife could not accept that this was the case. She doesn't ask me but shout at me" (Male IDI 10, rural).*

Fear of violence and divorce has also interfered with uptake of and compliance with HIV prevention strategies. Health care workers made particular reference to condom use, which is commonly advised to people who are diagnosed with HIV infection and to people on STI treatment. During the interviews health workers testified that some women do report back to the facility admitting failure to comply with condom use. Providers explained that non–compliance to condom use is very common because men would like to have 'plain sex' (sex without condoms) with their wives and women have to comply due to lack of economic independence. Some female survivors reported that adhering to HIV related instructions including condoms use is made complicated in families where violence existed.

> *"Many patients at ARV clinics are advised to use condoms and we have seen some women saying; 'at home my husband told me to pack and go because I suggested use of condoms.' Men want to have sex without condoms so women accept it because of poverty or they are afraid to leave marriage and go home because they would be asked why they came back. So because they are afraid of this they stay on." (HCW FGD, health centre)*

One of the male survivors admitted refusing condoms when his wife introduced the topic on condom use for the first time in their marriage of more than ten years:

> *"When she introduced the condom issue in the family I refused because I wanted to sleep with her plain... without condoms. I asked her when this did start... We started using her condoms. Later I told her there is nothing that is happening [not enjoying sex]" (Male IDI5, urban)*

Men perceive that condoms are meant for relationships outside marriage or they associate them with having sex with prostitutes.

In discussions with young people, rape was seen as barrier to accessing HIV testing and counselling, because it was associated with increased fear for the testing results.

Testing following rape is very difficult. You think should I go and have my blood tested, let me just stay like this. It's very difficult. You consider the looks of the person that has raped you; you imagine that man, can that one be HIV positive (all participants laughing) and in the process you find that you no longer pursue the matter further. It's different if your motive is just to learn of your status... you have the confidence to go and have your blood tested but in an event of rape you feel a lot of pressure... You just imagine yourself safe especially when

you are fat (all participants laugh). Are you laughing at what I am telling you? This is true... (Some participants agree with the speaker). (Young women FGD, urban).

Spontaneous reference was made to antenatal HIV testing, which was discussed in all FGDs with health workers without the need for specific probes or questions. Antenatal HIV testing was associated with violence against women in most of the interviews with health care providers. Participants explained that women who test HIV-positive during the antenatal period are faced with myriad challenges when it comes to disclosure of their diagnosis. This was perceived as particularly relevant for first time mothers or mothers with newly found partners. Health care workers noted that most people get into marriage without knowing their HIV status. They learn for the first time about their status during the antenatal period. Women then become the 'first people' to know about their HIV-positive status and are therefore blamed for introducing the virus into the family. In most cases, these women are not well prepared for HIV testing. They go to the clinic without an idea that they will be tested for HIV and come out of it with an HIV-positive diagnosis. For some, this period becomes the first time that women get to know that their husbands have long been diagnosed with HIV. Some women are abandoned by their husbands and left to suffer alone and care for the baby because of the HIV-positive diagnosis. One HIV- positive health care worker confirms the sufferings of fellow women in the following comment:

> *"Eeh! There are so many families that are complaining. In fact, I am also HIV positive that's why my friends feel free to tell me that their families are in trouble. They tell me, since I told my husband that I have been diagnosed HIV- positive I am not having peace and I see the family breaking up and the man marries another woman. So women are struggling with life." (HCW II , Health centre rural)*

Discussions on antenatal HIV testing revealed that some believed it to be mandatory as illustrated by the following response:

> *"What is happening nowadays is there is a law that every woman attending antenatal clinics whether she likes it or not should be tested based on the advantages." (HCW FGD, Health centre urban)*

Typical cases of HIV related violence and how they are handled at community level were also given in one of the FGDs with village health committees (VHCs). Narratives showed

that women were not necessarily passive. They actively sought assistance on how to deal with their situations as illustrated by the following excerpts:

"On issues of violence, I remember we had a certain case; the woman went for HTC and was found positive. She came back and informed her husband about the diagnosis. The man denied it. The woman went ahead and started taking ARVs. What used to happen is that the man used to steal the ARVs from his wife and was taking them (participants laughed) yet he was not aware of his status. The woman came to complain to us. This is what is happening but when I tell him he beats me. When people come to stop the fight and try to enquire about the cause of fight, I hide the truth and say its marital issues. Then she said but I am now tired of this because the drugs finish before time. Sometimes I am given drugs for two months but because we are sharing, the drugs finish within a month. I then stay for the whole month without medications waiting for the date that I was given." (VHC FGD, rural)

6.6.2 Violence and reproductive health

Other reproductive health consequences appearing frequently in the young people's FGDs included abortions, pregnancy and frequent childbirths. Unsafe abortions were a recurrent theme in the discussions with young people and perceived to be very common with many young girls reported to be dying from abortion-related complications. Mothers of girls who become pregnant were particularly blamed for encouraging and performing abortions, and this was seen by many girls as a form of violence in itself. Where abortion was not sought the dangers of childbirth complications were recognised.

"Mothers in these houses are responsible for these things. They ask you, are you pregnant? Its better you abort this pregnancy. They may force you to abort against your will... She tells you here are the drugs, abort this pregnancy." (Young women FGD, rural)

"But these parents who are aborting their daughters pregnancy ah! (Chorus) they are increasing tremendously. In this village there are so many." (Young women FGD, urban)

6.6.3 A link between violence and psychological ill-health

Violence was also associated with psychological symptoms or distress in all the FGDs and interviews conducted. The symptoms included depression, anxiety, fear, suicidal ideas and

attempts, loss of appetite, drug and alcohol abuse. In many cases, suicide attempts, alcohol and drug abuse (in particular cannabis or "*chamba*") were perceived as means of escaping violence.

Health care workers explained that they felt there were many women presenting with psychiatric problems who had violence as an underlying factor. Health conditions such as hysteria, fainting attacks, depression and minor illnesses of unknown origin were cited as examples of psychological complaints. Patients who experience severe IPV-related psychological symptoms were felt to have been misdiagnosed. In some cases women were prescribed psychiatric treatment. A health care worker working in the medical department confirmed that she had referred some women to the psychiatric department during the month the interviews were being conducted.

> *"In another case, the husband was very violent. The woman had severe depression and she presented with symptoms like meningitis but later it was discovered it was violence." (HCW II, hospital)*

A GBV service provider felt that many people in Malawi are depressed but it seems no-one knows how to handle them

> *"Do you know that most Malawians are depressed but no-one knows what to do? They just resort to go to church. You need to see a profession who will assist you. I think there is more. There should be more because intimate partner violence the dangerous part of it is that it is psychological. It is because you are abused, beaten somebody whom you love. You know that's the confusing thing" (Female GBV service provider, KII)*

Fear and anxiety generated by violence was another dominant theme among female participants. Many participants said women in violent relationships live in a continued state of anxiety and uncertainty. They are always occupied with what would happen next, what would be the reaction of their husband.

> *"Sometimes it makes us speak a loud as if we are talking to somebody else. As if you are exchanging conversation with another person. It is not because of other reasons but violence in our relationships. You are always anxious and full of fear, thinking how he is going to receive me when I arrive home, what I am going to experience, how things are going to be. " (Olderwomen FGD, rural)*

6.6.4 A link between IPV and physical health

Physical problems associated with IPV were mentioned primarily by health care workers and triangulated well with findings from the community FGDs and individual interviews. The physical manifestations described were both as a result of physical and of sexual violence. These included: loss of consciousness, bleeding, fractured ribs and arms, split eyelids, swellings of the forehead, bruises aches and pains, deep wounds, genital injuries; vaginal tears and cut penis and abdominal injuries, loss of body function, loss of weight, high blood pressure and death.

Interviews with health service providers working in the reproductive and out patients department s revealed that many patients with suspected IPV reported with injuries in anatomical locations close to the genital areas, such as inner thighs. They perceived that this was because many cases of IPV originate around quarrels over sex and extramarital issues. Specific cases involving genital injuries were mentioned in all the FGDs and interviews. In one community where sexual abuse in the form of 'finger insertion' was said to be prevalent, an example was given of a woman whose vagina was torn because her husband had set his hand into the vagina; the woman sought health services but lied about the cause of the tear at the hospital.

> *"This is a big problem. A certain man tore his wife's vagina... He inserted his hand into the vagina. The whole hand entered up to the wrist. By the time he was removing the arm the vagina was torn. Why? Because he wanted to check the moves of his wife... The man removed her shirt and used it as a sanitary cloth and took her to the hospital. At the hospital the wife cheated the health care providers that she fell from a tree." (Elderly women FGD, rural)*

Health providers in the reproductive health department cited a recent death of a woman whose death was mistaken for a maternal death but examination of her body revealed that she might have died of strangulation. The case was inconclusive since guardians refused a post-mortem, saying that they did not find helpful considering that life was already lost.

6.6.5 A link between intimate partner violence and harm to children

The data reveal a number of perceived links between parental IPV and child health. Violence against children was perceived as extremely serious by all participants. As well as highlighting the seriousness of child rape, participants reflected on the interwoven nature of different forms of violence that children experienced. Violence was said to affect the health

of children both directly and indirectly. The main areas raised were that children raised in violent homes were said to be emotionally neglected; at risk of malnutrition; direct physical violence and sexual abuse.

Participants explained that children are very much affected by violence in relationships; even though they are not being beaten. They may be neglected and cannot go to school or may drop out of school. It was said that children growing up in violent homes tend to develop fear towards their parents and may find it difficult to request essential things out of fear. Witnessing violence may result in poor concentration and poor performance at school as they may be pre-occupied with the thought about the violence they have witnessed: may be thinking about the injury one of the parents has sustained, trying to figure out the cause of violence.

The psychological impacts of violence on children included engaging in anti-social behaviours such as running away from home and engaging in prostitution. It was said that children growing up with a violent father may associate his coming home with violence and may develop a negative attitude towards him. Fighting parents were also thought to be a great shame to their children. One of the young women in a FGD commented:

"It's very shameful to watch your parents fighting everyday and for people to watch them fighting every day. The person that feels more ashamed is the one that is not involved in the fight... in such cases you feel like you can do anything even prostituting making things even worse. Many children have gone astray because of such situations. Most of the street kids come from unstable marriages; they start stealing and prostituting" (young women FGD, urban)

Certain forms of violence such as wife abandonment, greed, family neglect and financial or economic abuse were closely linked to child malnutrition.

"Sometimes parents may not be able to meet the needs of children. If they are not talking to each other the man might just leave in the morning without leaving anything for the children to eat." (HCW II, health centre, rural)

In one of the interviews a health care provider suggested that targeted screening be conducted with mothers of undernourished children. Direct violence was also reported. In the following quote the health care provider talked about a baby who was injured during physical IPV and serves as a typical example of direct consequences of IPV on the child:

"So violence may lead to harm to children like in that case disagreements between the parents led to harm to the baby. […]." (HCW II, hospital)

Cases of child sexual abuse linked to parental IPV were directly reported in two individual interviews. One involved a step daughter who had learning difficulties and the other involved a sister-in-law. The motivations were not clear from the interviews. In addition interviews with a GBV service revealed that one of the factors related to increasing cases of incest in recent years has been fear of HIV infection. Some women who are accused by their husbands for failure to meet their sexual desires resort to giving their daughters to their husbands in trying to please the husband.

"They fear that the man will get HIV outside the home so they would rather keep him in the house so it's like if he is not satisfied with his wife then the wife would say then you can sleep with the daughter... but then that does not prevent a man from sleeping with other women outside the home so you find that there is a whole vicious circle where the women contracts HIV, the daughters contracts HIV and the man is HIV-positive" (Female GBV service provider KII, urban)

Interviews with survivors confirmed that IPV co-existed with child rape and physical abuse. Cases of other forms of abuse were revealed in three of the seven interviews conducted with female survivors. These were sexual violence cases that involved a domestic servant, the young sister of the survivor and an epileptic step-daughter. In another case, the biological daughter was physically and verbally abused by the father. Male survivors reported child neglect and acts of physical violence directed towards children. This woman describes the effects of violence on her daughter.

"I think one of my children has been mentally affected. Sometimes when she is quiet you see tears falling down from her eyes. When I ask her what's wrong with you. She says nothing. So I know that it's something to do with issues within the family. Her father says she doesn't resemble him and because of that he claims that she is not his daughter. He says this in the presence of the child... she was saying that if I was a witch I could have killed my father... Her father said that he dreamt her bewitching him. He grabbed her and undressed her and told her I will beat you and throw you out of this home. You are going to sleep outside naked if you don't reveal the person that sent you to bewitch me..." (Female IDI 3, urban).

6.7 Summary

This chapter has presented types and perceptions of intimate relationships, definitions and perceptions of violence in relationships, outlined the perceived magnitude of IPV, the range of forms of violence, the perceived causes of violence and perspectives on violence and health.

Various forms of intimate heterosexual relationships in Malawian society including pre-marital, marital and extra-marital relationships were described. Virtually all types of intimate relationships were described as potentially violent. Results of this analysis revealed that older participants perceived that marital relationships made women more vulnerable to IPV than other forms of relationships, and that the risk was even higher in 'eloped' (define) relationships compared to ideal relationships. Young people's experiences of IPV were underestimated by the older groups and services. There was also an expectation for women and girls to 'endure' violence, as a part of life and relationships.

The gendered perspective to IPV is contested in the Malawi setting resulting in mixed feelings about the magnitude of IPV against men (IPVAM) and IPV against women (IPVAW). However, the majority felt that more women than men experienced IPV. Power differences between men and women interacted with cultural, religious beliefs, economic and structural factors to produce women's vulnerability to IPV. A minority of participants (mostly men) argued violence does not need to be distinguished from a gender perspective. The study also showed some tensions with the human right perspective as they are blamed for increased unstable marriages that are likely to expose women particularly young girls to increased violence. Men blamed human rights organisations dealing with gender issues for turning women into men and for biased service provision that neglected the needs of men.

The chapter has also presented a range of behaviours which were described in the interviews and FGDs as forms of violence from femicides to neglect and deprivation. Other forms perceived as violence include use of love potions, infecting a partner with sexually transmitted infections and particularly HIV. These have been mentioned separately because they are not often described as such in the literature. Many of these occur concurrently and over a period of time.

Findings have also demonstrated high levels of concern about the potential health outcomes of IPV. Participants mentioned various adverse health outcomes including unintended pregnancies, abortions and risk for HIV and AIDS, interference with family planning, mental

health consequences and poor child health outcomes. HCWs too narrated different scenarios where they had encountered medical conditions that had IPV as an underlying factor. Some of the cases were wrongly diagnosed and treated before IPV was recognised. In some of the interviews HCWs even felt that health care services are populated by individuals reacting to domestic issues. Violence was generally perceived as a painful experience that turns marital relationships into a kind of slavery or prison for the survivor.

Having reviewed the legal and policy framework for IPV in Malawi (Chapter 5) and gained a deeper understanding of the perspectives on IPV at community, individual and service provider level (Chapter 6) the next step is to explore help-seeking options (Chapter 7). In view of the demonstrated links between violence and health a focus on understanding the interactions with the health sector is required. Bringing these three areas (legal/policy; community and individual perspectives and service responses) together will then allow for a triangulated understanding of potential context embedded and relevant interventions that will be discussed further in Chapter 8.

Chapter 7: Perceptions of IPV services in Blantyre, Malawi

7.0 Introduction

This chapter develops an understanding of the 'what next' after IPV has occurred or is occurring. It explores perceptions and experiences with informal and formal sources of support for IPV, considering the barriers and enablers to help seeking (section 7.1). The role of different actors including the actual and potential role of the health services is specially examined from the point of view of survivors, communities and health care workers (section 7.2). Routine record review data from a tertiary referral hospital are presented as a case study (section 7.3) in order to further define the potential and actual health services responses.

7.1 Help seeking options including barriers and enablers

In all the interviews and FGDs people described various sources of help for IPV categorised into informal and formal sources of help. All survivors and fewer FGD participants spoke of their experiences with these sources of help that took place during and after their abusive relationships. The majority used informal sources: family, friends, and neighbours, marriage counsellors, religious leaders/church; and traditional leaders—and a minority used more formal supports such as health services; the legal system, police and the courts. The role of the '*nkhoswes'*, traditional leaders and police were revealed as paramount.

7.1.1 Informal sources of support

7.1.1.1 Family support

The role of the family in supporting survivors of IPV was generally appreciated by all: mother's brothers, sisters, in-laws and grandparents were commonly mentioned as sources of support. In some of the cases, support from relatives was offered without being solicited. In one of the Female FGDs, a participant indicated that relatives may enquire about violence if they suspect that something is not well.

> *"Some courageous relatives may even ask you 'Are you sick?' You say no. 'OK but what is eating you away? Are you at peace with your husband?' When they ask you like that you remain silent for some time because you can't just respond... you pause a bit thinking how best to respond to that question, should I disclose that he is violent? Now if the person you are dealing with is an elderly person, he understands that in your silence... you have communicated." (Young women FGD, rural)*

Examples of positive support from relatives were given in both male and female in-depth interviews. Four said they were sheltered by their own relatives either following divorce or when they needed shelter for safety. Female survivors who required health services had their mothers escorting them to the hospital and police to seek help. In some of the instances family rushed to diffuse the anger between the couple or rescue the survivor. A female survivor recounted how her husband's uncle reported his nephew to police after he severely beat her

> *"He beat me again in Zomba... His uncle told him this is Zomba...I will send you to jail... His uncle reported him to police he told the police he is my nephew but he started this behaviour long time ago." (Female IDI 11, urban)*

Negative encounters with family, lack of family support and/or distrust of family, were also encountered by many as this quote illustrates:

> *"His brother had nothing to do with us. When he heard that my husband was beating me he just said: 'It's up to them. This is what they wanted." (Female IDI 3, urban).*

These experiences left the interviewees reluctant to turn to family members. One of the survivors who expressed that he was still in love with his abusive wife and kept returning to her felt that relying on relatives to come and sort out violence–related issues has proved a challenge for him because of the repeated nature of violent behaviours followed by conciliation. Relatives withdrew their support because they got tired of resolving the same problems.

For young people consulting parents for support was not considered an option. Many girls said they were too scared to disclose violence to their parents for fear of a negative reaction. Boys shared similar sentiments about even disclosing they were having a relationship. Both girls and boys complained about a lack of open communication between them and their parents, particularly on sexual issues and expressed a desire for more opportunities to communicate to help them develop. Other authority figures such as teachers were not trusted because of their own involvement in sexual violence and abuse.

7.1.1.2 Marriage counsellors

The important and culturally sanctioned role in conflict resolution of those family members designated as marriage counsellors was widely recognised in all the FGDs and interviews. Most participants viewed them as their first point of contact. It was said that the right

approach to IPV was to first approach the *nkhoswe*. Their roles were perceived as conflict resolution, building marriages and promoting behaviour change in the perpetrators; which at times requires instituting some measures of punishment. They worked in the best interest of children's welfare. It was also mentioned that formal sources of help could refer survivors back to their *nkhoswe* for mediation. A female interviewee described the characteristics of a good *nkhoswe* as somebody who should be able to handle each problem that has been referred to him/her because they were chosen out of trust. He/she should be mature and shouldn't be jealous. These sentiments of the survivors were shared by many participants in the FGDs who felt the success with the system depended on the wisdom of the *nkhoswe*. Little was mentioned about the lack of training or support systems for the *nkhoswe* in fulfilling difficult roles.

Emphasis on the role of marriage counsellors during many of the FGDs was focused on their role as marriage builders and not destroyers. Many participants explained that marriage counsellors are not there to destroy marriages but to unite couples. Other sources of support were to be approached if the *nkhoswes* failed to resolve the conflict. A participant who disclosed that his son was once a victim of IPV commented:

> *"Like in my case, my son was in such a situation, so I talked to him to follow the right procedure, by going to the marriage counsellors' but the counsellors failed to sort out the problem and he just resorted to go to victim support unit." (Elderly men FGD, urban)*

Procedures for reporting IPV to *nkhoswes* and resolving conflicts were described. Participants in the FGDs said that the person who is wronged is supposed to present his/her complaint to the marriage counsellor of her/his partner. Then the partner's *nkhoswe* will invite the *nkhoswe* from the abused partner or complainant to a hearing. Both partners are given a chance to explain their side of the story beginning with the abused, marriage counsellors are then expected to cross-examine the stories, draw their own conclusions and come up with possible solutions that may help the couple to stay together. Reconciling the couple was the ultimate goal of the counselling couples received from the *nkhoswe*, followed with an observed period for change of behaviour. If violence persists then *nkhoswe* may refer the couple to the village headman or victim support unit depending on the individual situation.

Divided minds existed over the effectiveness of *nkhoswe* in dealing with IPV, with the majority feeling that they were less effective. Some participants felt that marriage counsellors were poorly equipped to handle complicated issues like violence which are considered police case. This was put down both to deliberate taking of sides and to lack of skill, training and support for a difficult role that often resulted in burnout.

Despite the sanctioning of their cultural role the majority of participants felt that advocates may deliberately or unintentionally cause harm either through fostering their own agenda as relatives of one party or through lack of skill and support in dealing with complex counselling issues. Marriage counsellors were blamed for failing to genuinely represent the interests of the couple and for seeking to advance their own agendas through the couple. This mentality was described as "a stand for myself mentality". In an FGD with males, marriage counsellors were likened to Chinese products [fake]. Some participants felt that some marriage counsellors would keep grudges against the woman if they perceive her to be blocking them from accessing what they want from the family. As such, they fail to administer justice accordingly because they may use it as an opportune time to get rid of the woman. Marriage counsellors were blamed for siding with their relatives even when it was thought to be obvious that they were wrong, and for encouraging women to endure very difficult situations. Women said that their complaints are downplayed by the nkhoswe:

> *"We are ignored. They don't take our complaints seriously. So I feel these marriage advocates are not helping us". (Older women FGD, urban)*

Marriage counsellor burnout was perceived as a major stumbling block for help-seeking in situations of recurrent violence. Participants explained that *nkhoswes* would gladly assist when you approach them for the first time but repeated visits to nkhoswes were met with negative outcomes. Participants talked about *nkhoswes* tiring easily especially after repeated visits:

> *"You know sometimes we have difficult men. When you go with an issue the first time to the marriage advocate, they try to help. If you go again with the similar issue after a month, the nkhoswe gets tired, and actually mentions it openly to you that you are troubling us. This is too much we are out of it because you are not changing. It is up to you to stay together or not but we are not involved anymore, so we feel that they have failed. "(Older women FGD, rural)*

These attitudes in turn left participants feeling dissatisfied with the help received from counsellors as the following quotes show:

"The first time I experienced violence in my relationships people proposed that we engage our marriage advocates but things didn't change. My satisfaction was short lived. I saw some temporary change in my wife. I reached the stage that I gave up taking issues to marriage advocates" (Male IDI 5, urban)

"I got very angry. I think that was time that my marriage should have ended. My marriage and his marriage advocates came. I told them this is the end of this marriage but he used threats. The marriage advocates were also afraid to endorse that the marriage should end. As a result the marriage advocates were apologetic. Please forgive him, such things do happen go back he is your husband they were saying all this because of his threats" (Female IDI 3, urban)

Wealth inequalities between the perpetrator of violence and advocates were seen as another factor affecting the marriage advocate system. A survivor who was married to a prospering business man felt that men who are economically empowered look down upon their advocates who most often are lay people from the rural areas. Thus marriage advocates felt less able to handle conflict. In the following quote a survivor narrates how this disparity played out in her own marriage:

"If I reported the issue to my husband's relatives, his marriage advocate would say I am unable to solve your marriage problems because your husband doesn't listen to me. When I took the issue to my relatives, my husband posed big to them...and you know if you are coming from the village and you are dealing with somebody who lives in the city, somebody with money and a car, you know there was nothing that my relatives could say. He disrespected my marriage advocate" (Female IDI 1, urban)

Urbanisation has strained the marriage advocate system even further. This was particularly true for couples residing in urban areas, away from their relatives. Participants in urban Blantyre felt geographically delinked from their traditionally designated sources of support. Distance was perceived as an obstacle for accessing help. Participants cited lack of transport money to get back to their villages or to call people from their village to come and assist them.

" It's difficult to complain to the marriage advocate because he is in the village and it's difficult to get money. If my husband is failing to supply some of our needs here it is very difficult for me to get 800Mk to go and get my marriage advocate from Zomba." (Female IDI 2, urban)

Similarly another woman said:

"I did not report to our marriage advocates because they are in Nsanje and that's where both of us come from." (Female IDI 6, urban)

7.1.1.3 Prayer and religious leaders

Some of the key informants reported that they have noticed that many people are turning to churches with violence issues. Participants and interviewees who self-identified as Christians; and those who believed that violence had a demonic origin perceived that prayer was the first strategy to overcoming the problem. While acknowledging the role that many people, including marriage counsellors, have in reconciling the couple, they felt that they are also human beings; as such they may have their own challenges which could make them fail to give effective help. They said many believe that violence as a behavioural problem may perfectly be dealt with by divine intervention and transformation of the spiritual life of the individuals concerned. Others noted a common teaching during pre-marital religious counselling which discouraged newlyweds from consulting *nkhoswes* with marital problems as they have their own problems. In the following quote a participant explains why pastors are his first choice in terms of help seeking for violence:

"For me a person whom I can tell without difficulties is the one who knows the Lord...I sometimes go to the pastor...the first thing I go to the man of God to explain my problem before going to a marriage counsellor...because whatever he is going to help me with will be accepted both in heaven and earth" (Older men FGD, urban)

The following quote describes how prayer works to reduce violence:

"I would say that the first thing is to pray. Ask God to deal with your situation. Sometimes you get the answer there and then or God gives guidance to approach the right people that can help sort out your problems." (Male IDI 8, urban)

Female survivors explained that they drew their strength from prayer. Two women who had their cases appealed in court talked about going to the mountain on every Saturday morning for prayers and fasting; asking God to help them get justice done.

Seeking help from women and men of God had its own pitfalls too. A woman who explained that the wrangle between her and her husband stemmed from her husband's desire to have a male child following tubal ligation and resorted to prayer hoping that God would open her womb once again. She told of how the prayerful woman she regularly consulted started an extramarital affair with her husband and ended up getting married to her husband.

Other participants in the focus group discussions felt that the role of church and religious leaders may be limited to only those that attend such forums. They recognise that there are some people who may not belong to any denomination and those need to be reached as well. Marital vows were raised in one interview as hindrances for some women to exit violent relationships. However, this was not discussed further in the interview or FGDs.

7.1.1.4 Friends and neighbours

The role of friends and neighbours was prominent in most of the survivor's accounts of violence despite the fact that many FGD participants and some survivors were sceptical of telling others about their experiences of violence.

Young people in particular turned to close friends who were trusted with their secret information and often acted as go-betweens in their relationships (see section 6.1.1). The majority of young people interviewed explained that they share their experience of violence with trusted friends. Although peers provided valuable support, they shared confusion about the acceptability of rape within relationships. Some of the participants admitted that when confided in they are unable to offer tangible advice. Others expressed dissatisfaction with the help they get from friends.

> "Your friends will say you refused him that's why he has done this to you. It's good that it has happened like that next time you need to discuss properly (all laughing)...We expect them to help us, maybe lead us to somebody who can assist only to be told that that is what a relationship is all about. It's disappointing because if we knew that this is a relationship we couldn't have bothered to approach her to assist. It's like she is pushing you deep into the trench." (Young women FGD, rural).

Help from neighbours was frequently associated with severity of violence. Neighbours were likely to intervene when they perceived violence to be severe, and when violence was disclosed or witnessed by them. In many of the survivor's narratives, neighbours assisted in the immediate aftermath of the violent episode especially where injury or life was endangered or where mediation was required but counsellors were inaccessible. These neighbours or friends played many roles including that of mediation, advising or encouraging survivors to seek help from relevant sources and calling for police help in times of danger; providing the survivors with food supplies and in rare cases they helped by giving transport money so the survivor may escape.

A male interviewee narrated how his female neighbour was the first to arrive at the scene and managed to call for police intervention

> *"She heard the noise of the house trembling coming out from our room. She rushed to see what was happening. When she came she found me. I called her to come to see then she said no I will call your fellow men. Then the men came to see me. Then they took me outside, I was in bad situation. Other charcoal sellers came running when they heard about my situation. The charcoal sellers at the market saw a policeman passing by, they called him and when he saw my situation he called for police car". (Male IDI 9, urban)*

Another male survivor talked about how a female acquaintance helped him seek help from a community based organisation (CBO):

> *"A certain woman stays up there. She receives same medication as me. When she saw how I was treated in my family, suggested that I should go and complain to the organisations. I thought people have advised me, should I just remain silent; hide these things, that's when I made the decision to go" (Male IDI 10, rural)*

Similar stories were told by the female interviewees. One remembered receiving 200MK (less than 50 British pence) from her husband who had deserted her for over a week, leaving her with nothing to eat with their children. Her abusive partner impregnated his step-daughter; and went on the run fearing police arrest. His disappearance meant that she and her children had to starve since the breadwinner was not there. She recalled how female neighbours intercepted him and pleaded with him to support his family after he briefly

showed up at his home, sitting on the veranda of the neighbour's house and disappeared without leaving her with anything.

> *"As he was going some of the women called him, please would you come they told him. You know this woman is suffering together with the children. She has no food. For her to eat with the children we have to give her maize to mill and give her some flour in a basin. What are we going to do? Why can't you provide transport for her to go to the village? She is suffering very much. She has become our burden we have to feed her yet you are just wondering." (Female IDI 2, urban)*

A similar story of wife desertion, subsequent reliance on neighbours and women interventions was told by a woman in an in-depth interview. Her husband packed his clothes and disappeared for a week leaving her with nothing. She told how as a pregnant woman she had spent four days on an empty stomach and fainted as a result. Neighbours, particularly female neighbours rushed to call a man who assists people to deal with marital issues. She also told of how women gathered at her house with the intention of beating her husband

> *"There were several women at my house and these women had ganged up to beat my husband... The women asked him, tell us why are staying at the market? Are you not aware of what happened here? He answered I know. Why are you doing this, they asked him. This is my wife. Whatever can happen here is none of your business. Just leave these things; I am the one that pays rent for this house. The women said let's sit and talk because if your wife has reached a point of collapsing it means there is a big problem here. He answered them I am washing my hands over this woman's issue (telling the women). From today onwards you are going to be responsible for this woman why are you accusing me of extra marital relationships when i have never been involved in that. He refused having extra marital relationships yet he was caught red handed." (female IDI 6, urban)*

Perpetrators' challenging attitudes and survivors' merciful or loving hearts were perceived as obstacles for neighbours to effectively help survivors. Lack of trust with the information received from the neighbours was the other. It was commonly said in the FGDs that friends may give wrong advice because they are eyeing the same man so they want the survivor to divorce to snatch the man from her.

City life made help seeking for IPV even more difficult. One survivor in urban Blantyre described life in the city as a sub-culture that is completely detached from the communal life of the village or rural areas. Another of the survivors explained that in the rural areas there is social cohesiveness. Families are surrounded by members of the extended family who can quickly come and intervene in violent situations. He explained that people in the city lead an individualistic life style, where each one minds their own business. In one of the interviews a survivor likened life in the city to life in a jungle emphasising the lack of available social support:

> *"It's difficult for neighbours here in town to know the violence you are experiencing in your family. In the village it is easier; uncles are there, staying very close to you. Here in town we are like living in a jungle...people in the city are town men, they have learnt the city culture, and everybody minds their own business." (Male IDI 9, urban).*

7.1.1.5 Traditional leaders

Traditional leaders in their various capacities: chairmen (ruling party chairmen or chiefs assistants), neighbourhood watch, village head men and traditional authorities (see section 3.1) were cited by study participants as points of referral for family issues including IPV. The role played by traditional leaders in violence prevention was acknowledged by many in the FGDs. Some of the survivors also reported having contacted or being summoned by the traditional leaders over IPV. The different categories of traditional leaders seemed to work in close collaboration with the village head; and the traditional authorities were superior to the village heads. Neighbourhood watch was more applicable in urban and semi-urban locations and was associated with helping with violence that erupts during the night. Chairmen were often described as village head men's assistants and were first approached with issues of violence before the cases were referred to the village head man.

The role of the village head was not very distinct from that of the marriage counsellors. Participants explained that the village head gives advice and encourages behaviour change. They also don't have the power to dissolve marriages. However, the village head had power to write referrals for police intervention and to charge the perpetrator with wrong doing. Participants indicated that the chief receives referrals from marriage counsellors, chairmen, community victim support units but sometimes survivors can go directly to complain to the chief especially where other point of referrals are non-existent. They also receive back

referrals from the police. Some rural women perceived help seeking from the traditional leaders as a reflection of the change in the way IPV is being perceived; that is moving IPV from [419]the domestic sphere and making it a public issue. Women said when things reach the point of seeking help from traditional leaders it means, violence or conflicts have become public; the process which many associated with a lot of shame.

> *"When marriage counsellors feel that there is no change they give you an okay to take the issue to the chief. This now becomes an open thing because he has refused to heed to the good (in-house mediation). This brings a lot of shame because it is made public." (Elderly women FGD, rural)*

The photo below shows a public hearing of a similar case that had been taken to the chief in Ndirande.

Figure 7.1 Traditional hearing

Photo by Diana Cammack

The traditional authority was perceived to be the last person in the line of authority in the traditional point of referrals. They have more powers than the village heads, they receive

referrals from village head and can dissolve marriages but with consent from either or both of the partners. Women emphasised that the power to end a violent relationship or marriage still is left to the survivor.

> *"Even the traditional authority does not end somebody's marriage but the concerned parties do. There is a question that is asked, these issues have passed through many forums at home, and that now you are here...if the woman has felt too much heat she has the power to end the marriage" (Elderly women FGD, rural)*

There were mixed feelings about the effectiveness of the traditional leader's interventions in violence issues. Some of the participants explained that the village headmen's interventions were helping in reducing violence. They noted that men are thinking twice before acting violently against their partners.

> *"The judgement from the village head is good especially for those who understand it. Other men are indeed stepping back from violence because they are afraid of the judgement although some men are still resisting it" (older women FGD, urban)*

Communities that reported that the police was far away from them felt that reporting violence to the chief was more convenient because of accessibility

> *"The village chiefs are also helping us in the villages. Sometimes it may happen that there may be a man or a woman has experienced violence and the victim support unit is far away people just go to the chief, my husband has thrown my pot away, and he beat me yesterday and made me sleep outside" (older women FGD, rural)*

Some problems with seeking help from the chiefs were highlighted. Public hearing of domestic violence issues was perceived as an obstacle for help seeking from the village headmen. Other participants indicated that the chiefs are less useful because of the government involvement [police victim support units] in domestic violence issues. They push every single case to the police instead of trying to resolve some of them in the village. Traditional leaders were also blamed for being lenient with perpetrators; for being inconsistent in their judgements. Corruption with the traditional system was blamed for perverting the course of justice. A group of young women expressed their dissatisfaction with the traditional leader's judgement:

"We are not satisfied... they charge you MK1000 so that your case can be judged appropriately. Without money your case will not be judged rightly. This means that you are going to continue suffering. Those with money receive justice and their relationships are sustained. If you have money justice flows like water if you don't 'zako zada' meaning you are doomed" (young women FGD, rural)

On the other hand, one woman in a different FGD in the same area as the above participants reported that their village headman was a corruption-free person. He was very tough on corrupt practices and does not engage in corrupt practices. She explained the traditional leader demands *'chabwalo'* chief court fee which is a legally bound fee for hearing cases. Other participants in the group did not argue against or for. The moderator did not probe separately to find out whether the participant was related to the traditional authority or she herself may be one of the chief's helpers.

Some of the survivors had made contacts with the traditional authorities over IPV related issues. In the case of one female survivor IDI, neighbours report them to the chief for fighting when there was a funeral in their neighbourhood. The chief charged her husband a '*chindapusa*' (stupidity) fee of MK5000 for beating his wife. Failure to pay required that they from the area for being violent. Her husband chose to move away from the village and rented in a different location within city, detaching the women from her social network.

Another interview participant registered her disappointment with the traditional leader's judgement after he decided to forgive her husband who had beaten her during pregnancy. She explained that in the traditional leaders ruling he considered the fact that she was heavily pregnant, that she could go into labour at anytime and that she needed support.

7.1.2 Formal sources of support outside of the health sector

7.1.2.1 Organisations dealing with GBV

Generally, knowledge of organisations that deal with GBV was poor among participants largely because these organisations were inaccessible both in the urban and rural areas; and the role of organisations on matters of IPV was perceived to be newer. Young people's FGDs mentioned a general lack of community-based organisations dealing with violence, explaining that most community development programmes communicate primarily with elders who may have limited understanding of the challenges young people face. In general participants were more confident to talk about CBOs that were dealing with HIV than GBV.

In certain areas women mentioned that such organisations once existed but they ceased their interventions due to lack of funding. In many cases organisations were associated with the city. In certain places, participants said they only hear about these organisations they don't know who they are, what they do or where to find them. However, they voiced a need for GBV organisations. These organisations were requested to fill in the gap in the counselling needs of couples.

> *"There should be organisations that can help us on this. We just hear that there are organisations but we don't know where they are. So instead of going to police, we can go there and get counselling from those organisations... So we wish if there were many such organisations. Maybe if such organisations were increased maybe abuse would reduce"(older men FGD, rural)*

Lack of knowledge about GBV services was a cause for failure to seek help. Lack of familiarity with the city and its services acted as a hindrance for seeking help.

> *"When we saw that we felt that the police were less helpful so we felt like we should go to the organisations because we perceived that the police knew something about it. But we have moved from Makheta and I am new to the city so I couldn't" (female IDI 11, urban)*

Three interviewees, one man and two women, did seek services from NGO/CBOs. In all these cases NGOs/CBOs were the last to be approached. The first made contact with NGOs when her husband reported her to one of the NGOs for child abduction. The second came from a patrilineal society where children belong to the father upon dissolution of marriage. Upon separating from her husband she went to her children's school and ran away with her children and hid her children. Her husband accused her of child abduction and she was called by the NGO. Similarly, the third survivor had problems with access to children and maintenance. She sought help to allow her to see her children and receive maintenance support from her husband. She recounted visiting another organisation to help her appeal her case with the high court after she felt let down by the magistrate rule.

Talking to leaders of some of the NGOs based in Blantyre revealed that many are struggling with getting funding for GBV activities. Many listed gender violence as secondary activities, others talked about mainstreaming GBV in their programmes yet others talked about shifting their focus slightly to empowerment, reproductive health and literacy programmes. During

the interviews examples of NGOs who were failing to operate due to lack of funding were given. Providers explained that their activities are donor-driven, which limits the extent to which organisations can operate based on their passion and need. This service provider perceived donor dependency as a major obstacle to implementing programmes:

"Most of the times when you are depending on somebody else's money you don't fulfil what is at the centre of your passion. I can say, we are donor driven and that is our big challenge. Really in the city I wish I would work even with girls on the streets. I wish I would really reach them. How would I incorporate them? I tell the young people in the organisation please write some projects to try and reach the 14 and 15 year olds that standing along the road at Kamba it's really a problem" (Female GBV service provider, KII,)

Many participants were optimistic that if organisations could engage with the community more people would seek help for IPV. One of the male survivors had a personal connection with this idea. He felt that getting outside help or having outsiders to come and talk to them over their problems would probably help to save his marriage. He observed that relying on relatives to come and sort out violence related issues has proved to be a challenge because of the repeated nature of violent behaviours. He said his relatives do not consider the love he has towards his wife. The majority of participants voiced concern over issues of privacy on matters that concerns violence in relationships. Some participants explained that organisation should establish a private room within the community where individuals could be heard in privacy if issues are held in public then people would not be free to talk about their issues. Some suggested that a similar set up be made at the hospital like they do for HIV testing and counselling.

"If those organisations are established they have a room where someone can go and share his concerns to be helped individually. That's people can be helped but for people to do it in a group while everybody is seated... that's what we have already said that people fail to reveal for they are laughed at and they become ashamed" (older men FGD, urban)

Some participants felt that existence of these organisations will promote disclosure among survivors because many women especially in the village fail to report abuse because they are scared of police. They said some village people think that once violence is reported to police, their spouse may be arrested

218

"For people to get to police, they are scared of course. Some village people think that if i go to police my husband will be arrested its better for me to leave it just like that...most people are afraid to report to the police"(older men FGD, urban)

Some participants suggested that some tough measures needed to be put in place to curtail violence. However they felt that institution of tough punishment should go together with establishing mechanisms for thorough investigations of cases of violence.

7.1.2.2 Police

The role of police in IPV was highly recognised with spontaneity in all the focus group discussions and interviews conducted. There was a general consensus that police through its victim support units were offering tremendous help to survivors of domestic violence. The exception to this was among young people, who were aware of the availability of services such as police victim support units, but did not feel these were appropriate sources of support for them.

In some of the communities participants reported that police was the only GBV service they knew about. In recognising the efforts police services had done in engendering its services, one of the GBV service providers recommended that health services ought to learn from police on how they ought to handle violence. Some participants in the focus groups reported having accessed the services at one point yet others said they have heard about the services. Several referral pathways were described including self referral, marriage counsellors, community victim support units and the village head man referral.

That the police have a role in violence issues was clear:

"Violence is an issue for the police... The police know that this person is violent; we should assist in this way to reduce violence..." (Female IDI, urban)

However, people's expectations of what the police should do are quite varied and sometimes a bit confused. In the following quote a health care worker comments on the magnitude of cases of domestic violence police attend to:

"We will be overwhelmed if we put that for victims of domestic violence because the victim support unit that's all they see. They see lots and lots of cases for domestic violence" (Male policy maker, II)

Women were specific about the cases that can be brought to the attention of the police. Some women explained that domestic violence and rape cases are criminal cases so the police have a mandate to intervene in such situations. Some noted that it's not all cases of domestic violence that reach the police but those involving fighting, perceived to be severe and where injury has been sustained. Participants and interviewees explained that people go to police with domestic violence issues for several reasons but the primary reason was to get permission to seek health services. Survivors perceived this to be an important role of police and also as a means for the seeking of justice. The need for hospital referral letter, desire to have the perpetrator punished and hope for referral to relevant organisations were some key motivating factors for accessing police intervention.

> *"Go to police (all laughing). Because you haven't succeeded after going to the chief therefore just go to police so that he can be punished a bit... beat the person (laughing)" (Female participant, community FGD rural)*

Four of the seven female survivors interviewed had made contact with police in relation to violence in their relationships. Three of them contacted the police for help whilst one of the survivors was taken by police to answer charges levelled against her by her husband. Many survivors explained that police helped them in a number of ways. All women who reported to police with violence related injuries except in one incident were given a referral letter to seek health services and were advised to report back after treatment. Survivors reported that police routinely responded to their complaints by giving them a referral letter to seek health services, advice to report back after treatment and inviting perpetrator to report to police for mediation.

Some reported that the police seemed to be more compassionate before the women sought health services but their actions following health service intervention varied. In some cases perpetrators were invited for negotiations at the police station. Sometimes women were asked whether they wanted their husbands to be locked up. Mediation appeared to be the key police intervention. However, this was at times contradicting with the expectations of the survivors. Two of the female survivors felt that there was a mismatch between their expectations and the corresponding police action. This they said was despite the fact that they made it clear to the police what action they (survivors) expected the police to take. Many women felt that police were less helpful because they never took heed to the women's voices and seemed to care less about the welfare of the survivors.

Stories of delayed action from the police were clearly stated by survivors. In some of the interviews police were accused of making promises that they never honoured

> *"I thought was I crying but soon I realised that it was blood; my upper lid was split... Immediately I took a wrapper, covered myself and rushed to police... In my heart I thought my husband would be punished for the violence he subjected me to. At least some kind of punishment... I wanted the police to arrest him... In my heart I had purposed that he should be arrested. This is the help I was seeking from the police... All I wanted was for them to tell me get on the vehicle, hide here so that you can lead us to your house to arrest your husband...but they kept on telling me, go, we are going to find you but they never showed up. When I went there for the fourth time that's when the police gave me their phone number. From what happened I concluded that the police was less helpful."(Female IDI 2, urban)*

One of the female survivors felt that her husband must have bribed the police to suppress her case. She had strong evidence justifying her claim against the police because her husband frequently drunk with the police. She concluded this after her husband was released from police custody earlier than she expected. She argued that there was no way a person under police custody could bail himself out without any one witnessing his bail. In the case of her husband everyone, including his uncle, refused to visit him in custody. In addition, she reported that her efforts and those of well wishers to find out what might have happened for her husband were frustrated by police.

Some survivors complained that sometimes it took police too long to act on IPV brought to their attention. Women explained that they had to make repeated trips to the police station to be helped. Because of the delayed action some women took desperate action for example seeking the help of the village headman to make sure that her husband should be brought before the police but this did not help either. In some cases women felt that the police prescribed actions which were culturally incongruent. For example, when IDI 2 husband went into hiding fearing police arrest, he used to come home around past midnight. IDI 2 went and informed the police because she had desperately wanted her husband to be arrested for inflicting injuries on her. Instead the police gave her a phone number to alert them of his presence yet she had told them she doesn't have a phone. They advised her to use her neighbour's phone. She explained that she did not request the neighbour to borrow her phone as she felt it was in appropriate to wake up a married woman in the middle of the night just

for a phone. In other cases, it seems police struggled to maintain a balance between the mediation role and that of assisting survivors who they felt were experiencing severe forms of violence. In one of the instances a survivor reported to have been informed by police that they were not there to end people's marriages.

"We are not here to end people marriages neither are we the marriage advocates to build or destroy marriages but it all depends on the owners whether they want to end their relationship. It's all up to you mum if you don't want to continue being tortured but if he doesn't change please don't hesitate please come" (Female IDI 11, urban)

There were some sentiments of resentment from participants with seeking police intervention. Fear of divorce, imprisonment and further abuse dominated every discussion on police intervention. Many participants reported this as a challenge for many women in particular to seek help or disclose violence, and for the fact that many women are dependent on the very same man as a breadwinner. In one of the FGD women reported that violence may exacerbate following police custody.

"When they come back from police they add more fire. They tell you to go back and report again. Sometimes they tell you to pack and go" (Older women GI, rural)

"If you can go to community police and report that my husband has beaten me and that person goes to police, he will be severely punished to the extent that he may not wish to continue with the marriage (all laugh) because of his experience at the police. There is a (certain officer) eh! He knows to punish. From the police that will be the end of the marriage. So that's why some women fail to disclose because they fear that their marriage would come to an end." (Older women FGD, rural)

Some of the service providers shared similar sentiments. In one interview a service provider explained that she would hesitate to refer to a woman to the police unless she was sure the women was determined to put an end to violence in her relationships. Similarly a member of the community victim support unit shared:

"When they find the community police, we tell them, no, this is not the right approach, go back and discuss because this is marriage and it's not good to make a hasty decision to have him jailed. Go and think again because the step you are taking is that there will be no negotiations but having him jailed, may be the decision was

222

made out of anger but they should discuss with a sober mind. (Older women FGD, rural)

A group of young women feared that sometimes the police may fail to follow issues properly resulting in over judging the situation and unfair imprisonment. Examples of cases of unfair arrests for men included beating of a stubborn wife and a wife who was refusing to have sex with her husband.

"I feel that it is difficult for the police to settle marital issues because arresting a husband before thorough investigations of the issues may somehow be unfair to men. They may arrest him yet it's the woman who is refusing sex in the home". (Female participant, community FGD urban)

Narratives also revealed that women face several obstacles. Marriage advocates were perceived as deterrents for seeking police intervention in some cases:

"The marriage advocates cannot advise you to go to police to have their relative imprisoned, it's impossible. They are going to back him and tell you that this is what marriage is all about"(Older women FGD, rural)

Some women said instead of the police helping them; they are referred back to marriage counsellors. Yet others claimed that the police charge money for them to get assisted yet in the end they don't get the assistance they were expecting from police. In one of the FGDs participants gave examples of families in their communities who had experienced violence in their families, the village headmen referred them to police but were charged penalties for withdrawing the case. Some participants in the FGD, said several families in their community had encountered this problem

"For example, a man had extra marital relationships and was leaving nothing at home. So the woman complained to the chief and was given a letter to go to police. The police called the suspect. He was kept in custody for two days. Since the issue was not discussed the police charged each MK3000 to deter them from continuing but it didn't help... they use it at the police station. The police man uses it. Several families have experienced this". (Older women FGD, rural)

Some participants thought in terms of the challenges that police are facing in addressing issues of domestic violence. Participants who spoke on the challenges described the referral

system as failing the police. The chiefs who were blamed for rushing cases to police before exhausting the mediating factors in the village resulting in an overwhelmed police victim support units and inefficient services.

> *"The chief doesn't take time to sort out the cases; most cases are pushed to police... police offers tremendous help to such people but the challenge is police receive certain cases that they are not supposed to receive. Instead they just jail (put them under police custody) the alleged perpetrator because they are overwhelmed by the so many cases they are receiving some of which were not supposed to handled by the chief" (young women FGD, urban)*

The role of community victim support units (CVSUs) was discussed alongside the main stream Police victim support units. CVSU are formed by community members, work hand in hand with the village headman and the police to fight crime in the community. In some of the community FGDs, they were perceived helpful in dealing with certain forms of violence like child abuse but not so much for IPV. In one FGD, women explained that the experiences of some women who sought help for IPV from the group were discouraging. Women said, they are just castigated, and their problems are *undermined. They attributed this to the fact that marital problems are not seen as a big issue.*

> *"They say, are these problems? There are others who are meeting huge problems, far much bigger problems than what you are experiencing. They just sit on the issue and they are never assisted."(Older women FGD, rural)*

Members of community VSUs explained that they give reports of violence occurring on their villages but noted that their collaboration wasn't very successful. They pointed out one weakness in the process is delay or not even responding to cases of violence that are reported to police and raised lack of training as a concern. When asked what had motivated them to become members of the VSU one of the interviewees said he would like to help others not go through what he has experienced in his own relationship.

7.1.2.3 Courts

Referral to the court of law was perceived as an important step for women who have finally decided to dissolve the relationship. The courts were seen as being used more for cases that come to divorce rather than being seen as a place for judging and sentencing perpetrators for a criminal offence. Women who were knowledgeable about divorce proceedings explained

that the court provides letters confirming divorce. This was perceived to be more protective for the woman from further violence from the ex-partner as narrated by one of the participants in a community focus group

> *"Some men are hard to imagine, they don't want their ex-wife to get married to another man. When they hear that somebody is proposing her, he comes back to fight the other man. In such a case, people get interested to find out how the marriage ended" (Elderly women FGD, rural)*

The courts were perceived as unfriendly to survivors of IPV. Many people shun away from seeking help from the courts especially if it's a family matter. Public hearing of family matters was seen to be very problematic for people especially for cases involving high profile cases. Concerns were made in relation to the behaviour of media, who would like to create news and sales out of such stories. In one of the interviews, a GBV service provider explained:

> *"not everyone will like intimate things to be held in public so it has been our cry as service providers that why don't we start lobbying government to give us a family court where such cases can really go to such courts where the judges, the abuser and the victim all feel welcome and their respect at least kept... in an open court the media is there and if you are a high profile person you should know that it's going to make news for one full week you will be in the newspapers'. This is where I find that our system is really not helping us." (KII, female GBV service provider,)*

For health care workers, the courts represented an intimidating environment as far as giving evidence on cases of violence was concerned. Many of the participants interviewed had never had the experience of rendering evidence a court of law. The few that did, expressed frustration with the whole process. Health care workers felt that they are inadequately prepared for the type of questioning that happens in the court of law which made them look stupid. Lack of support from the ministry was also a cause of concern for some who had used personal resources to attend court proceedings. Persistent adjournments from court hearings and lack of seriousness on the part of the law enforcers were also seen as stumbling blocks. In some of the interviews health care workers admitted that many of their colleagues were avoiding attending to survivors of violence in case they got asked to give evidence in court.

225

"When one is told to go to court and tender evidence, Oh! There is that fear, tension suppose they say the evidence I am giving is not true then I can be prosecuted for giving false evidence. There are lawyers there; they ask a lot of questions. You look stupid in the court when you cannot answer questions in your own field. People start saying uh! Uh! but also these allowances and other things. One goes there and spend the whole day adjourn, the magistrate is busy, adjourn come again, adjourn so with the crisis of shortage of staff here. This also contributes to people not to be compliant failing to attend court proceedings. "(Male HCW II, hospital)

"I and another colleague of mine, a male nurse who works here too; I can't cheat you mum, we run away. When I see a police vehicle coming here I can't come here mum because when I go there I have to use my own money all the time. I will be using my pocket money, the thing that I haven't budgeted for. I hear they give allowances but ever since I have never received any allowance, I use my money" (Male HCW II, health centre).

Survivors too expressed some frustrations with the way the courts handled their cases. Three of the female cases had been heard in court. One of them had her abuser prosecuted and the abuser was serving six months jail sentence for inflicting pain on her. Though her case was presumably successful in that her perpetrator was prosecuted, she was disappointed because she was not given a chance to be heard until the last day of judgement on police insistence to allow her to give personal testimony of the harm she had suffered from him. However, the court told her that her testimony could not change the ruling since the ruling had already been made. The two remaining survivors registered similar complaints and both were in the process of appealing their cases in the high court. The challenges faced by these survivors were slightly different from the first survivor because their husbands were successful businessmen and they had hired lawyers over their cases. This posed great challenge to these women as they also needed to look for lawyers and it was very difficult to get free lawyers for their cases.

7.1.3 Reasons for not seeking help

7.1.3.1 Cultural barriers to help seeking

Discussions on why survivors of IPV do not seek help centred on the prevailing culture of silence surrounding marital issues in Malawi, perceptions of marriage as endurance and normalisation of violence. Participants mentioned that in Malawi marital issues are private.

Cultural advice given to newlyweds on how to behave in marriage was also perceived to condone a culture of violence.

Participants in a FGD explained that violence is so prevalent in the community that often people do not regard violent behaviours as abnormal unless it is severe and has resulted in injuries.

'Normalised' violence was described by health workers:

> *"Many men may beat their wives and may slap their wives but they don't regard it as violence. Only when it is extreme for example there is swelling or there are cuts that are when they see it as violence...On the part of the women, mostly it is just the same. They can be beaten up and they would think that may be the husband is just disciplining me and they don't regard this as violence. May be the husband is forcing himself on them sexually but they can't take it as violence they just think it's just the way things should be. "(Female HCW II, hospital)*

A survivor who reported that violence in her marriage escalated in 2008 explained that her husband was violent to her before 2008 but she didn't recognise the behaviour as violence.

> *"I used to treat violence as part of the normal married life. For example if he locked me out I could take it to be normal. Because people have said that such things sometimes do happen in marriage. Our life continued like that. I had experienced violence on and off but after some discussion we could resolve it and because of that I didn't take the earlier experiences as violence. "(female IDI 1, urban)*

FGDs and interviews revealed that people endure violence for a long time before it is made public. Narratives revealed several reasons why survivors may endure violence in their relationships including the belief that the violence would be temporary, fear of losing economic benefits from their husbands. Participants also explained that the social structure of men and women and the wife's identity have also played a part. Some women believed that it is innate for them to endure. Others felt that women sometimes have to struggle with trying to maintain the picture of a good, stable and faithful woman; their children would like to have. The fear of contracting disease if they leave one husband for another due to violence was also perceived to be a contributing factor for underreporting.

In some of the interviews participants felt the tendency to endure violence is applicable to both men and women. Participants explained that men are socialised to be strong and as such they would endure violence because they avoid appearing weak, vulnerable and stupid. In one of the focus group discussions, HCWs explained how norms of masculinity in the Malawian culture have fostered a culture of endurance in men and therefore; poor help seeking strategies.

> *"There can be violence in the home but unknown to other people and when things become public it means things have really gone out of hand. Sometimes it is the belief that men take themselves to be machos so they say if I come out I will be exposed and embarrassed among my friends." (Mixed HCW FGD, hospital)*

While acknowledging that the concept of marriage as endurance has prevented survivors from seeking help, there was recognition across data that there is a limit to endurance. In many cases this was measured by time span in terms of the period an individual has been exposed to violence but also in-terms of severity of violence one has been exposed to.

> *"Most of them who come here will say that things have reached beyond endurance...they are fearing that they might die, meaning that she has lived with that for quite a long time but she was silent." (Female HCW II, hospital)*

7.1.3.2 Institutional factors

Institutional fact ors were highlighted too. Fear of stigmatisation, harassment and blame by HCWs was making health care services inaccessible to survivors of some forms of violence. Analysis of interviews showed that some HCWs have negative, stigmatising and unfriendly attitudes towards survivors. Women and girls were often blamed for rape, domestic violence and child abuse. Some HCWs commented that their colleagues probably perceive violence as a funny experience or a laughing matter. Others talked as if women enjoy rape. Rape survivors were also accused of being prostitutes by some of the health care workers. Yet others felt that this behaviour towards survivors could be influenced by stereotypes regarding who can and who cannot be raped or beaten. In the following quote, one of the HCWs explains how she struggles to believe that rape can occur in a boy and girlfriend relationship.

> *"As for me, when a girl gives history of being raped by a boyfriend as stated by P1 I don't really understand. When somebody says I was with my boy friend what come to my mind is that these people had agreed. So we think like... she had agreed but after*

sleeping with her boy friend she fears being impregnated by him and because she knows that we give them emergency contraceptives that's why they come here reporting that she has been raped" (Mixed HCW FGD, Health centre)

One health worker denied the existence of violence in a marital relationship

"Let me tell you the truth... I don't know whether I am wrong but in this world there is no violence. It exists because people have labelled misunderstandings between two partners as violence... Every patient that comes with police report, when I start questioning them, the story they narrate is very small. I tell them sister (because the majority of the patients that I see here are women)..., why can't you discuss; not necessarily going to the marriage advocate but discuss in your own house." (Male HCW II, health centre)

HCWs insensitivity to damaging effects of violence is also expressed through comments they make and through the mode of questioning.

"People have different attitudes. As I said that one would come to examine the patient, shouting at the same time. Were you really raped? Did you assist him when he was doing it? Others are laughing at the same time You know every time somebody sees somebody that has been raped; she thinks may be its something funny...every time she sees a wife who has been slapped by husband, which to me is a sad thing others think it is something funny." (Male HCW II, Hospital)

HCW insensitivity was to the damaging effects of violence is also expressed through comments blaming women for sticking to their abusive partners:

"I disclosed to the doctor that stitched my eye. He asked do you intend to go back to your husband considering what he has done to you; this is a gruesome violence considering that you are also heavily pregnant... I replied, I cannot say much regarding my going back to my husband. This is not my village. The doctor said you women are always like that. Once you feel better you will not think of doing otherwise. That's how the story ended." (Female IDI 2, urban)

One of the female survivors with recurrent STIs reported that she was nearly sent home without treatment because of her history of partial treatment. She did not blame the health providers for acting in that manner because she felt they were justified:

"Like today they were sending me back, they told me we are not going to treat you today unless you bring your husband...I don't think the doctors were wrong" (Female IDI 11, urban)

The poor reception patients receive from HCWs was cited by policy makers, community members and providers themselves:

"Reception for patients by nurses is bad. We know it's not all the nurses but there are some nurses including clinical officers who don't receive patients well...so if even if people had problems they can't tell them. Our psychological care is real traumatic." (Female HCW GI, hospital)

Commenting on the same patient reception one of the GBV service providers said:

"The attitude of the staff members is not good. The way they look at you, they question you and dismiss you is not good. May be if a specific room is set up uh the system is not conducive. At QECH there is room the way they stare at you eeh!! 'tikuthandizeni' can I help you that is difficult for somebody already experiencing violence" (KII, GBV service provider)

A service provider who disclosed IPV in her past explained how the staring of the HCW left her confused, feeling empty and not sure whether he was concerned or laughing at her:

"I remember going to the hospital and I remember saying to the doctor that my husband has beaten me. He kept on staring at me as if he was feeling very sorry for me. You know he will treat you and then he says go home. I felt empty I don't know what the doctor was supposed to do... maybe he could have referred me but I think that's what I was hoping... You know I don't know but it was like that's the end of the story. The doctor just looked at me. I was worried that may be he is laughing at me know then I went" (KII, Female GBV service provider).

There was also a feeling among some of the participants that HCWs invalidate survivor's complaints. They don't believe the survivor's story instead they accuse them of bringing violence upon themselves. Complaints of non-consensual sex from girls were often treated with scepticism. Health workers believed that young girls lied to them to get access to ECP and PEP. This attitude from HCWs was believed by some to be responsible for pushing girls and boys away from seeking health services. The following narrative demonstrates this:

"It happens like in intimate partner violence clients sometimes are asked questions like how can you say your husband raped you; don't you know sex happens in marriage? If it is a girl she is asked: you, the way you dressed, what did you expect? So most of the times we speak like that making them know that they are to blame." *(Female HCW II, hospital)*

Some interviews revealed that HCWs attitude towards married women's complaints of intimate partner violence hindered women from both seeking health services and pursuing justice by challenging the women's motive for reporting violence to police

"When she tries to explain, they say your husband is going to be arrested. Is this what you want? So the other thing is the attitude of health workers." *(Female HCW GI, hospital)*

In other interviews HCWs explained that women failed to report to health services because they perceived that they have to go through the police if they are to be assisted by health services.

"In most cases, intimate partner violence involves a wife or a husband. They may fight in the morning and reconcile in the afternoon. Asking them to go to police was like asking them to crucify their loved one. This hindered most people from seeking health services." *(Female HCW II, health centre)*

Not being not ready to have husband be imprisoned for an act of violence inflicted on her hindered IDI 1 from revealing violence following a broken arm she had sustained during a fight with her husband

"I did not reveal to the health workers that my husband broke my arm. I told them I fell. The doctor attending me asked falling down? I remained silent. Because of my silence the doctor indicated a question mark on the statement that I provided... you know the hospital protocol requires one to get a police report once violence has been revealed. I was not ready to report my husband to police. I felt it was something that could easily be sorted out between the two of us without police intervention... you know where hatred already exists it's not good to flare that up."(Female IDI 1, urban)

In one in-depth interview explains how the change in the sexual abuse guidelines may improve reporting in health facilities. Commenting on the previous referral system she said:

> *"Now that we are encouraging them to come and receive care at the time violence occurred, we feel that many will come to seek care. They will realize that even if they don't bring the assailant they will still be assisted. While in the past it was like we were after finding the assailant. So they felt like they are not going to be assisted in the absence of the perpetrator or without police letter." (Female HCW II, health centre)*

7.2 Health sector response

7.2.1 The actual role of health services

Participants 'descriptions indicated that healthcare workers within the MoH recognise that it has a duty of care for survivors of violence. Narratives, however, illustrate that the overwhelming feeling in the MoH is that the duty of care is in treatment or responding medically to violence that has already occurred (PEP, EC, STI, wound suturing) rather than providing holistic services that incorporate prevention activities, care and support to survivors of violence. Though there are moves to incorporate judiciary and social services through One Stop Centres, there was a perception among some stakeholders that the role of the MOH is primarily treatment-based:

> *"In the MOH we are more focused on treatment honestly. In the advent of HIV we have to prevent HIV and manage physical injuries. Issues of unwanted pregnancies those are our duties, teen pregnancies, STIs so it's more biased in-terms of service delivery than prevention." (male policy maker, KII)*

> *"I will talk of the pre-service. All the syllabuses that all nursing colleges in Malawi are using to develop their curriculum have topics that are dealing with violence especially gender based violence. Although it is there, most were not addressing post violence care. We have seen that most of them talk about PEP, ECP." (Female policy maker, KII)*

Descriptions from participants further revealed the common perception that health care services for survivors of violence tend to lean towards clinical management (provision of PEP, ECP and STI treatment) of survivors of sexual violence rather than other forms of violence.

"We have guidelines on the management of sexual assault but on bodily physical part I think the health workers just take the initiative because there are differences in terms of presentation." (Male policy maker, KII)

In spite of this, HCWs perceived that an important aspect of their role was to try to assist women and men to 'resolve conflict' which might involve providing them with 'good counselling'. In most interviews health care workers asserted that they do provide counselling to survivors of violence. However, there was widespread confusion between counselling and education, information and advice giving. In some interviews, when probed to explain further what they meant by counselling, health care workers admitted that they were better at education and advice giving than counselling. One of the psychiatric trained provider commented.

"I am talking from experience that these patients are not counselled. We can say that people mistake counselling for advice giving. What we do better is education and advice giving which doesn't assist the patient at all." (Female HCW GI, hospital)

Even the already established counselling services for people with HIV and AIDS is perceived to be lacking according to one of the policy makers

"In terms of counselling I don't think we have specific people who are counsellors in the Ministry. They might be nurses but I am not sure. We have counsellors in our hospitals that manage people with HIV and AIDs and the like but the capacity is not hundred percent." (Male policy maker, KII)

The general lack of capacity in counselling was widely acknowledged by all sectors dealing with violence issues. Interviews with participants from the Ministry of Health both at policy and implementation levels clearly indicated that the gap between treatment need and capacity for providing psychosocial counselling was huge. The case was the same for the Malawi Police services. Interviews with some community police officers identified counselling skills as an area where they required training. Similarly, most of the NGOs interviewed in KIIs acknowledged that they are not confident with the counselling services they offer to survivors. The capacity of social workers to provide counselling was also doubted by other service providers, yet this is the department entrusted with handling child protection issues according to law (as outlined in the CCPJA). One key informant summed up the discussion and revealed uncertainty as to who has responsibility for counselling survivors of violence:

233

"There is a lot of psychological damage which I don't think our hospitals are addressing. We don't have such kind of service in our hospital being offered to patients you will find that what will happen to this woman she is treated with aspirin and the others no counselling… I don't think we have such a service so I don't know whose job it is? Is it we NGOs or the hospital? As for us we can claim that we do counselling. The truth is we don't. It's just feeling or sometimes we use just a lot of experience. We use that experience but to say that we have been trained how to handle a client maybe just through reading. Those who are trained may be those that have gone through Magomero may be at a certain level they don't even go higher. This is where we have a lot of shortage or a short fall or a gap in our system. Even in the police we need trained counsellors, in the hospital we need trained counsellors even us as NGOs we need trained counsellors to be handling these issues but now it's just a matter of trial and error." (Female GBV service provider, KII)

There are many barriers identified to quality counselling being provided to survivors of violence. These included inadequate time for counselling due to providers' multiple roles and lack of knowledge on violence issues as well as specific psychosocial counselling skills. These two factors were consistently highlighted in all the interviews. Participants felt that curricula based on the bio-medical model made them less prepared to deal with psychosocial issues as this typical quote reveals:

"The education system didn't look at it to be something big to be brought into the curriculum. And again, I think we are looking at it as not part of the health system because most of the times it is psychological but our health system has mostly concentrated on physical illness leaving aside other issues like psychological or social. This is why it hasn't been included but I wish if it was included." (Female policy maker, KII)

Insights into how topics on GBV are taught in the training institutions revealed a lack of seriousness in the way the topic is delivered. In some institutions, including mature entry programmes, it is listed under self-study topic and mentioned in passing as either a consequence or determinant of a 'major health problem'. Where students may have the opportunity to make a presentation on the topic, the lecturers and students often display little interest in the topic:

"They just told us to go to the library and find information on rape but the generic programme had none." (Female HCW GI, hospital)

"Like in our group when we were in third year, you would see that when you were presenting on the issue, the interest of both the teacher and the students was not there. So even if the topic is there, the way it is handled it seems as if it is of no importance." (Female HCW II, hospital)

It was clear from the interviews that prevention efforts towards violence were barely existent in health services. Furthermore, health providers gave mixed responses regarding their role in prevention of violence against women and children. This policy maker commented that going into primary prevention would be stepping outside the mandate of the health services.

"If we are to say that we are going to go to the community because this is bad I think then I am lying. Though we can have moral obligations but looking at the capacity challenges we cannot do that. To say yes that's lying honestly. They can treat or do counselling to prevent further occurrences so secondary prevention and not primary prevention." (Male , KII)

However, most of the service providers felt that prevention of violence falls within the mandate of health care services because they deal with direct and indirect consequences of violence. Some participants felt that they can engage in primary prevention by providing health education, conducting sensitisation or awareness campaigns among others. Others felt that the health services could not be the best place for primary prevention messages as most of their clients are women, who often are survivors themselves. Engaging health services would mean missing out on the larger targeted population, men, who engage in these behaviours.

"The only problem is that more people who come to the hospital are women and we don't get more men. So we will give the women information unfortunately, most perpetrators of violence are men." (Male HCW II, health centre)

Despite the recognition that violence is underreported, HCWs in all the interviews explained that the violence against women and children is not actively identified in health services. Identification of violence is dependent on voluntary disclosure upon history taking and police referrals. Although most HCW said that they collect detailed history from clients; others felt that the history taking in health facilities is very brief. Most HCWs do not probe even where

violence is suspected. Others explained that they use the clinical picture of the patient as a cue for identifying survivors of violence. A health care worker explains below how she identifies survivors:

> I: how do you identify violence cases?

> P: By her looks. A well dressed woman but smelling because of STI; and some are depressed. You just greet them to find out how they are and the next thing you discover they are already in tears. (Female II, hospital)

Health care workers themselves described screening processes as inadequate and suggested that staff might need more training to recognise suspicious cases where, for example, children had been admitted with a number of fractures. One health worker explained that it was important to probe further in some cases and guidelines were needed to assist with this process.

> "I don't think we have guidelines in place but then what the woman is saying can make you think i.e. if she says 'I fell' you need to dig deeper. But then not all cases that come with violence can be identified. It is because of complacency of us health workers we don't probe further when a patient tells us." (Male HCW II, health centre)

A question on the possibility of screening for violence in health services amongst health care workers at implementation level yielded mixed responses. Many of the service providers felt that screening is possible and supported its implementation in health services. Some participants felt that it could be good if it was used as a preventive tool to help understand the causes of violence and find solutions on how to deal with it. This was perceived to be a better approach to violence rather than responding to it. Others felt that it could be used as an entry point for understanding the burden of violence in health services. Yet others felt that screening would help people to talk about it.

> "I agree with my friend that it will help us to know the causes of violence and also our clients will open depending on how we are screening them and if we know the type of violence the government may find ways of overcoming these problems." (Mixed HCW FGD, Health centre)

Some providers made very cautious statements regarding the feasibility of such a programme in the Malawian health system considering all the challenges, such as shortage of human resources against increased numbers of patients. Some participants felt that although screening was helpful, engaging in it would also mean going beyond the health services' perceived mandate.

> *"It can be helpful but it is a big challenge because sometimes we will be going deeper into places we are not supposed to go as health care providers. The expectation of the community is that our role is to treat people with medication." (Female HCW II, hospital)*

It was also felt that the hospital setting itself does not provide conducive environment for disclosure of violence.

> *"The problem I can foresee with screening is that most of the times health workers do not have good environment for history taking and for screening to allow patients to open up. (Female Policy maker, KII)*

Other providers felt that screening may not necessarily increase the workload since it would be implemented with patients already presenting at the health facilities. However, the burden may arise if cases requiring prosecution were identified.

> *"Maybe the workload may increase if court issues are to come. Otherwise in the beginning I don't anticipate many problems." (Male HCW II, health centre)*

On the other hand, a few participants rejected the idea of introducing screening for violence in health services. One provider felt strongly that such a programme would mean forcing people to disclose abuse when they are not ready to do so. It may also be treated as intrusive.

> *"I tend to differ because if the victim does not disclose we just treat according to presenting problems. It could be that [s/he] does not want to disclose...we also do not want to interfere with his or her personal issues." (Mixed HCW FGD, health centre)*

Whilst screening is in the HSSP framework (see section 3.3) there are no concrete plans from the policy makers to actually conduct screening in health facilities.

In line with the review undertaken of policy documents above (section 3.2), interviews revealed that there are no indicators of VAW and VAC in the HMIS for monitoring and

evaluation of these problems in the Ministry of Health. As such, there is no database at national level within MoH. Poor data and information management has made it difficult to understand or appreciate the magnitude and the burden of violence against women and children in health services as cases are not well documented.

> *"Well there are gaps in the care, recording and monitoring. Each disease has been classified and when a patient is seen at OPD is registered. VAW and VAC are not recorded or monitored so it is difficult to show that it is a significant problem." (Male policy maker, KII)*

> *"There is no specific code in the HMIS system for reporting violence. All injuries or trauma due to violence are lumped together with trauma code 47A. The HMIS are being reviewed soon and there is opportunity to revisit this if is advocated for in the next few months. However, our system is paper based and we may not want to overburden the system." (KII, policy maker)*

One of the policy makers observed that the poor documentation cannot be entirely blamed on the monitoring and evaluation system but also on lack of training on the side of the service providers.

> *"Honestly the magnitude cannot be well elaborated due to poor reporting. Our monitoring and evaluation has not been good. Even though we can blame the M&E system but also to some extent most of our HCW are not well trained in management of these and may not know what to report." (Male health development partner, KII)*

In some of the interviews, health care workers admitted that they didn't think that documenting such cases was part of their responsibility. This was consistent with the observation made by the policy maker above

> *"Sometimes we think it is not our duty, may be because they have gone to police, the police have their own ways of recording them but our duty is to help them recover." (Mixed HCW FGD, rural hospital)*

Interviews also revealed that self-reported rape cases were better documented than other violence and that documentation focused on medical management. However, inconsistencies existed. In some health centres rape cases were recorded under sexually transmitted infections (STI) because survivors are provided with STI preventive treatment. In others,

they were recorded under ARTs because of the provision of PEP, and yet others recorded them separately in the gynaecology and paediatric wards. Narratives from service providers in all the interviews conducted seemed to agree that physical violence was not captured at all in any of their hospital records and that outpatient registers lacked indicators for specifically monitoring violence cases. The following narrative demonstrates the variations that exist:

"Rape cases may appear because of the prophylaxis but this does not mean that we have somewhere separately to record. We record as ARVS. She will appear because of the prophylaxis." (Male policy maker)

"If a victim has sustained a fracture, that case will be recorded under fractures. If a raped case has some diseases then she may be entered as STI. May be if we had specific indicators for rape cases and another for physical violence because the data entered in HMIS is the only data with indicators." (Mixed HCW FGD, rural hospital)

Articulating the current role of health services in IPV appeared to be difficult in all the community FGDs and interviews conducted. In many cases, this was a question that was only responded to after long pauses or with probing. In some of the FGDs and interviews were honest enough to say they have never heard about health workers taking part in preventing domestic violence. However, its role in managing injuries, treatment of sexual abuse survivors and helping women with reproductive health issues particularly family planning was widely acknowledged, but misconceptions about management of sexual abuse arose in several communities seemingly originating from limited knowledge regarding the actual procedures conducted in terms of post rape services; these were prominent in females FGDs. In one of the communities participants believed that HCW pump out semen from the survivor's vagina.

In this FGD women said that they have never heard that health care services can offer services to people experiencing violence. Based on their understanding, health services are there to cure diseases and not to deal with domestic issues. In the following narrative a participant expresses her surprise in response to a question about the role of health services pertaining to issues of violence. This quote represents the typical picture of the perceived role of health services:

"I have never heard, never heard, uh! Never heard... I have never heard that there are pills for treating violence" (Elderly women FGD, rural)

239

7.2.2 Barriers to improving the health sector response

Implementation of comprehensive health services for survivors of violence is perceived to be a massive project that requires investment in human resources as well as finances. The complex nature of the problem was thought to require a multi-sectoral approach. Policy makers are faced with the challenge of redressing the shortfalls within the Ministry of Health whilst negotiating with other Ministries to release their staff members to work on a health care team tackling violence holistically.

"Capacity, personnel is the biggest challenge so that is the reason we are trying not to use health centres [as a basis of One Stop services]. We are hoping that training of more nurses, medical assistants and more members of staff would help. This is the biggest challenge. We also have to convince the police department to send police officers to all our health centres. We have to make sure that we convince the police department and police officers then we have to make sure that we use social welfare personnel they should also fully work in that particular unit." (Male policy maker, KII)

"If it is comprehensive then we need to do a lot of capacity building so it might not only be here [in health services] but even outside, counsellors, police and counsellors in the Ministry of Gender. I don't know whether they have them. All those be brought together and be trained." (Male policy maker, KII)

Gaps in knowledge and care provision were also prominent in other narratives. Several gaps that were noted in the management of services and process of care provision suggest deficiencies in the competence of providers. The negative attitudes among providers related to lack of knowledge as a result of culture, inadequate coverage in the curriculum and prioritization of physical over psychological and social problems in the health care system. One of the challenges identified by participants was capacity building. Health care workers felt that non-governmental organisations and other government departments working on violence have neglected the health services in their efforts to deal with violence issues. Training efforts have concentrated on other sectors including training of members of the community. One of the focus group members made the following observation:

"You find that people working in the [non-governmental] organisations they have more knowledge than us. There has been much training on violence out in the

community there but no single health workers have been involved." (HCW FGD, rural hospital)

The burden of work and shortage of staff may also have influenced the manner in which psychological issues, which are perceived to be more complicated and time consuming, are handled in health services. In one of the FGDs, health care workers explained that:

"We have a lot of work as they have already indicated and also because of lack of skill we fail to think of how to handle that patient. This is why we deal with the physical problem only and leave the psychological or just little bit of it and send the patient back home." (HCW FGD, rural hospital)

Lack of proper infrastructure was perceived to be one of the major challenges impeding the scaling up of One Stop Centres in the health care system in the country. The situation was felt to be particularly bad at primary level. Participant's descriptions suggested that the Ministry would prefer a phased approach to the implementation of One Stop Centres and that lessons learnt at a particular implementation phase will be incorporated in the next phase.

"In terms of description of the infrastructure, bigger institutions are capable of doing that but guidelines will be distributed widely… we are mindful of the challenges that can be at primary level because we do not have adequate infrastructure, the police may not be close, social workers may not be available so we may need to find alternatives…in some facilities not everybody has the capacity to provide ARVs and have functional laboratories. That being the case we have some limitations as far as primary level is concerned but for community hospitals that is possible. Rural hospitals may cope." (Male policy maker, KII)

At one of the health centres, providers explained that low case rates has further impacted on their skills and competency. There was also a general consensus in all the FGDs and interviews conducted that survivors tend not to seek help from informal or formal services at the beginning of partner abuse speaking from the experience of dealing with survivors of IPV a GBV service provider reported that many domestic violence survivors don't usually report that they are being beaten. She noted that there is a tendency among women to protect their husbands even when they are being abused by them.

7.2.3 Potential role

Despite the challenges, health care workers in almost all the interviews recognised the association between violence and psychological ill-health and were optimistic about the role that psychosocial counselling can play in ameliorating the psychological effects of violence.

> *"We need counsellors at the hospital. Most of the clients that we see at the hospital do not suffer from infections but rather psychological issues. I feel we could have eliminated a lot of problems in the health services if counselling was to be done."*
> *(Mixed HCW FGD, health centre)*

Health care workers also provided solutions or strategies for improving counselling services to survivors of violence. They proposed training in counselling skills, referral to psychiatric nurses and collaborating with other organisations such as social services to handle the counselling aspects. Task shifting and task re-alignment was perceived to be the best way forward to achieving good counselling for survivors in order to avoid overburdening the overstretched human resource in the hospitals. One of the health care workers felt that the government has the responsibility of ensuring that something is done.

> *"Maybe if the government can do something about it; may be recruiting special counsellors for some of these issues so that we can refer these clients to them. Those people will be specific, they can counsel or may be ten people a day that's ok but expecting the same nurse to see patients, attend antenatal and work in labour ward, the same doctor should attend to outpatient clients and even have spare time for counselling people it is very difficult"* *(Mixed HCW FGD, health centre)*

In almost all FGDs participants identified counselling as their major need. They explained that what is lacking in communities is counselling and education on the effects of intimate partner violence. Some proposed that organisations should be established in the villages and be involved in mass awareness campaigns. They felt having an organisation within the village would make it easier for them to access help

One of the participants explains why he thinks violence is getting worse. He explains that health care providers are few compared to the demand

> *"We can say that some things are not working because we have few counsellors in this area...like health workers they are few and villages are many. There should be*

relevant counselling and telling people where to go...some forms of violence are hidden because of lack of proper counselling"(elderly men FGD, urban)

In the same FGD another participant suggests mobilising the local community into action with the assistance of the chief and let this team work collaboratively with health care providers

"It would be good if health workers should ask the chief to choose for them some people whom they could work hand in hand in this area. We should not wait for the government to send us people" (elderly men FGD, urban)

One survivor believed that that strength in health services intervening in the issues of violence lies with the respect that society accords health care providers. She explained that some people strongly believe in what the doctor or health workers say more than they would believe any other person or their own relatives. She said people over the years have entrusted their lives into the hands of health workers. Individuals feel free discussing their whole self, starting with problems inside their bodies and outside their bodies with their doctors. Yet they only provide scanty information to their relatives. In the following excerpts she explains how actively asking people about different forms of violence in their patients' lives would assist the government to get feedback over violence issues:

"If health workers take up this responsibility of finding out from us what forms of violence we are experiencing and giving us the opportunity to explain to them I think it would prove to be very helpful. If also they have a chance to feedback the government of various forms of violence people are experiencing I think it will be helpful because people will now refrain from engaging in violence" (male IDI 5, urban)

Focussing on STI, one of the GBV service providers explained that such issues need to be discussed thoroughly with patients and health services should find means of inviting men to come and receive treatment. She explained that the current partner notification methods are not very effective because of the power differences

"Especially when it comes to genital! Genital issues! You need to discuss these things well. You need to recognise that she doesn't have the power to go back and tell him that you have transmitted infections to me so you also need to go and get treatment. Most of them will receive treatment and try to close her legs. Hoping that it may not

243

happen again but you find that it happens again and again. But the health practitioners have more authority, it carries weight, you tell him the hospital are saying that, the doctor says this carries more weight according to me. May be HCWs should be making phone calls to partners. Like what we do once a case comes" (Female GBV service provider, KII)

Survivors made suggestions regarding how health care services can deal with violence. References were mostly made to HIV programmes. Many survivors were of the opinion that violence issues should be handled the same way HIV issues have been handled. Some suggested that people can be given advice on issues of violence; encouraged to freely discuss violence issues; just as people are encouraged to be open about their HIV status. They said violence is a source of HIV in the family or outside the home. One of the survivors sums up the link between violence and HIV

"If a man leaves a woman with nothing, some of the women end up prostituting because of that so that they can find food. Some people also know that they are HIV positive but because of the bad heart of violence they don't tell their husbands or wives that they are HIV positive this is also violence. So if the health care providers are encouraging people to talk freely about the violence they have experienced I feel like this can also protect so many other things"(female IDI 3, urban)

The same survivor felt promoting openness about violence issues would encourage disclosures:

"Health services could promote openness so that people can come into the open to talk about their experiences but because such things are not there that's why people are not free to talk. But if such things were discussed freely for example at the clinics about issues of violence somebody would have been free to talk about it and that can motivate other people to talk about it"(Female IDI 1, urban)

The need for gender equity in dealing with issues of violence, particularly violence against male partners was called for. Some participants felt that organisations that deal with violence respond differently to violence against men rather women.

7.3 Case study on the number and typology of violence within Queen Elizabeth Hospital, Blantyre

This section presents the findings of facility observation and presents the data from a quantitative study on the typology of violence at Queen Elizabeth Central Hospital (QECH) using register data from a one month period. Further details on the methods may be found in section 4.9.

7.3.1 Reporting and referral

Other than the DHS no accurate data exist on the prevalence of violence in the district of Blantyre. Estimates from 2010 DHS data for women (since data on children in the DHS are sparse) indicate a prevalence in the previous 12 months of violence having been experienced of close to 30% of women, of whom 48% stated they reported this to someone in their family or community. The scale of under-reporting in Blantyre can be gauged from the following calculations and figures:

- 325,022 women are said to reside in Blantyre city (National Statistical Office, 2008).
- 97,510 of these women were exposed to violence in 2010 (DHS 2010).
- 46,800 women reported violence to family and community members (DHS 2010).
- 2015 women and 460 children reported that they had been victims of violence to the police in 2011 (Regional Office)
- 116 women and 80 children reported that they had been victims of violence to police in Jan 2011
- 'adults' (aged 13 - 18) and 23 children reported to QECH in January 2011.

Figure 7.2: Reporting rates of violence against women in Blantyre city, January 2011	Figure 7.3: Reporting rates of violence against children in Blantyre city, Jan 2011

Figure 7.2: Reporting rates of violence against women in Blantyre city, January 2011
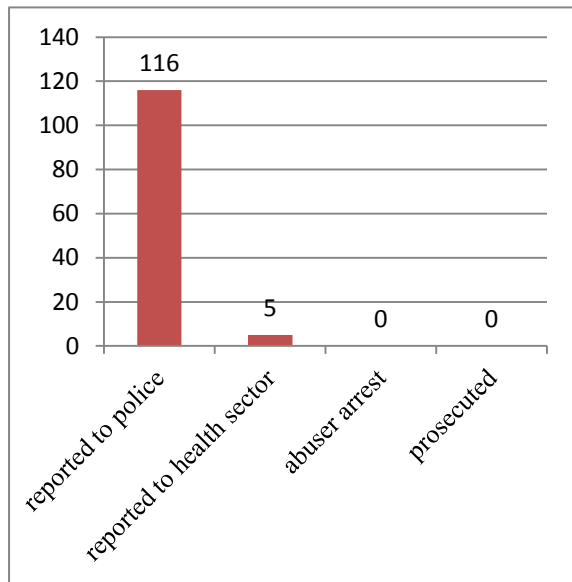
Figure 7.3: Reporting rates of violence against children in Blantyre city, Jan 2011
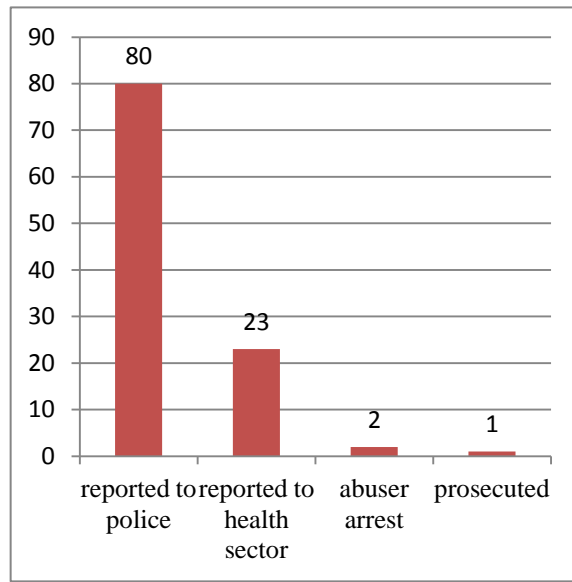
7.3.2 Client flow at QECH

Adults seeking health care services at QECH have a variety of entry points to care. Firstly they may be admitted directly to the wards, secondly they may be admitted through the outpatient departments (casualty or Room 6) and finally they may be seen and treated as an outpatient (including at the STI clinic). Each person is registered at a central point and issued with a unique code, however if they are admitted they will be issued a separate admission number making it difficult to track individuals to the ward. Details of name, age, gender and presenting complaint are entered in the registers. In addition separate registers are kept in the various rooms and wards. ART clinic registers are stored separately and the attendances are not recorded in the main register. An adult survivor of violence may present in any or all of these manners. Overall facility observation revealed that there is a lack of a clear access point for adults, lack of time for staff to deal with survivors and a lack of clarity on what action to take.

For children the process is more streamlined, with children presenting directly to paediatric services, through the paediatric admissions and emergency department or directly to the wards during the night. Child abuse cases are seen by the One Stop Centre service comprised

of a dedicated team of professionals. Currently operating out of the paediatric wards it is due to be re-housed in a purpose-built building.

7.3.3 HCWs perceptions at Queens

Health care workers interviewed and taking part in FGDs at QECH perceived that violence against women and children is a very big problem in Blantyre and that poor urban women are bearing the largest burden. They estimated an average of 2-4 clients reporting with violence related issues per day. Conditions commonly associated with violence included abortions, STIs, HIV and AIDs and common unexplained minor ailments like headaches and abdominal pains. In addition genital injuries or cuts and bruises inside the thighs were also commonly mentioned. The general feeling among HCWs was that survivors of violence in adult services are poorly received, there is no urgency in attending to them and that this attitude was in turn subjecting survivors to further trauma. The environment at the outpatient department was generally felt to be un-conducive for attending to sensitive issues. Most HCWs felt that separating the services as is being done for STIs and HIV patients would assist greatly. Referral mechanisms between different service points within the hospital were felt to be non-existent. Very few participants knew that an OSC was operational at the hospital but when told about it they saw the erection of the OSC building as a solution to the many problems that survivors have been encountering. Many of the general issues, attitudes and concerns that these health care workers shared are covered in more detail in section 4.

7.3.4 Patient characteristics

3501 records from patient registers of adults who reported to gynaecology wards, outpatients (rooms 6&8) and STI clinics of QECH were reviewed. The aim of the review was to establish the typology of violence, describe the general characteristics and the treatment outcomes of survivors of violence reporting in health services using QECH as a case study. All registered records were included in the study. The mean age of this group was 31.3 years (SD=13.4 years) and the median age was 28 years (IQR=14 years). Of these, 61% (2241) were female. The mean age for females was 29.3 year (SD=12.2 years) whilst their male counter parts had the mean age of 34.5 years (SD=14.6 years). Outpatient department (Rooms 6) registered the highest number of cases.

7.3.5 Quality of record keeping and storage

Records for children attending the One Stop Centre were separate from adult and general paediatric services and the overall quality of these was good. Demographic data,

presentation, treatment and outcome data were collected as well as information on where they were referred from.

Record keeping for adult patients was weak overall. Although some entry was made in each record the only information that was consistently well entered in over 80% of records were the demographic details presented above. OPD entries often amounted to little more than a scribbled note with abbreviations and acronyms widely used. Handwriting was often uninterpretable, dates were missing, and full information on diagnosis was only present in a minority of records. An exception to this was the record keeping for the 5 cases of rape: these had data entered on a standard 5 page proforma and missing data were minimal.

Storage of registers was meticulous but column width and coding in these only allowed for two or three words to be entered. Storage of files (including rape cases and inpatient records) was *ad hoc* with no formal way of retrieving past records (see figure 7.4). The absence of filing cabinets, storage space or support system in the wards made this a big challenge, despite the willingness of staff. Upward reporting using diagnostic data was not done for OPD records. Any formal screening programme would need to take this into consideration and design a prospective study since the quality of available data is severely compromised.

Figure 7.4 Records storage in a ward at QECH

The data presented below need to be interpreted in the light of the findings on data quality.

7.3.6 Sexual violence presenting to adult gynae services

There were few recorded cases of sexual violence in adult services during the month. Only five (0.1%) of the 3651 registered records had a reported history of sexual violence. All were reported in females. Their median age was 16 years, ranging from 13 to 18 years. This could reflect under-reporting in older women. Only two of these reported to have known their abusers. Sixty percent (3) reported during the day and most of them were self-referrals.

7.3.7 Physical violence presenting through adult outpatients

No cases of physical violence against adults were documented in the registers. However, proxy indicators (traumatic conditions, reproductive health conditions and psychological conditions) were used to estimate the extent of violence against women and children reporting in health services. These conditions were selected based on published literature linking violence to health as discussed in section 2. In addition, DHS data has also used traumatic conditions such as bruises to estimate the severity of physical violence; and this is also in line with the HSSP (2011-2016). Findings revealed that trauma-related conditions were common among males while women reported more of the reproductive health outcomes and slightly more cases of suicide than their male counterparts (see table 7.1 below).

Table 7.1: Proxy indicators of violence by gender among adult admissions at QECH in January 2011

Variable	Total n=3651	Female (% in bracket)	Male (% in bracket)	OR	CI	P value
Assault	38	7 (18.4)	31 (81.6)	0.4	0.1-0.3	<0.00*
Trauma	19	3 (15.8)	16 (84.2)	0.1	0.0-0.4	<0.00*
Facial Injury	19	1 (5.3)	18 (94.7)	0.0	0.0-0.2	<0.00*
Fractures	84	20 (23.8)	64 (76.2)	0.2	0.1-0.3	<0.00
Human bites	12	3 (25.0)	9 (75.0)	0.2	0.0-0.8	<0.01*
Soft tissue injuries	133	33 (24.8)	100 (75.2)	0.2	0.1-0.3	<0.00
Cut wound	151	32 (21.2)	119 (78.8)	0.2	0.1-0.2	<0.00
Suicide	11	6 (54.5)	5 (45.5)	0.8	0.2-2.8	<0.64*
STIs	588	329 (56)	259 (44)	0.8	0.6-0.9	<0.00
HIV	294	199 (68)	95 (32.)	1.3	0.9-1.9	<0.12
Burns	23	14 (61)	9 (39.1)	1.0	0.4-2.5	0.95
Rape	5	5 (100)	0 (0.0)	-	-	0.88*
Depression	5	1 (20)	4 (80.0)	0.16	0.0-1.5	0.08*
Day Shift	2591	1643 (63)	948 (37)	1.4	1.2-1.6	<0.01
Night shift	995	552 (55)	443 (44.5)	0.7	0.6-0.8	<0.01

The extent to which these proxy indicators are actually related to violence was not documented and cannot be determined from the records. Rather they give a sense of the magnitude of any future proposed screening programmes. While trauma may be a useful indicator in women, men were significantly more likely to present with trauma and this was felt likely to be due to injuries other than IPV. As measures for monitoring spousal violence they may not be useful proxy indicators at hospital level although they are used in the HSSP and DHS at community level.

7.3.8 Violence reporting at the One Stop Centre

The month of January 2011 (the comparator month for the adult cases described above) had a recorded number of violence cases at 23 (31%). Data available from the OSC over a longer period (we have used longer-term data to minimise the bias of month by month variations) show an average of 15-20 cases per month. Of these, 95% were sexual violence cases and 5% were physical abuse cases. The majority of the cases of sexual abuse were female (99%).

Physical violence was more commonly experienced among male than female children. 80% of the children reporting to the OSC who were victims of sexual abuse were under the age of 13; the remaining 20% were aged 13 to 18. Most cases were referred from the police, with a small number of self and health system referrals.

7.3.9 Comparison between data from adult services and OSC

The proportion of children reporting with violence was higher at the One Stop Centre (n=23) than in the services meant for adults (n=5). The general characteristics of survivors (sex, gender and outcome) were compared between those reporting in adult services and those at the OSC. In both cases the majority of clients were females who presented with sexual violence. While the OSC was specifically focused on children and registered children from very young age, the survivors seen in adult OPD and gynae were adolescents aged 13-18 and thus overlapped with the profile of those attending the OSC. One question the data raise is what criteria is used for referring survivors either to the OSC or adult services. This may suggest that there is some confusion in the health services as to who is considered a child when it comes to paediatric attendance. When available treatment and outcome data are compared it is clear that survivors at the OSC were given more support following the event compared to their counterparts in the adult services. It has also been noted that there are few prosecutions despite the fact that many survivors admit having known their abusers. While abuse was confirmed in more than half of cases seen at the

Table 7.2: Comparison of survivor characteristics, referral patterns and treatment outcomes for survivors seen at One Stop Centre and at general QECH adult services January 2011

	OSC %	General adult OPD/Gynae services %
Characteristics		
Female	99%	100%
Male	1%	0
Mean age		15 years
Abuser known	87%	NK
Sexual abuse confirmed	53%	100%
Referral		
Police	87%	0
Self	4%	5
Health centre	3%	0
Treatment		
PEP in cases of confirmed sexual abuse	62.5%	75%
EC	1%	100%
STI prevention in cases of confirmed sexual abuse	77%	80%
VCT	57%	100%

centre only three quarters of these were given PEP (with some presenting after 72 hours), few got emergency contraception (with many pre-pubertal girls being seen), and not all received antibiotics for STI prevention in either group.

Rates of reporting violence in the Blantyre district are low, particularly so among adults. Outside of the One Stop Centre the perception of health care workers is that they see 2 to 4 cases per day that they identify as violence but available data are too poor to confirm or refute this. Figures that compare reporting levels to the police and the health sector show that referral systems are only functional for children and young adults. While 80 child cases were reported to the police and 23 to the health sector during a one month period in January 2011 only 5 'adult' cases reported to the health sector against 116 to VSUs. All of these were girls aged 13-18. Relying on trauma as a major indicator for violence in women is also shown not to be a useful proxy indicator unless additional screening questions were to be added.

7.4 Summary

A part from presenting seeking perceptions of services from a multiple perspectives, the chapter highlights the voices of survivors and health care workers and other service providers to elicit information on experiences with help seeking. The data also revealed various options for help seeking for survivors of IPV, majority of which were informal sources: family, friends, and neighbours, marriage counsellors, religious leaders/church; and traditional leaders—and more formal supports such as health services; the legal system, including police and the courts. Among the informal sources of help, the role of the nkhoswe was paramount as they acted as the first point of contact for couples with marital conflict. Decisions made at this level affected subsequent help seeking for survivors. With formal sources, police were the most frequently mentioned sources of help. These did not cater for young people. Although the magnitude of IPV was perceived to be very high in chapter 6, few survivors of IPV seek help for IPV. Interviews with various stakeholders, data from the police and estimates from the DHS data triangulated well with the case study at QECH to demonstrate underreporting of IPV. Barriers to seeking help were many at every level of service provision. All survivors interviewed had made at least one contact with one of the service provider. It has also been revealed in the study that the most relied on sources of help like the *nkhoswes* and police were less favoured in many cases for various reasons. There was a perception that IPV is generally underreported and given little attention in the health services. Responses were captured on factors perceived to have contributed to

underreporting in health services. Challenges at an individual and family level, society/community and institutional levels were often cited by participants in the interviews. Participants often cited fear, shame, culture and dependency.

The study has also revealed that despite the distinct role of each source of support for IPV, all lean towards a conflict resolution model. The role of each source of support; and the strengths and challenges faced by each source of support has been described. A lack of clear referral pathways for IPV resulted in a vicious cycle of help giving leading to a dead end and withdrawal from help seeking by survivors. This was made worse by lack of knowledge and skills in dealing with IPV by service providers. These factors entangled with each other in the care-seeking process making it difficult to blame a single individual or the system for underreporting of cases. However, optimism on the role of health services still exists and participants made suggestions regarding the direction the health services should take in addressing IPV. The call for counsellors and counselling service providers was loud in these findings. The need to remove gender sensitivity in the provision of IPV services was highly pronounced among male participants and interviews, supported by some service providers.

Chapter 8: Discussion and conclusions

8.0 Introduction

This chapter will discuss how the main research findings relate to the reviewed literature in chapters 2 and 3; and responds to the research questions set out in chapter 1. The chapter also outlines the contribution the thesis has made to the existing body of knowledge on IPV, and makes suggestions for future areas of research. The ecological framework presented in chapter 2 and chapter 4 is also briefly discussed here to show the reader how the ecological framework helped the thesis to better explain the findings of the study. The findings presented in chapters 5, 6 and 7 explored the perceptions, experiences of IPV and the health services response to IPV in the three districts of Blantyre, Lilongwe and Mangochi. There were more environmental factors perceived to be associated with IPV than individual factors. For example, gaps in the policy and legislative environments and poor reinforcement of the existing laws were associated with inadequate protective measures for the survivors and ineffective deterrent measures in the case of the perpetrators; allowing violent behaviours to flourish. Cultural and traditional beliefs and the hierarchical nature of intimate relationships, the male privilege of having multiple sexual partners, poverty, lack of education, dependency on men, alcohol and drug abuse were all perceived to be environmental factors that shape violence.

Figure 8.1 links the thesis findings to the ecological framework and illustrates how these factors are fitted at different levels of the ecological framework. It is also important to note that some of the factors were cross-cutting in that the factors perceived to be associated with IPV risk were also responsible for underreporting of IPV and inadequate health care responses. For example cultural factors operated almost at every level of the ecological framework and were also found to interfere with reporting IPV and health care providers' effective responses to IPV. Findings confirmed the role of environmental norms as risk factors for IPV and potential deterrents for effective health service delivery. For example, at the macro level the legal system could not enact a law that addresses sexual violence in intimate relationships because it is culturally consent to sex in marriage is perpetual, at health service delivery level, health care providers felt that counselling for IPV was the responsibility of marriage counsellors and at individual level normalisation of IPV made survivors fail to report IPV to formal service. This is in spite of health effects being a dominant issue of the findings. The qualitative findings were supported by findings from the

quantitative study which revealed low access numbers for IPV services at one of the referral hospitals in Malawi.

Figure 8.1 Factors shaping risk of and response to IPV in this study

Gaps in the legislative and policy documents	Lack of prioritization in health services	Private nature of IPV	Alcohol and drug abuse	Power differences between men and women	Family planning	Lack of education
Lack of clarity regarding the role of health services	Lack of evaluated models	Normative nature of IPV	Controlling behaviors	Type of marriage	HIV infection	Young age
Poor dissemination	Competing public health issues	Culture of secrecy	Witnessing violence in the family of origin		Observance of traditional and cultural beliefs surrounding child birth and abortion	Dependency on husband
Democracy and human rights	Lack of resource allocation for IPV	poverty				Alcohol
	Bio-medical approach to health	Witnessing violence in family of origin			Differences over Resource distribution	
	Lack of clear referral pathways					
	Poor management and documentation					

255

Figure 8.1 above shows how understanding drivers of responses to violence through the lens of the ecological framework enables us to unpick the complexity of how despite the perceived magnitude and consequences, IPV is under-reported and the health sector response is inadequate. The discussion synthesises the main research findings organised under the following themes: section 8.1), complexity and context, section 8.2 IPV perceived as a health issue, 8.3, disconnect between recognising magnitude and health sector response and section, 8.4, limitation of study (see fig 8.2).

Figure 8.2 Key thematic areas for discussion

Key thematic areas for discussion have been structured as:

8.1 Complexity and context

8.2 IPV perceived as a health issue

8.3 Disconnect between recognising magnitude and health sector response

8.4 Limitations of study

8.1 Complexity and context

8.1.1 Trustworthiness and depth of qualitative data

The research strategy employed in the study elicited multiple perspectives and experiences on this topic from survivors (men and women), communities (men and women), and those involved in providing care (HCWs, gender-based violence organisations, social workers) as well as policy makers and from health development partners. This generated data that helped to elaborate both the gendered manifestations of IPV in both young and old people's relationships, and their social and structural context. It also enabled the use of written archives as a means of triangulating to provide a fuller picture of the phenomenon under study [420]. Inclusion of men's and young people's voices has allowed the exploration of neglected voices on the study topic. Seeking perceptions as opposed to experiences in the FGDs enabled the generation of rich data since participants were not silenced by fear of making personal disclosures [385]. IDIs allowed for eliciting of intimate data that would have otherwise not been said in a group. Likewise, the rich oral Malawian culture [384] and sense of humour shared by participants presented in chapter 6.1 created a conducive environment for debate of a culturally sensitive topic, allowing lived realities to surface [385].

Young people, in particular, used a range of language in discussions, which evoked both modern and traditional concepts. Words used to describe certain aspects of their relationships demonstrated clearly that language is evolving and advancing. For example, language that was used to justify pre-marital sexual relationships tended to portray modernity as a driving force; using metaphors such as computer passwords and contrasting their attitudes with 'old fashioned' ones. These findings are consistent with the studies done in Malawi with adolescents [314] and underscored the importance of using language deployed by young people in discussing sexual issues as a way of facilitating direct and open communication on this topic by signalling a non-judgemental approach. However, the inclusion of men and men's perceptions and experiences of IPV against them revealed some important aspects to the cultural construction and interpretation of violence that require attention in interventions, which are further discussed below (8.1.4); this is a topic that is barely discussed in the international literature.

8.1.2 Socio-economic context and need for IPV services

Previous IPV studies both international and Malawi have demonstrated that although IPV is a global phenomenon the proportion of women reporting IPV varies within and across countries [40]. In the multi-country study on DV and health, the lowest prevalence rates of IPV were observed in industrialised countries; for example rates in Japan were 7% compared to rates of 71% in Bangladesh [421]. Similarly, many studies in Africa have found a higher prevalence of IPV in rural than urban areas and in socio-economically disadvantaged contexts as compared to richer areas. In contrast, the Malawi DHS data between 2004 and 2010 has shown that trends in IPV prevalence rates have shifted more towards urban areas. While in 2004 there were more rural women reporting physical violence, the results of the 2010 DHS data presented in chapter 3.5.1 showed the opposite, with more cases in urban than rural areas of Malawi. Previous studies in the international literature have explained the intra and cross country variations of IPV prevalence rates in terms of cultural differences, variations in data collection instruments and study design, and stigma associated with the nature of IPV [41].

In the case of Malawi presented above, the study design and data collection instruments may not be particular issues because both results were generated by DHS. This study has suggested some possible reasons for the unexpected findings and highlights the importance of developing services for urban as well as rural residents. Chapter 3 has shown that in Malawi there is rapid urbanisation, increasing urban poverty and that many parts of Blantyre city are

largely poor. This means that the basic living conditions of the urban poor may not differ from those of their counterparts in the rural areas. However, interviews with service providers in Blantyre found that many have rural areas as their sites of interventions because of donor priorities and their dependency on donor funding, despite observations that urban poor report late and severe forms of IPV. Community interviews revealed that isolation from their informal sources of support (*nkhoswe* and family members), individualistic city life style, lack of properly arranged marriages and lack of activities dealing with IPV in the city increases vulnerability to IPV. Previous studies both in Malawi and elsewhere have documented that IPV survivors largely depend on informal sources for support with IPV.

Culturally, marriage issues are regarded as a family matter, to be handled by *nkhoswe*. In the absence of these, survivors in the city may be left with limited options for support with IPV. The implication of the study is that the gap that has been created by migrating into the city needs to be filled by formal services. Having said this, the weaknesses of the *nkhoswe* system in handling severe forms of violence, wealthier spouses or relatives, repeated forms of violence and how this system functions to subject women to continued abuse have been clearly articulated by a range of participants. The deficiencies identified with the traditional system of handling abuse has created a great desire for more formal community-based services to help deal with violence issues at community level, which many participants felt would be a non –threatening environment. There is a need for such services to be tried out in both urban and rural areas.

8.1.3 Legal and policy context for IPV response

As outlined in chapter 3.5 IPV is endemic in Malawi, traditionally normalised as a means of resolving conflict and regarded as a private matter out of the realm of external interference. However, the democratic constitution in 1995 enshrined the protection of women and children from abuse and discrimination as a human right, shifting IPV from the private into the public domain. Some of the advantages of having legislation on domestic violence highlighted in chapter 2.7.5.1 include legitimisation of the problem and shaping responses to it. The legislation and policy analysis in chapter 5 demonstrates Malawi's commitment to addressing the problem of IPV through ratification of a number of treaties at international and sub- regional levels and domestication of some those at local or national level. The chapter also offers qualitative insights into the local knowledge, perceived usability and gaps in these instruments.   Although international treaties are important in ensuring government

commitment to human rights issues including violence, they may be less effective in propelling the domestic violence agenda than the local laws [422]. Previous reports on the effectiveness of the Prevention of Domestic Violence Act (PDVA) seems to suggest that the legislation criminalising DV has largely been ineffective citing unrelenting IPV prevalence rates and few prosecutions of GBV perpetrators under the PDVA [297, 327].

Interviews with some of the key informants also revealed that the narrow legal definition of rape has discriminated against married women and this has left married women who experience intimate rape unprotected by the law. Community interviews revealed that women are exposed to unpleasant and painful sexual experiences within intimate relationships but suffer in silence because the cultural norms, communities and the law does not recognize their experiences as rape. This has also increased women's vulnerability as helping sources are not forth coming to help with such kind of issues. However, literature shows that there is little evidence currently supporting the effectiveness of broadening the definition of rape from the countries where this has been achieved [423]. It is necessary that such legislation be accompanied with massive community awareness campaigns and messages that would help to desensitize communities over the cultural shame that is associated with marital rape and messages that deal with issues of male entitlement over sex. The role of gendered cultural norms with regard to perceptions of sexual violence is further discussed in the following section.

However, findings presented in chapter 5.1.5 and 6.4.1, suggest that stakeholders do perceive some ways in which the PDVA has supported IPV prevention. They reveal that although there are gaps in the legislation and challenges with dissemination and implementation of the PDVA legislation, stakeholders perceive that the legislation has helped to clarify the role of police in domestic violence issues, improve prosecution of DV cases and curb violence. There also seems to be some evidence supporting the positive effects of domesticating the domestic violence laws in chapter 3.2., compared to ratifying international treaties. Malawi ratified CEDAW in 1987 but a proliferation of responses to IPV have emerged with the democracy and more especially following the passage of the PDVA in 2006. These include improving gender sensitivity of the Malawi police service in 2006, inclusion of GBV in the HSSP 2011, SRHR 2009 and inclusion of IPV (though scant) in the guidelines for the management of the One Stop Centre in 2012. The OSC guidelines have slightly departed from the usual health care focus on SV by mentioning IPV (although not substantially), unlike the 2005 sexual violence guidelines, which focused on sexual violence only.

8.1.4 Cultural context of IPV

8.1.4.1 Normative nature of violence

Chapter 2 has shown the importance of cultural context in theories of IPV and previous studies discussed in chapter 3.5.2 have indicated that violence in Malawi is normalised. Physical violence is seen as an unavoidable means of resolving conflicts and sexual violence is not perceived as occurring within marriage. However, the findings of this qualitative study have shown that the normative nature is complex: to some extent IPV is accepted but people are also not comfortable with the current levels of IPV, perhaps to a differing extent between men and women. The study has shown that the discomfort is partly influenced by human rights approaches or the enactment of the PDVA. Chapter 6.3 offers some insights into how the passing of the PDVA may have influenced the perceptions of IPV and impacted on the way participants defined IPV.

A general consensus in the definition of IPV was that violence is wrong and violates one's rights. This impact on perceptions seems to be greater among women than men. In some areas there was an indication that people perceive that cases of physical IPV are reducing due to increased awareness of human rights, demonstrating a positive impact of legislation on the lives of the individuals. These findings support a previous quantitative study, which examined the effects of domestic violence legislation in Malawi on attitudes towards wife beating between 2004 and 2010 using the Malawi DHS data. The study found that there was a 14.9% decrease in the number of women and 3.65% decrease among men accepting wife beating under any circumstances between 2004 and 2010 [422]. Again the impact on women seems to be greater.

In addition to the likelihood that men may perceive IPV as operating in their favour by supporting their power within families, a lack of interventions targeting male perpetrators of IPV could be one of the factors influencing this gender difference. Since the majority of survivors are female, services target them and not men. However, my data supports the argument that IPV to a larger extent is about men abusing women rather than vice versa. As such men ought to be a core group for interventions aimed at reducing IPV. Targeting women without subsequent interventions with men would likely result in ineffective responses and a backlash in this context where power differences between men and women are perceived to be the major underlying factor for IPV and that physical violence is used to

assert power and impose behaviour against a spouse (chapter 6.4.1). The study suggests that serious interventions targeting men's attitudes towards violence are urgently required.

8.1.4.2 Conflicts between women's and men's perceptions of violence

Findings in chapter 6.5.5 indicate that there is also tension with human-rights-based approaches as some people consider them to be responsible for violence, with women seeing them as enabling men to pursue and get away with bad behaviour and men seeing them as making women arrogant. My study identified a range of ways in which men's attitudes towards IPV differ from those held by women. Both women's and men's interpretations of violence are influenced by their gendered cultural expectations of their spouse's responsibilities. For example men expect sex from their wives when they want it, whilst women see faithfulness as a responsibility of a husband. These gendered expectations are also subject to cultural and socio-economic change, which adds to their complexity and also to uncertainty and discomfort around change, which fuels conflict [82]. However, women's interpretations of violence seem to be more influenced by concepts of individual bodily integrity (that is, not to be beaten or forced to have sex) whilst men's may be more influenced by their expectations of their rights as husbands. As a result there are some direct conflicts between what women and men perceive as violence; for example women believe that men forcing them to have sex is violence, whilst men believe that their wives denying them sex is violence. In essence there is no way both these understandings can co-exist as violence.

The publically accepted view is that there is no such thing as sexual violence in intimate relationships, which is the current stance of the PDVA. Denying the existence of SV in intimate relationships when people are experiencing it is retrogressive. Interventions therefore need to recognise that campaigning and awareness-raising messages against violence are interpreted within these cultural scripts or they may not actually reduce violence unless there is direct engagement with these scripts. Primary prevention interventions therefore need to develop participatory dialogue with both women and men about changing community norms around gender roles and responsibilities and about individual couple communications. Discussion about community norms could include both the threats perceived by women and men due to change but also the possible benefits of change to both sexes and for family life.) Work on individual communications could include resolving conflict through non-violent means. For example the Stepping Stones programme includes

sessions on couple communication, such as the use of 'I' statements (rather than 'you' statements) to avoid conflict whilst asserting preferences and desires [424]

8.1.4.3 The generation gap and young people's experiences of violence

Tensions with human rights perspectives were also pronounced in discussions around pre-marital intimate relationships and violence. Generally, premarital sexual relationships are not condoned in Malawi particularly for the girl child. However, young people in this study demonstrated that they perceive such notions to be old fashioned and acknowledged that having intimate relationships and engaging in sex with their intimates has become a norm in premarital relationships. Older people who would like to enforce old morals find the behaviours of the youth to be strange. Many older people especially elderly blamed these behaviours on human rights discourses. They said young people claim that they have rights to do what they want. As such older people felt that 'excessive human rights' have resulted in increased stubbornness among the youth such that they do not listen to counsel. Human rights were associated with 'light punishments' that encouraged many to continue engaging in wrong doing knowing that they can get away with so many wrong behaviours. As a result there is an overwhelming limitation of avenues for support and communication between youth and authority figures such as parents, traditional leaders, health-care workers and teachers.

Young people who experience violence in their relationships are blamed for bringing violence to themselves because of their unruly behaviours. In turn young people fear seeking help from adults because they realise that their behaviours (engaging in pre-marital relationships) are not condoned by the elders. Thus adults who might be expected to support young people often enhance vulnerability rather than build resilience. Older people in the study had little understanding of the power dynamics of young people's relationships with most of them denying the presence of violence and blaming young people for not listening to advice. This study contributes to understanding why adolescents who experience sexual violence in intimate relationships in Malawi as in many other contexts rarely seek help from adults, turning instead to their peers [425, 426]. However, young people clearly expressed their wish to be listened to and the limitations of support by peers.

There are several ways in which the needs of the young people's need for support for can be attained. First, the Malawian education system introduced the life skills subject both at primary and secondary schools. The subject was first introduced as a means of preventing

HIV and to help the youth deal with everyday life challenges such as peer pressure, cultural norms and traditional beliefs[427]. The curriculum does include issues of human rights, drug and substance use and abuse, violence and delinquency, harmful cultural practices, human rights (children's rights) and gender issues[428], but content may extend to include issues of emotional management, healthy relationships and health effects of violence. Through learning Life skills, the youth may develop skills attitudes that may enable them to develop healthy relationships and practice healthy dating relationships. Interventions at this stage of development are necessary considering the amount of evidence from the reviewed literature linking childhood exposure and adolescent antisocial behaviours to partner violence later in life (see chapter 2). However, these interventions may only be able to reach school going and not out of school children. As such interventions at community levels targeting out of school children may be necessary. Peer interventions and education including strengthening of youth friendly services could be considered given that young people in the study do not turn to adults as their sources of support but rather to their friends. Therefore young people need to be empowered with knowledge so they can effectively help one another.

Parents and authority others need to be sensitised on the needs of young people, young people's experiences of violence in their own relationships and how the prevailing normative nature of violence in adult relationships may be shaping the norms within young people's relationships. The social learning theory could be applied in this case to help adults understand how their behaviours as role models are impacting on the next generation. There is a need to engage with service providers and significant including school authorities others to persuade them that denying young people's lived experiences of IPV may be counterproductive to the efforts against prevention of IPV and protection of young people and their development, so that they can understand their role as sources of help for the growing generation.

Healthy parenting curriculums also present another opportunity for preventing violence among the youth. Currently in Malawi, there is a parenting project being implemented under the leadership of the World Health Organisation. However, a literature review conducted by Heise for DFID [6]revealed that many of these programmes in the developing countries are lacking emphasis on gender socialisation and less rigid gender roles[14]. Considering that power differences between men and women in the Malawian society is perceived to be the core in the production of partner violence, it is important that healthy parenting programmes

engage significantly with gender socialisation and transformation of rigid roles that introduce hierarchical positions in relationships that places women at risk for IPV.

The use of mass media and modern technology such as use of text messages as a way of passing relevant information to the youth need to be explored. Young people in this study demonstrated some knowledge on the issue of technology so there is need for people to utilise these means to make sure that young people have access to information.

8.1.4.4 Dilemmas in eliciting emic definitions of violence

Eliciting an in-depth understanding of context-specific perceptions of violence has raised an important issue with regard to defining violence in research, policy and programming. As discussed above, the study findings also revealed that there are a broad range of behaviours that are considered under the definition of violence and confusions about the boundaries of what constitutes rape in intimate partner relationships. This supports findings from previous studies with a range of age groups in Malawi, which found both a wide range of experiences perceived as sexual violence by some participants (particularly women), and disagreement on whether rape could occur in intimate partnerships. These findings confirm the importance of utilising open definitions for IPV and sexual violence research since narrow definitions may conceal the diversity and magnitude of the problem. However, the international literature also demonstrates that the use of varied definitions of violence in surveys has led to uncertainty about prevalence, which has contributed to the lack of priority accorded to the issue of IPV internationally and nationally (chapter 2).

One recommendation for escaping the confusion is to agree on uniform definitions for IPV [429]. The use of narrow or standard definitions such as those recommended by the CDC or The UN definitions on violence that emphasises on harm have the potential benefit in epidemiological studies because they may enable cross and intra country comparison of data. This may help to increase visibility of the problem and such statistics may help advocates against violence to lobby for resources to fight against GBV since one of the reasons given in literature for underfunding GBV programmes has been unreliable data (see chapter 2). The UN definition in particular would be very useful for lobbying health sector responses to IPV. Gender advocates can use the potential harm to convince health authorities that IPV is a public health problem that is worthy of prioritisation considering that it underlies the 'major health problems' such as mental health problems and HIV and AIDS and

other sexual and reproductive health problems; most of which are impacting on the millennium development goals.

However, it is also clear that IPV is a product of social context, such that the contextual factors producing IPV and how it is perceived based on its sources may differ from one context to the other. The narrow definitions may be limited in terms of the extent to which it may fully speak to the understandings of the intended communities. The example of conflicting definitions of IPV by women and men in Malawi further demonstrates that in programming it would be difficult to impose a definition of IPV that would meaningfully influence behaviour, and suggests instead the need to engage with gendered cultural specificity in prevention efforts. This is particularly relevant in programmes aiming to change social norms surrounding IPV. These understandings may serve as entry points for effective community engagement.

Broader definitions may present a challenge for designing service-based responses for IPV. Using broader definitions such as those used by participants of this study may mean that almost everybody qualifies as a survivor of violence. If such a definition is used in screening, services may be overwhelmed and fail to cope with increased demands for the services. In this case, narrow definitions may help to ensure that only those in greatest immediate need or most likely to benefit from services are prioritised in a context of limited resources. Wider definitions may be more useful when designing primary prevention programmes. There is therefore no easy answer to the dilemmas raised in defining IPV and different definitions may be required for different purposes – that is for research into magnitude and for programming. Thus a consensus-building is required nationally and internationally on the issue. This is particularly relevant for building a feasible health sector response. The implications of adopting various definitions for the health sector response are further discussed under screening for IPV.

8.1.4.5 Drivers of a conflict resolution model of responding to violence

In relation to the type of services or interventions that are needed most by communities, all participants in this study identified counselling services or intervention as the most required or needed service ; and the limited number of cases that reach the police victim support unit (VSU) (generally severe cases) were seen as to some extent effective, although there were limitations. However, situating these services within the police services was also perceived to be a hindrance to many for seeking help for abuse even among those that have been

severely injured as a result. Participants alluded to the fact that IPV is underreported because participants fear partner arrest. Some of the survivors indicated that they still love their husbands but want to seek help to stop violence. Information provided in chapters 3 and 7 clearly indicates that many women are dependent on their perpetrators and there are no social structures to help women who may report or have their husband's arrested. To many women, getting their husband arrested for IPV is like biting the finger that feeds them.

Secondly, punishments given to IPV perpetrators are lenient unless it has resulted in a fatal outcome. Women whose husbands have been arrested but not charged or imprisoned are not provided with any social support so they return to their matrimonial home with their abuser only to suffer worse consequences in retaliation. In this context where violence is normative, women who 'get their husbands arrested' do not get support from the communities; instead they are labelled as "bad women". Corrupt practices contribute to making the current model and outcomes of arresting a partner less effective. In this context a conflict resolution model is often the most acceptable approach to violence considering the normative nature of violence, the cultural importance of maintaining marriage, women's dependence on men, and lack of resources in the context to support women to take up other options.

8.1.4.6 Dilemmas about the role of the health sector

The appropriateness of a conflict resolution model raises the question of whether both community-based dialogues and work with individual couples and their support structures in conflict resolution is the role of the health sector. This study did not manage to answer this question fully as health sector providers identified a range of barriers to playing roles in primary prevention, which are discussed further in sections 8.2 and 8.3. International and local literature has revealed that formal sources would be utilised only if the informal sources of support have failed or are non-existent (see Chapters 2.5.2 and 3.7). The Malawi society is unique in that marriages come with an in built conflict resolution system. Since survivors are reliant on these, the question would be how can the already existing system at the micro level be empowered and improved to better serve the needs of the survivors? For example through dialogue with and support to village heads, community victim support units, and marriage counsellors to support their work with community groups and couples.

The current international focus is on the need for health sector to play a role in primary prevention in addition to offering a range of secondary prevention options. Wolfe and Jaffe describe public health interventions as those that act "along a continuum of possible harm"[39]

266

Primary prevention is a key strategy under the public health approach to prevent IPV and requires focusing prevention strategies at the individual, relationship, community, institutional, and societal levels but this is not happening in Malawi.

Perceptions of community members and health care workers all converge to agree that IPV is a health issue although, some community members were not sure the exact role that would be played by health care services in prevention. Within the Ministry of Health there was general agreement that the health sector should respond to IPV as a public health problem. However, some HCWs expressed concerns about stepping out of the mandate of the health sector if they are to provide counselling ('becoming *nkhoswe'*) and engage in violence prevention despite these being currently supported by existing health sector policies as highlighted in chapter 5. A minority of HCWs and policy makers felt that the role of the health sector should be limited to medical care for injuries, leaving other sectors to lead prevention efforts.

What was obvious from participants' narratives is that the health sector in Malawi has approached violence from a narrow bio-medical perspective. Narratives from health sector participants indicated that the duty of care is in treatment or responding to violence that has already occurred rather than prevention and rehabilitation. Care for survivors of IPV was perceived through this acute care model of 'quick fixing' it with drugs and suturing and not as a continuum from prevention to rehabilitation. This finding echoes those of a Malaysian study which found that HCWs follow the traditional role of treating and solving IPV as "medical problem", as they tended to focus on the physical aspect of the injury, minimise the underlying cause of the problem and ignore emotional care for patients [430].

The narrow biomedical and tertiary prevention approach used may be counterproductive and does not reflect the public health approach to violence. If the current health sector response to violence in Malawi was to be described using the borrowed public health metaphor of attacking violence upstream described by Harvey[13], it would be clear that the health sector response is inefficient because it is busy with rescuing those already involved yet failing to stop or close the source; and could be categorised under tertiary prevention or could be placed at the far end of the continuum of care. This is in contrast to the holistic perceptions of the health impacts of violence expressed by community members and survivors, who saw IPV as a threat to the whole person's health and well-being. This is also contrary to the existing policies such as the SRHR endorsing prevention of domestic violence as one of its strategies for reducing the reproductive health consequences of IPV.

Lack of service provision on a continuum of care has created a gap in terms of psychological care and reduced health sector capacity to engage in violence prevention activities. This study has revealed that the gap between treatment need and the capacity for providing psychosocial counselling was huge. Services providers identified 'proper' counselling skills as an area where they required training and community members perceived counselling services as a major need within their communities. In addition to the limitations of the health sector provision, there is also a lack of clear referral pathways to organisations or service providers outside the health sector to provide psychosocial support. There are inconsistent levels of awareness among health workers of the basic referral pathways available to them to deal with violence against women and children. For example health care workers are sometimes unaware of NGOs and their activities, which make direct referral between NGOs and the health sector difficult. There is a lack of awareness among some health staff of the role of One Stop Centres as a point of referral. There is also no existing protocol for referral between the health sector and community and religious leaders and/or government/non-government agencies.

Theobald and colleagues argue that what Malawian and other African gender advocates have significantly achieved in mainstreaming gender in health is the development of specific policies and strategies including making gender visible in general policies, plans and strategies [274]. However, the major challenge remains with implementation. Failure or limited translation of policy to meaningful practice is also known as 'policy evaporation' [276]. This study has revealed that as one of the factors that may have contributed to policy evaporation on IPV.. To mount an effective response to IPV the health sector needs to step out of its comfort zone and start embracing broader approaches to public health problems and start to offer services on a continuum of care as described by Jaffe[39]. The role of the health service in primary prevention remains unclear (see chapter 2). One of the most widespread institutional level tertiary prevention strategies for violence against women and children in healthcare facilities is universal screening. The Ministry of Health in Malawi has incorporated screening for gender based violence at all levels of the health delivery system in its strategic plan (see chapter 5). The challenges to implementing this policy are discussed in section 8.3.3.1.The human capacity in the health services outlined in chapter 3 reveals a potential challenge if all preventive efforts along the continuum from primary to tertiary prevention are heavily left lying on the shoulders of the health services. Given this, a feasible role of the health sector in primary prevention, at least in the medium term, may be limited to

giving health education on the harms of IPV and participating in violence campaigns to raise awareness among people on the effects of violence. The Health Education Unit of the Ministry of Health may also have the capacity to work collaboratively with other relevant ministries such as gender and communication to develop violence prevention messages that place much emphasis on the health outcomes of IPV.

Considering that IPV is a complex problem that is caused by a web of interlinked factors a coordinated multi-sectoral approach to primary prevention of violence is required in Malawi as elsewhere. The question is can the health sector play a role in driving a multi-sectoral response? The health sector is probably best placed to lead in the prevention of HIV related violence as it has a mandate and some resources – especially related to HIV (for example counsellors trained and available to some extent). As such, the health sector can lead the multi-sectoral response by supporting the training of the other sectors in counselling skills to enable them better handle the psychosocial and economic needs of the survivors since the NGOs, Police and social services including some health care service providers expressed deficiencies in counselling skills.

The findings presented and discussed in this thesis have uncovered the complexity of the specific context in shaping the forms of IPV and the ways people understand and respond to it. The legal, policy, socio-economic and cultural context all interact in multiple and complex ways. Such complexity means that there is no magic bullet or single 'one size fits all' solution to IPV and the health sector's role within this. The priority role of the health services in Malawi may be in secondary prevention and tertiary prevention through screening for IPV in health services and referring survivors to relevant services, and in tertiary prevention for dealing with a crisis situation or the immediate aftermath of a violent episode. The development of secondary prevention in Malawi, including the development of One-stop shops is further discussed in the sections below.

8.2 IPV perceived as a health issue

8.2.1 Holistic perceptions of health implications of IPV

"There is a big battle between health and violence and violence wins and destroying the health of the whole person so that a person who is experiencing violence becomes unhealthy" (Male, FGD)

IPV has long been associated with myriad health conditions as documented in chapter 2.6. The reproductive health effect of domestic violence on both men and women have been acknowledged in the National Sexual and Reproductive Health and Rights (SRHR) (2009) Policy of the Ministry of Health in Malawi which aims to reduce the incidence of DV through service integration. Various strategies include promoting awareness of the health consequences at community level. Similarly, the findings presented in chapters 3.6.6 and 5.2.2. recognise the role of violence and gender vulnerability in the spread of HIV infection. The findings of this thesis show that the perceptions of the key stakeholders in Malawi are in concordance with the literature documenting the health consequences of IPV. Participants in the study showed high levels of concern about the potential health outcomes of IPV, which are in line with documented adverse health outcomes including unintended pregnancies, abortions and the risk for HIV and AIDS infection and injuries such as cuts, bruises and fractures (chapters 2.6 and 6.6).

Health care providers also narrated different scenarios where they had encountered medical conditions that had IPV as an underlying factor. Some of the cases were wrongly diagnosed and treated before IPV was recognised. In some of the interviews health care workers even felt that health care services are populated by individuals reacting to domestic issues. These sentiments are supported by previous studies documenting that abused women more frequently access health services compared to their non-abused counterparts [431].

The following sections discuss perceptions of IPV as a health issue and the detailed issues around the health sector response.

8.2.2 Implications of IPV for health sector programmes

IPV is a major hindrance to the smooth running of major health programmes for women in Malawi such as family planning and HIV AIDS programmes, including prevention of mother to child HIV transmission. These findings may not be unique to the Malawian setting as previous studies presented in chapter 2 have highlighted these links. However, this thesis provides important new information on the links between IPV, family planning, HIV/AIDS, and mental health, which has implications for health policy in these areas as discussed below.

8.2.2.1 Implications for family planning programmes

Use of family planning methods was a recurrent theme related to violence among female survivors, health care workers and in community FGDs with women, as presented in Chapter

6. Participants explained that many men do not support the use of family planning and most men who oppose family planning are abusive. Interviews and FGDs with health care workers revealed that many women access family planning methods without the knowledge of their husbands. These findings are supported by findings in Malawi[432] and elsewhere (chapter 2.4.1.4). According to women's descriptions men who perpetrate family planning related violence can be categorised as the vulnerable, the less knowledgeable and the deviant or violent group. The vulnerable group perpetrate violence because of jealousy, fear that their wives are going to engage in extramarital affairs and perceptions that women are looking much younger and more attractive than them.

The second category perpetrates violence because they feel that family planning methods will make them sick, particularly as a result of culturally specific illness perceptions. For example lack of menstruation after taking Depo-provera is interpreted within cultural beliefs surrounding the resulting accumulation of 'bad blood', which are perceived to lead to illness in sexual partners (see chapter 6). Prolonged menstruation is also problematic in this context since the man is not allowed to have sex with a menstruating woman. Yet, many women using clandestine family planning methods may prefer these long-term methods so as to avoid being discovered by the partner. These findings echo those of a Ugandan study showing that men fear ill-health due to family planning methods [59]. This study did not explore this further with men's groups to understand what the nature the illnesses might be. However, previous studies in Malawi have found that women and men do not use family planning methods due to side effects [433]. Depo-Provera is known for side effects including loss of libido prolonged menses and amenorrhoea [434]. This could be a potential area of conflict in families, considering the role of sexual problems as triggers of violence cited in the literature. Lastly with regard to the 'deviant group', women explained that many men who prohibit their wives from using family planning are abusive, meaning family planning may only exacerbate the already existing violence in the family. These are likely to be very controlling men.

These findings have practical as well as policy implications. Knowledge about these categories of men would assist family planning providers to better assist their clients. For example one of the IDI participants had visited the clinic to request for Norplant removal prior to her husband slitting the skin of her upper arm in attempt to remove it after she was advised against doing so at the hospital. Currently efforts are underway to encourage men to get involved in reproductive health matters that concern their wives[432, 435, 436]. However,

health providers ought to be aware that not all hospital escorts do so to support their wives. Some controlling men would escort their wives to ensure that the wife has succumbed to their wishes. Therefore the implications of this study are that there should be efforts made to ascertain the safety of the woman before engaging their male partner. Health care workers also need to be aware of the cultural implications of particular side effects such as prolonged bleeding/amenorrhea and their potential to trigger conflict and violence, so that they are able to take these into account in counselling individual clients.

8.2.2.2 Implications for HIV programmes

Discussions on antenatal HIV testing revealed that some believed it to be mandatory as illustrated by the following response:

> *"What is happening nowadays is there is a law that every woman attending antenatal clinics whether she likes it or not should be tested based on the advantages." (FGD, health centre)*

Another recently published study has shown that Malawian women perceive HIV testing to be mandatory and suggests that some may avoid ante-natal care as a result [437]. This supports studies from elsewhere including Uganda where the lines between mandatory and voluntary testing are effectively blurred in HS delivery[438]. Data presented in this study shows that HIV testing can be a violence trigger, supporting other international studies. Policy in Malawi is not that HIV testing is mandatory, but in 2005, the PMTCT programme changed from an opt-in to an opt-out system of testing, which may explain women's perceptions [439]. The current implementation of policy as interpreted by women does not respect their right to choice and may have serious implications for them in terms of IPV, utilisation of Prevention of Mother to Child Transmission (PMTCT) programmes and antenatal services (see Section 2.6.2). The fact that women perceive that antenatal counselling is mandatory or coercive when it is not supposed to be the case raises another question about the quality of HIV counselling services, and this is important considering that our data has revealed perceived deficiencies in the area of counselling. Further investigation is needed of the source of the disconnect between policy and perceived practice, since it is unclear whether the message that testing is mandatory results from health provider attitudes or implied pressure for testing from policy makers/managers.

The implications are even greater for the "universal test and treat" strategy in HIV (where testing is followed by immediate treatment for those testing HIV positive) considering that

about two thirds of the women in PMTCT programmes do not complete the required interventions for effective PMTCT[440]. Malawi rolled out a "universal test and treat" strategy for pregnant women called Option B Plus in 2011. The strategy, uses immediate lifelong ART for all pregnant women who test positive with the aim of trying to eliminate paediatric HIV [440]. Findings of this study (see Chapter 6.4.4 and 6.5.7) also support previous studies documenting problems with disclosure of HIV status to partners and the struggles people face after receiving an HIV diagnosis including: hiding drugs, being forced to share drugs with partner, failure to enforce safer sexual practices and abandonment. Difficulties in partner notification following ante-natal HIV testing may contribute to this loss to follow up, since increased partner notification has been linked to improved uptake of PMTCT [441].

Women reported abandonment or neglect as a form of violence in men's response to them having HIV. Service providers echoed women's voices by indicating that men don't care for wives when sick despite the fact that women care for men when they're sick; although abandonment and neglect does happen to men, it is seen as more unacceptable socially. This is related to cultural gendered expectations and the lack of a cultural script or model for men to follow when wives are chronically or terminally ill. It would appear that widespread HIV-infection and the context of increasing poverty and economic insecurity have created this new type of violence of neglect and abandonment of wives with HIV. These findings support international literature showing vulnerability of women with HIV (see Chapter 2.4.1.3) and has implications for HIV Testing and Counselling (HTC) for care and support for women living with HIV and PMTCT programmes.

Implications for HTC are that counsellors need to pay more attention to providing support for disclosure. Couples HIV Testing and Counselling (CHTC) aims to promote immediate disclosure within the counselling sessions and to facilitate discussion of how the HIV positive partner(s) will access care and support. However, CHTC does not usually explicitly address issues of violence, which has been seen as a barrier to the utilisation and effectiveness of the service. The potential for expanding and deepening CHTC to explicitly address violence is discussed in section 8.3.2.4. Discussion of these issues is also needed as part of the health promotion and primary prevention interventions with the wider community in terms recommended in section 8.1. Innovative programmes that would address the problem of the lack of a cultural script or model for men to follow when wives are chronically or terminally ill with HIV are required in Malawi.

Despite the multiple and complex connections between HIV and IPV revealed by the perceptions and experiences of the participants in this study, a recent published study examining the relationships between women's self-reports of IPV and their confirmed HIV status, using DHS data from ten low and middle income countries in Asia, Africa and America, did not find a significant association between the two. Only a third of the country specific data showed significant associations. Malawi was included in the analyses. The study concluded that the IPV and HIV link may not be a global pattern and that if so HIV prevention efforts need to focus on other areas and not adult IPV [329]. However, this study contributes to the literature presented in chapter 2.4.4 in suggesting that a link between IPV and HIV exists, particularly in some specific contexts, but the pathways are complex. There is a possibility that such complex links cannot easily be established through quantitative methods. However, this calls for more longitudinal population based studies since the data used by Harling [329] was cross sectional and as such causal relationships were only inferred.

8.2.2.3 Implications for SRH programmes for young people

The study findings show a high level of concern about the potential health outcomes of sexual violence among young people and particularly young women, which are in line with documented adverse health outcomes including unintended pregnancies, abortions and risk for HIV and AIDS [442-445]. Negative, judgemental attitudes and denial of young people's experience of sexual violence contribute, along with a range of other individual, cultural and institutional barriers, to low utilisation of health services following violence. Low access to and utilisation of post rape services in turn further limits young women's options to prevent pregnancy and HIV infection (through emergency contraception and Post-Exposure Prophylaxis). Previous studies have reported that premarital and extramarital pregnancies are highly stigmatized in Malawi [446], with some parents being more distressed about the possibility of their daughters' premarital pregnancy than they were with the possibility of HIV infection (37). The study supports the previously documented role of parents and particularly mothers of young women in decisions to seek unsafe induced abortions, and young women's recognition of this as a further form of sexual violence. The findings also suggest that the contribution of sexual violence in intimate pre-marital relationships is an under-recognised health problem for young women in Malawi and its contribution to unsafe abortion has received insufficient attention [447].

This study also supports findings in Malawi and sub-Saharan Africa that the giving of gifts and money to young women is a commonly expected component of intimate partner relationships [448, 449], which contributes to power differences and compromises their ability to resist forced sex and high risk sexual behaviours [449]. There has been some discussion about whether such gift giving in young people's relationships in Malawi constitutes 'transactional sex' as characterised in the HIV literature[448]. This data suggests that young women did not perceive the gifts they received from young men as directly transactional in nature, but that the gifts contributed to limitations on their ability to decide whether to have sex or not in a context of threatened violence and wider gender inequalities.

The implications of these findings are that further attention to the specific needs of adolescent and young unmarried women and men is needed in reproductive health programming, including strengthening efforts to improve the youth-friendliness of reproductive health services [450]. Community-based IPV prevention programmes also need to include specific efforts to address young people's situations, by recognising the prevalence of IPV amongst unmarried youth and targeting them separately in discussions of the specific gendered norms and power relations they experience.

8.3 Disconnect between recognised magnitude and health sector response

The findings of this study have revealed a gap between the perceived magnitude of IPV and the subsequent health sector responses. Narratives from all stakeholders pointed to the fact that the problem of IPV is perceived as extensive in Malawi. A significant proportion of women, young people and some men are perceived to have experienced various forms of violence including physical, sexual, psychological and economic forms. Chapter 5 has shown that the health sector frameworks, policies, guidelines and some of the training manuals reflect this and acknowledge the role of IPV as a risk factor for major health conditions including HIV and AIDs. Nevertheless the responses to address IPV in Malawi have been limited until recently. As discussed in Section 8.2 above, gaps in knowledge and care provision are related to inadequate coverage in the curriculum, prioritization of physical over psychological and social problems in the health care system, and a lack of primary and secondary prevention interventions. Negative attitudes of providers as a result of culturally scripted understandings of violence were also prominent. The following sections discuss first the evidence for the factors influencing the inadequate health sector response, and then the

available models and opportunities for improving the health sector response in the specific context of Malawi.

8.3.1 Why isn't the health sector response adequate?

8.3.1.1 Lack of political prioritisation

Despite the overwhelming acknowledgement that IPV is a huge problem and a determinant of some of the major health problems in Malawi; Chapter 5 shows that IPV is not regarded as a priority public health problem. Discussions on prioritisation of violence in health services revealed that some do not regard IPV as a legitimate problem for the Ministry of health as these were perceived to be under the jurisdiction of the Ministry of Gender, Police Victim Support Units and Non-governmental organisations. The lack of recognition of violence prevention as a public health priority has been documented internationally (chapter 2.7.1.3), and this is a major challenge for advocates of an improved health sector response to violence [4]. Since historically much of the gender advocacy in Malawi has occurred outside the health sector, this has not always made links sufficiently to biomedical outcomes to inform health sector prioritisation, as observed [358]. Interviews with some key donor agencies revealed that it had never occurred to them that the health sector could be an avenue for violence prevention activities. The lack of evaluated and disseminated models for health sector responses to IPV documented in the international literature is likely to contribute towards this. HCWs reported that most interventions are developed and implemented by the Ministry of Gender and non-health NGOs, and tend to focus on awareness raising and training related to justice such as training for the Police Victim Support Unit. Many HCWs are unaware of the health consequences of IPV because GBV has never been part of their professional training [451]. The findings of this study partly support these observations. However, HCWs in this study seemed to be conversant at least with some of the major health consequences of IPV such as the links between IPV and HIV, poor reproductive health outcomes, physical and mental health consequences. However, many participants viewed the narrow biomedical approach to health adopted by the training institutions, which prioritises physical over psychosocial determinants of health, as problematic. HCWs admitted that they meet survivors of violence in their daily work but they are inadequately prepared to handle such cases.

Priority setting, which is influenced by politics and policy incoherence, impacts on the quality and quantity of human and financial resources made available, and the up-take of new

ideas targeted at underdevelopment [419]. Although to some extent stakeholders believe that legislation and policy have been helpful in changing norms and driving some changes at service provision level (see 8.1), this study (chapter 5) shows that participants also acknowledge that IPV has a low political priority and this influences resource allocation. Key informant interviews presented in Chapter 5 revealed competing priorities for the Ministry of Health. Discussions around prioritisation of VAW in the ministry are generally centred on comparing it with what are perceived to be the key health issues such as Malaria, Tuberculosis and HIV/AIDS. While local conditions may have influenced this perspective, areas of focus at international level, including the MDGs may also play an important role with regards to positioning of violence issues in the ministry of health. Lack of funding for violence at international level has been documented[244], and was prevalent in the accounts of gender based violence service providers (chapter 7). The situation could be even worse for the Malawian health sector with all the human, health and resources problems highlighted in Chapter 3.

Interviews with key informants highlighted how lack of a clear channel of resource allocation presented a key challenge for implementation of violence activities in the health sector. For example, IPV activities are not part of the essential health package (EHP) and this means there is no office charged with responsibility for IPV services. Lack of an office responsible for IPV, VAW and VAC meant there was no funding allocated for violence against women and children. Budgets are prepared by responsible directorates and SWAp funds activities according to what has been budgeted. Furthermore, there has been poor coordination within Ministry of Health directorates dealing with the various aspects of violence due to the lack of a co-ordinating body.

8.3.1.2 Implications of aligning violence activities in the directorate of non-communicable diseases (NCD)

The study has found that the Ministry of Health in July 2011 established the Non-Communicable Disease and Mental Health (NCD). The intention was to cover cancer, diabetes, cardiovascular diseases, other chronic illnesses such as epilepsy and a broad range of mental health issues including violence and trauma. Considering that IPV has lower direct health burden compared to the other disease in the NCD there is a possibility that violence issues may be forgotten within the department. This may be true in light of the lessons learnt from the implementation of the OSCCs in Malawi. A previous study on OSCCs in Malaysia revealed a lack of commitment from top level policy makers despite the existence of a

Violence and Injury Prevention Unit at the Ministry of Health as priority was given to clinical conditions such as cardiovascular diseases [452]. Competing priorities within the NCD may mean that IPV will still be undermined within the Ministry of Health in Malawi. In addition, the NCD may be less gender sensitive compared to services such as reproductive health and HIV services.

Implications for mental health services

However, an opportunity for effective implementation of violence activities exists within the NCD especially if violence is aligned with mental health services. Mental health problems and IPV are interlinked because they share common risk factors such as alcohol and drug abuse. Findings in our study revealed that men who use alcohol and abuse drugs are perceived to perpetrate the most severe forms of violence. Mental health services can therefore serve as an important entry point for dealing with violence issues. People who abuse alcohol and drugs may be screened for IPV within their relationships (as either victim/survivor or perpetrator, or both). Therefore, specialist interventions that are geared towards addressing mental health, alcohol/drug abuse and IPV and their intersections are needed.[453]

Implications for alcohol interventions

The relationship between couple conflict, drug and alcohol abuse has been described as complex and reciprocal; and results in high levels of relationship dissatisfaction, instability and both verbal, sexual and physical aggression. These conflicts are common among couples in which only one partner abuses alcohol and drugs and where the alcoholic has relapsed. Several interventions have been used to deal with both IPV and the problem of alcohol such as ' turning up the pain' (the individual is confronted with unpleasant consequence of abuse), Communtiy Reinforcement Approach (providing incentive to stop drinking) and these have been extended to include family training or behavioural couple therapy. Literature has demonstrated that community approaches have proved to be more effective than individual interventions or confrontational approaches. Interventions therefore need to recognise the role of alcohol as a trigger for IPV and the impacts of both alcohol and IPV on mental health at campaigning and awareness-raising messages against violence. Participatory dialogue with both women and men about the role of community, significant others including

spouses and about individual couple communications is required. While passing the law of controlling age of alcohol consumption and availability by increasing the sell price of alcohol may be effective, community approaches are more relevant in Malawi. Many people consume local brewed beers making it difficult for law enforces. The Malawian family has a strong familial ties where significant others including nkhoswe are involved in resolving family conflicts as such community reinforcement approaches and family training approaches may be to be more effective given the familiarity with family involvement in domestic issues. There is also a need for exploring alternative income generating activities with women as many may depend on beer brewing as their main source of income.

8.3.2 Cultural values: private nature and normalisation of violence

The lack of prioritisation of violence in the health sector is also related to the cultural interpretation of violence across Malawian culture. As outlined in chapter 3 marital issues in the country are considered to be private and the responsibility of the marriage counsellors. As shown in Chapter 7 1.3.2 HCWs as members of the communities also believe that IPV issues should be dealt with by marriage counsellors unless there is a physical injury that cannot be handled by marriage counsellors. As such many HCWs feel obliged only to do what they are supposed to handle and leave the rest to the marriage counsellors to sort out. It was clear in this study that some HCWs felt that if they have to provide counselling to couples undergoing violence then they may step into the role of the marriage counsellors, which they felt is out of their jurisdiction.

The other challenge that may lead to the lack of prioritisation of IPV in health services is the dominant cultural beliefs and values of 'normalisation of IPV. These values and attitudes inherent in the HCWs and policy maker's opinions may inform how the health sector responds to violence. Normalisation of this problem results in low prioritisation by health services since most IPV is not perceived as a problem [44]. As mentioned above, this can lead to 'normalisation' of violence among health care practitioners. As a result it may be important for policy makers and providers in the health sector to be sensitised on gender issues, and deal with their own values so they are able to see IPV as a priority. It is important also to take into account that health practitioners dealing with GBV may well have experienced violence themselves. Research in South Africa found that among 36 female nurses undergoing GBV training (8 males were also interviewed) 25 had themselves experienced violence[269].

8.3.2.1 Gaps and inconsistencies in legislation and policy

As shown in Chapter 5, the implementation and dissemination of legal and policy documents is limited. The review of documents and interviews with various stakeholders' highlighted gaps and inconsistencies in the legislative pieces meant to fight violence including IPV. A number of conflicts and gaps can be identified in the legislative environment that undermines efforts to address IPV and Violence against Children in Malawi. The absence of a legal framework in the area of reproductive health is considered as a major setback for the development of a comprehensive health sector response to violence and abuse in the country. It is argued that such legislation would give individuals, including women and girls, basic rights and attendant responsibilities to decide freely on reproductive health issues free from discrimination, coercion and violence [454]. Considering that reproductive health rights are inextricably linked with the factors that predispose women and girls to HIV and AIDS, a reproductive health law would therefore give a framework for the protection and advancement of reproductive and health rights by all persons, including women and girls, contributing to their empowerment to protect themselves from HIV infection or re-infection.

Lack of clarity about the role of the health sector in justice processes for IPV in legislation (such as the DVA) has also led to weak medical-legal linkages including to poor referral mechanisms, lack of feedback and the unwillingness of HCWs to give evidence in the court of law (due to lack of training and resources provided for this). This echoes findings of a review of sexual violence legislation in sub-Saharan Africa, which found that many sub-Saharan African countries do not yet have substantial co-ordination between HIV and sexual and reproductive health services, the legal and judicial systems, and sexual violence legislation [272].

8.3.2.2 Under-reporting in the health sector

This study has shown that under-reporting is another significant reason for the low priority given to IPV by the health sector because it influences understandings of the magnitude of the problem and therefore political priority and budget allocation. Findings of this study presented in chapter 7 have revealed that IPV is generally perceived to be underreported in formal services including the health services. These findings are echoed by previous studies, both in Malawi (chapters 3.5.3, 3.7.3) and other contexts, discussed in chapter 2. These studies show that IPV is underreported because it is regarded as a private matter, a shameful thing, and a trivial issue, but also due to lack of availability of services and knowledge of the

existing resources to assist survivors. The literature has also documented more reliance on informal than formal sources of help and that women would only seek help from formal sources of help when abuse is perceived severe and there is no help forth coming from the informal sources (see Chapter 2.5.2). Our findings confirm that the majority of survivors use informal sources - family, friends, and neighbours, marriage counsellors, religious leaders/church - and traditional leaders more than they would seek formal support such as health services and the legal system, including police and the courts. In addition, this study found challenges at an individual and family level, society/community and institutional levels that acted as hindrances for reporting violence. These factors entangled with each other in the care-seeking process making it difficult to blame a single individual or the system for underreporting of cases.

Barriers to help seeking

Some survivors did perceive the need for assistance from formal sources of help including police and health services. The data revealed that violent situations that were perceived as minor were largely resolved within the informal setting while cases perceived as severe were more likely to be referred by traditional leaders for formal help (police, health services, NGOs and Judiciary). However, the data also showed that some of the cases that warrant health care interventions were nursed within the communities or disguised when they sought help from health services for fear of partner arrest. International literature has identified a similar phenomenon across cultures, which has led to the conclusion that the official statistics on the prevalence of IPV are but a tip of an iceberg and subsequently questions as to whether this hidden part of the iceberg is truly hidden from public scrutiny or whether communities maintain major silences around it [208]. This study has suggested that in the Malawian setting a significant proportion of violence is visible in the community (with the exception of sexual violence) but does not get reported to formal sources.

A previous study on help seeking for young people identified six pathways to help seeking including dead end, backfiring, circuitous, via intermediary and shaped [455]. Murray in their study explains the metaphor of a river of prior help-seeking pathways. This metaphor suggest that unproblematic prior pathways (direct) may assist crossing the river (i.e. progressing towards help seeking) while problematic prior help seeking pathways (dead ends) may impede crossing it (i.e. progression will not occur, or be delayed or be circuitous). Although the Murray study was conducted among young people and for cases of bullying some of the

categories identified by the Murray study are relevant for explaining the findings of this study. This study has revealed that many survivors pass through problematic pathways in their quest to seek help with IPV. Barriers to seeking help were many at every level of service provision. A multitude of responses were captured on factors perceived to have contributed to underreporting in health services and these could be better framed within the ecological framework model (see Chapter 2.3.6). Challenges at individual (micro systems) and family level, society/community and institutional levels were often cited by participants in the interviews. These factors entangled with each other in the care-seeking process making it difficult to pinpoint a single individual or system-related cause for underreporting of cases. The levels at which factors operate also clearly interact closely.

At the macro level, policy gaps and inconsistencies, a culture of normalisation of violence, secrecy, and endurance interact with the individual's beliefs or attitudes towards violence hindering individuals from seeking help for IPV. Once survivors engage on a journey of help seeking mostly starting with their *nkhoswe* they get little help. This is partly because of the pressures of cultural norms as discussed in Section 8.1, which operate primarily to preserve the stability and integrity of the marriage and therefore the extended family unit and relationships. However, it is also because *nkhoswe* often lack the skills and resources to help. Survivors are often discouraged at this point from taking further action in the interest of preserving the marriage. Soon the survivors reach a dead end and can no longer pursue the issues further. There also appears to be an excessive level of red tape at the community level for reporting IPV. As highlighted in chapter 7 the first point of contact is the *nkhoswe,* who may be comprised of a number of multiple individuals, who are sought in turn. Depending on the perceived degree of violence, the issue may need to go through various channels before it reaches the village head man who may refer the case to police then to health services or court. This referral mechanism may result in delayed justice for the survivor and withdrawal, due to thinking there is nothing more that can be done. At the institutional level some survivors hit a dead end because providers threaten that reporting IPV would result in partner arrest. Accounts of attempts to seek help backfiring were also common in this study. Survivors reported that arrest of partners resulted in worsening violence from partners or divorce leaving them destitute without any support and with the children. Often times the process proved to be circuitous, survivors ended up being referred back and forth without proper assistance. Whilst the adult survivors encountered circuitous pathways, the case was different for young people facing IPV in their relationships. The perceptions of young people revealed

that many young people hit the dead end faster than their older married counterparts because they literally have no support mechanism to report their issues to.   Help seeking from friends proved useless.

The study found greater emphasis on trying to resolve marital conflict at every stage of the help seeking process. Limited models of help giving to survivors often acts as a hindrance to help seeking at the next level. It may be seen from this, that responses from sources of help may pose a significant challenge to seeking further help considering the nature of the help seeking process being utilized by IPV survivors.

Poor referral pathways into health services

Chapter 7 has demonstrated that there are some informal referral mechanisms existing at the community level for IPV and to some extent for child protection issues. However it is also clear from the data that there are gaps and inconsistencies in the referral pathways used by formal sources of support. This study found a back and forth model of help seeking for IPV with formal services referring women back to their informal sources of help. By sending survivors back to informal sources of support, formal services acted as if they were not knowledgeable about the help seeking process involved in IPV; that survivors would only come to them after they have exhausted the informal sources. Formal sources seemed to follow a policy of non-interference in marital issues and there appeared to be an established norm that puts mediation at the centre of all services for IPV including those offered by reinforcing officers (such as police and social workers). This one size fits all intervention where the readiness and appropriateness of the intervention were not assessed resulted in many women getting frustrated and creating a sense of helplessness within the survivor that led them to withdraw from seeking further help..

Poor information management, recording and reporting

Although the majority of survivors do not seek help from formal services, a significant minority do seek help from formal services, especially when violence is severe (chapter 7). However, data on those who do reach formal health services is not well managed. Evidence from interviews discussed in section 7.1 and the register review in section 7.3 demonstrate that poor data and information management at institutional level has made it difficult to understand or appreciate the magnitude and the burden of IPV, which is acknowledged in the SHRR policy (chapter 5). The study found that IPV as cases in health services are not well documented. The HMIS does not include indicators for violence. Lack of indicators for

violence in the HMIS further undermines perceptions of the scale of the problem of IPV as a public health problem that results in poor or no documentation of IPV in health care records. Interviews with HCWs revealed that they feel obliged to document issues for specific reasons. SV or rape cases were documented not because they were violence cases but for the purposes of justifying why PEP was given to the particular individuals. Although there is some evidence of documentation of SV, the data are poor quality and inconsistent. Including indicators of violence in the HMIS or devising ways of recording and reporting IPV would assist to legitimise documentation of IPV cases as it would signal to HCWs that it is an important problem worthy of being monitored and evaluated. Specific categories of IPV, including SV should be included in this documentation. A lack of training on documentation of IPV has previously been identified as a challenge for documentation of IPV in health care settings [456]. Therefore it is also necessary to focus on the importance of training service providers to use the system appropriately. The challenge is that few rigorously designed evaluations have been conducted of training programs for healthcare providers [456], and data on effectiveness of these remain inconclusive [9]. It may also be important to recognise that lack of training may only be one aspect; there may be other reasons including fear of being called to testify in the court of law. Narratives from the HCWs and police have revealed that many HCWs are reluctant to provide evidence in court and lack of documentation may also lead to a lack of evidence in court. A previous intervention study in the US which sought to improve documentation of IPV cases in health care settings did find that HCWs were unwilling to document IPV because (a) they failed to recognise how documentation linked with a patient's ability to seek protection, (b) they feared that documentation could increase provider's risk of medical malpractice liability, (c) believed that documentation of IPV could compromise privacy and confidentiality issues, (d) believed that documentation will increase the likelihood of being called to testify in court, and (e) lack of specific training regarding time efficient documentation of injuries, patient statements and observations. The study also found that lack of completeness of the documents made the attorney's not utilise the records as sources of evidence [457]. Such flaws they concluded compromised the ability if the patients to get justice[457]. Similarly, interviews with police revealed that they had problems with reading the health care workers hand writing and interpreting the medical language which compromised the ability of the survivors to get justice. Consultation with different cadres of HCWs who would be required to record and report data would also be necessary in developing an improved recording and reporting system so that these types of issues could be

identified and the necessary support and resources provided to enable the sustainable operation of the system.

8.3.3 What are the opportunities for improving the health sector response?

This chapter has so far discussed the nature of and reasons for the inadequate health sector response to IPV in the specific legal, cultural, socio-economic, political and institutional environment of Malawi. The following section considers the current opportunities for improving the health sector response with reference to possible models emerging in Malawi and in comparable contexts such as other sub-Saharan African countries, and discusses the opportunities and constraints for their sustainable implementation in Malawi.

8.3.3.1 Screening

In spite of the inclusion of screening for Sexual and Gender Based Violence in the current strategic health plan (chapter 5), interviews with HCWs revealed mixed feelings about screening for IPV in health care settings in Malawi. Whilst other HCWs viewed screening for IPV as a positive move that would help to eradicate non -disclosure of IPV and help estimate the burden it poses in health care settings some were sceptical about its feasibility considering the human, resource, infrastructure and attitudinal problems of the HCWs. The choice between universal and selective screening was not clear either. Engaging in universal screening in the Malawian health services as outlined in the strategic plan (chapter 5) may need to be approached with caution considering that community perspectives of IPV revealed broad understandings of the word violence (see 8.1.4.5). Using the broader definitions adopted by communities in health services has the potential of identifying almost everybody as a survivor of violence. This may then pose a challenge for the already overwhelmed health systems as discussed above. The same fears were raised by HCWs, policy makers and other relevant stake holders and these were similar to those in the literature on screening reviewed in chapter 2. Considering that screening for IPV is an important in IPV prevention, I would argue for a narrow definition of IPV for effective health sector screening programmes. The definition adopted by the World health organisation may well be fitted for this because of its emphasis on the potential effects of harm. As argued by Kilonzo, gender mainstreaming policies often fail in health services because they do not adequately speak to the bio-medical consequences, therefore definition that speaks to the harm of IPV (health consequences) may be well understood by health providers.

A systematic review of barriers to IPV screening in health care settings has revealed that recommendations on IPV screening in the health care setting, and the patient's willingness to be screened do not translate into actual, sustainable screening practices but individual providers attitudes, and self-efficacy beliefs influence their willingness to screen[458]. In relation to the potential for mainstreaming screening it is important to emphasise that while this will be a key step in mainstreaming GBV in the health sector and in building a functioning referral system, it is recommended that screening be developed in tandem with in-service training procedures that build up sensitivity and capacity among health staff and also improvements in the health care settings environment that would promote disclosure of violence.

The intimate nature of questions used to screen for GBV requires that staff fully understand the consequences of establishing whether a woman, man or child has experienced violence. HCWs need to have clear instructions for how to deal with disclosures of violence and a pre-defined and visible referral pathway in order to be able to assist survivors appropriately. If screening procedures are implemented separately from in-service training and with no formal referral pathway established, survivors may experience worse trauma through disclosing intimate experiences with no clear benefit or outcome. In addition, sensitisation campaigns ought to be conducted with the masses so they understand why a problem they for a long time have considered to be private has entered the gaze of the health sector.

A lack of models of screening programmes for IPV in the sub-Saharan region may also present a hindrance for engaging with screening in health settings. However, a programme that is being tried out in Kenya may serve as a model if managed successfully [459].

However, the study did find that there are several entry points for IPV in the health care services such as STI clinics, ART clinics, maternal and child health departments, and outpatients departments among others. These findings are in tandem with findings of a literature review that examined models of health service responses to IPV in low and middle income countries [7]; and these have implications for IPV screening. Different entry points may mean that survivors present at different points with different health conditions. This has been identified as a challenge for screening interventions, and especially for selective or diagnostic screening. However, I recommend that selective conditions may still be used at different entry points as screening questions for IPV. For example, this study was able to identify some survivors of IPV using difficulties in partner notification and recurrent STIs as cues in the

STI department. These questions may be more applicable to the specific departments as such may need to be included in the screening tools for the particular department.

8.3.3.2 Training

As discussed in the sections above mainstreaming training on IPV, its consequences and potential health system responses is required as part of all HCW training. The literature on mainstreaming gender and HIV highlights the importance of taking a holistic approach with simultaneous action at multiple levels [460] and prioritising gender training for health workers and community level players, including a focus on exploring health workers' own norms and values[461].

However, there are few examples of such training evaluated in the literature from sub-Saharan Africa. An exception is a gender violence training module which was integrated into an on-going reproductive health curriculum in South Africa [269]. As discussed in Chapter 2.7.1.3, the training first elicited provider perceptions and then intervened to raise gender-awareness in both personal and professional capacities. The evaluation of the programme showed that the programme was successful in raising self-awareness of the health care providers, and led to increased involvement in actions to tackle violence. However, the authors conclude that more needs to be done to inform the development of appropriate training strategies for health care workers, particularly in developing countries.

In Malawi, there are curricula on family planning and couples counselling in relation to GBV already drawn up by the Ministry of Health and available for use in pre- and in-service training for health sector programmes (chapter 5). These are thoughtful, well designed and comprehensive curricula. However, these are only used to train staff in these specific areas (i.e. Family Planning and to some extent HIV services). An important step would be to make use of more comprehensive curricula in general pre-service training as there is evidence (see section 7.2.2) that the current curricula on IPV are more focused on the 'medical model' approach to violence in healthcare, without sufficient emphasis on the psychosocial and emotional care needed.

8.3.3.3 OSCs and referral pathways

One stop centres are currently the major response to IPV that is being developed in the health sector in Malawi. One Stop Centres have been implemented in order to facilitate case management for violence against women and children at primary health care level. These

Centres will be implemented nationwide in all the major district hospitals and therefore provide opportunities for mainstreaming of violence against women and children services throughout the health sector. An evaluation of the OSCCs revealed that sensitisation training, changes to care structures, time and privacy are necessary for the frontline to effectively function in their role and for the successful implementation of OSCCs. In addition to equipping frontlines, the study recommended that commitment and prioritisation of IPV are necessary at policy level [452] and that there is a need for flexibility in the implementation of OSCCs according to levels of service delivery. This study suggests that there are several areas regarding the function of the OSCCs that require improvement; which particularly centre on their effective linkages with and integration into the wider health system at all levels. It is important that a referral system is integrated into the development of One Stop Centres since these are being established to directly address violence and can act as a learning 'hub' for other sections of the health sector.

At the district and local level stronger links need to be forged between the hospital staff, many of whom are unaware of the OSCs, and the Centres. The One Stop Centres should work closely with hospital staff in order to facilitate reporting and referral between health practitioners. This could be facilitated by a district-level taskforce including members from different staff cohorts who could report on GBV cases monthly or quarterly. An additional area of opportunity for building an effective referral system is by making further use of the Social Welfare Officers located within hospitals as there is evidence that they already act as a point of contact between One Stop Centres and other departments within the hospital.

In addition there needs to be good communication links established between health clinics functioning at the community level and the district One Stop Centres in their area. It is important too that a referral system includes Health Surveillance Assistants and Village Health Committees since these potentially represent the 'first point of contact' for referral of SGBV in the community and are in a good position to make referrals to the One Stop Centres if appropriate. Training and sensitisation at this level is extremely important. However the centres may be too distant for some to travel to. This means that local clinics, VHCs and HSAs need to provide support and care for those who do not make it to the One-Stop Centre. This underlines the importance of linkages between the local health facilities and those at district level and also the importance and significance of training on GBV to reach health practitioners at ground level.

In addition, the Centres need to incorporate services for adults in order to effectively deal with gender-based violence among women.

8.3.3.4 Couples counselling

All stakeholders in this study perceived that counselling services would go a long way to reduce the effect of and prevent violence among couples. Members of the community felt that counselling services established within their reach would better to serve their needs whilst service providers felt they needed to be equipped with counselling skills to assist these survivors. The desire for counselling skills in the Malawian setting may not come as a surprise since culturally people have grown up in an environment where everybody believes marital conflict has to be mediated, hence the presence of marriage counsellors.

One of the few pools of relatively skilled human resources for providing counselling within the health sector is the HIV counselling and testing programme. Couples HIV testing and counselling (CHTC) is one option here that could be used as a starting point for developing counselling services that explicitly address IPV issues. Malawian HTC data show relatively low uptake among couples [319, 320] and no data on IPV [462], even though Malawi is one of few countries to have an IPV screening tool in its CHTC curriculum. This chimes with data from elsewhere in the region where utilisation of CHTC remains low [463] and a lack of consistent guidance on the components of CHTC remains a challenge [287]. Couples HTC curricula can range from simply HIV testing male partners in PMTCT services, to efforts to enhance communication dynamics within couples, to gender transformative counselling where providers are sensitized to the links between gender inequality and HIV and trained to challenge harmful gender norms, attitudes and behaviours in couples. These latter illustrate the potential for strengthening integration of HIV and IPV prevention services.

CHTC and IPV screening interventions that address gender inequalities have improved PMTCT outcomes [463-466]. In South Africa six sessions of counselling among women seeking IPV services decreased HIV risk when compared to a single workshop [467]. In Namibia brief motivational interviewing has been successfully used in alcohol reduction programmes among men[468]. However, HIV-positive women continued to face difficulties in condom negotiation and critics point to a lack of follow-up support with trained counsellors.

The subject of couple counselling in IPV in the international literature has been controversial for fear that a female participant might be coerced into participating in such programmes.

However, studies are showing that it is one of the promising approaches for secondary prevention of IPV where the couple agree to counselling, wish to remain together and there is low to moderate violence [219]. Most of these studies have employed cognitive treatment models. Studies have found that couple counselling is more effective than individual counselling and that group couple counselling was the most effective [21]. Couple counselling also appears to be effective in reducing IPV among people who are alcohol and drug abusers. Extending and deepening couples counselling for HIV to include IPV issues and their mutual gendered drivers may therefore be an appropriate, feasible and sustainable approach to improving the counselling options for IPV prevention. This study has shown that a deep understanding of family structures, violence and community norms around violence are also required if effective context-embedded IPV prevention measures are to be developed. There is a need to build the capacity of counsellors to directly address IPV and also develop community and health service-based referral mechanisms for couples experiencing IPV to CHTC, since self-referral is likely to be limited.

8.4. Limitations of the study

8.4.1 Limitations of the sampling strategy

The methodology used in this study had several weaknesses that need to be taken into account when interpreting the data. First, the qualitative findings draw substantially on a limited number of interviews with male and female survivors of IPV, especially with regard to help seeking behaviour and barriers. The recruitment of these survivors was conducted through a combination of referral from HCWs, NGOs and police and snowballing, introducing both selection and gate keeper bias in the selection of the participants. Using snowball sampling for recruiting survivors had several advantages considering that the research was dealing with a sensitive topic (IPV) and the majority of its survivors are submerged under the ice (see chapter 2). Thus, snowball sampling was used in this study as a method that helped to find the hidden population.

Managers and directors of various gender based violence service organisations were approached by the researcher to help with the identification of survivors. Institutions increased the visibility of the survivors because they had access to survivors they had dealt with. While institutions provided an easy way of recruiting survivors for the study it has been argued that snowballing also has the potential of reaching hidden populations because of its concentration on social networks. The case is likely to be for the study. Based on the

findings of this study (chapter 6), individuals that access formal services are likely to have experienced severe forms of violence. As such, the voices of people who might have experienced less severe or 'normalised' individual cases may have been missing in the study. This may have impacted the experienced the health outcomes narrated in this study i.e. participants to the study especially women reported severe consequences of IPV. Recruiting survivors using snowballing and through service organization has the potential of introducing both sampling and gate keeper bias. This may have limited the extent to which these results be generalized to the population under study. An alternative could have been to recruit participants using a random sampling which could have enabled the study to confidently draw inferences to the population involved in the study.   However, there was an ethical, time and financial constraint that was involved. A community based epidemiological study was way beyond your means and would also have its own limitations

   As a result the findings on the health implications of IPV may need to be understood within the limitations stated above.   The study depended on self-reports from individual survivors without getting accounts from their partners for ethical reasons (see chapter 4). Depending on self-reports from survivors may mean that survivors some of the accounts may have been overstated. It has been observed that people who are depressed may perceive their abuse to be much more severe compared to women who are not depressed, although our study did not measure depression among survivors.

In this study, survivor's interviews were complemented by findings from the community FGDs. This was the other major qualitative method used to understand the views and experiences of different groups in the wider community. As discussed in section 8.1.1, this method had great strengths in eliciting community perspectives. However, they may also have had weaknesses in terms of the tendency of the method to generate data on majority norms rather than deviant or minority views. In particular, it was noted that a number of the FGDs included relatively dominant participants, which might mean that informal opinion leaders were among the participants, which may possibly have further reduced the likelihood of dissenting views being expressed. Although eliciting community norms was an important part of the study objectives it is nonetheless important to recognise that minority or deviant views may be under-represented.

A range of different voices from within the community were purposively selected including younger and older women and men. However, the scale and complexity of the data collected

limited the opportunities to clearly distinguish between their perspectives and experiences throughout the analysis. For example the perceptions and experiences of younger and older women and men are clearly distinguished in the sections on perceptions of violence but less well separated in the sections on consequences of violence and help seeking, although efforts were made to identify key differences in these sections.

Although it would have been useful to differentiate between the voices and experiences of urban and rural women in the study, the specific study context limited opportunities to do this, due to the difficulties distinguishing between rural, urban and peri-urban areas in Blantyre city and surrounding districts, as discussed in Chapter 3.2.

8.4.3 The limited timeframe for review of routine data

The attempt to estimate the extent of violence using proxy determinants suffered from extreme limitations due to the use of register data which was very poor quality due to poor record keeping and the lack of requirement for recording and reporting violence. Reviewing records retrospectively highlighted the weaknesses in documenting violence evidence in the health sector in the country and the challenges to implementing a screening system.

Due to the limitations on record keeping and the extent of underreporting of violence in the health sector in Malawi documented in the thesis, the data are unlikely to adequately reflect the magnitude of the problem. The registers that were reviewed by the researcher were only for a period of one month. The researcher was over-optimistic that surveying routine data on one month would be adequate to gain useful insights using routine monitoring data. However, the period was too short to enable the researcher to draw conclusions about the rate of IPV reporting and documentation in the health sector considering that there are twelve months in a year. Moreover, January, the month under review is marked with celebrations. The researcher expected a particularly high level of cases during the festive period but despite that expectation, the cases were still low due to underreporting in health services. Whilst acknowledging the role of underreporting, the possibility that festivity may also have impacted on the quality of documentation also needs to be considered.

A prospective study over a longer period would be necessary to draw reliable conclusions on the quality of documentation in the health facility and to adequately explore the issues of poor reporting, whilst a community-based epidemiological survey would be required to establish true prevalence. However, these were beyond the scope and resources of the study.

8.4.2 The use of analytical framework

The complexity of the interconnected factors influencing perceptions, experiences and responses to IPV was difficult to capture in the analysis using the policy-oriented framework approach. Whilst the use of this policy-oriented approach may have advantages in making the data and narratives accessible to policy makers and providers, the greater use of theoretical frameworks such as complexity theory to interpret the data might have better enabled a deeper understanding of the interconnections.

8.4.3 Feedback from stakeholders

Finally, although a stakeholder meeting was convened to gain feedback on the study findings and potential recommendations, this was not systematically analysed as data and included in the findings. Where stakeholders did support recommendations this has been highlighted. However, further in-depth analysis of stakeholder responses to the data would be useful to inform strategic directions in terms of promoting the improved health sector response that is so urgently needed.

Conclusion:

This thesis set out to answer three main research questions. The conclusion will consider the major findings with regard to each question in turn.

First, how does the health related legislative and policy environment promote or hinder the health sector response to IPV in Malawi? This study has developed new knowledge in the form of a detailed analysis of the range of laws and policies relating to IPV in Malawi. The study found that there are a range of laws and policies that define and promote action to prevent IPV in Malawi and that these have had some positive influences on both community norms and health sector responses. However, ineffective promotion of the laws and policies has limited their effectiveness. In addition there are both gaps and inconsistencies in the laws and policies, including: the lack of clear definition of health sector roles in violence prevention, the lack of a clear law against marital rape, the lack of a holistic focus on survivor needs for services and the implication in the PDVA that access to health services for survivors should be through police or social workers. These reduce their potential effectiveness in guiding the health sector response to IPV.

Second, how do different stakeholders perceive IPV and the health sector responses to IPV in Malawi? The study explored the key stakeholders' perceptions of the definition and

magnitude of IPV, its health consequences, help seeking behaviour, the health sector response and the factors shaping it. These perceptions revealed a complex web of interconnected socio-economic, cultural, political and institutional factors that shape perceptions, experiences and responses to IPV.

The data showed that perceptions of violence are culturally normative and related to gender roles and expectations. There are therefore important differences between women's and men's perceptions, and perceptions are influenced by socio-cultural and policy change, including human rights discourses. A generational gap also exists between young unmarried women and men and older generations, who do not perceive the violence that young people experience, nor do they provide advice or support in negotiating intimate relationships. The inclusion of male voices on IPV against men, and using emic definitions of violence revealed conflicts between women's and men's interpretations of IPV, particularly with regard to sexual violence and the transgression of gender and marital roles.

The specific socio-economic and cultural context strongly favours a conflict resolution model of responding to violence, which raises questions about the potential roles that can be played and the mandate of the health sector can play in developing capacity for conflict resolution. However, the health sector is well placed to play a leadership role and has some resources, such as HIV Testing and Counselling staff and curricula to offer in a multi-sectoral response.

Most stakeholders, including HCWs, perceive IPV as a significant problem and recognise multiple impacts on health. HCWs also generally recognise the negative implications of IPV for the effective functioning of health sector programmes including HIV, Family Planning and Sexual and Reproductive health programmes. However there is a clear disconnect between the magnitude of the problem and the health sector response. IPV is not prioritised in health sector strategies or activities. Despite many community members and survivors' holistic perceptions of the health impacts of IPV, the health sector response is too narrowly focused on medical treatment for survivors and does not engage in primary or secondary prevention.

The study identified a range of factors influencing the inadequate health sector response, including: lack of political prioritisation, which is in turn influenced by under-reporting; gaps and inconsistencies in policy; and a culture of normalisation of violence, and in particular sexual violence.

Third, to what extent can health services rely on proxy determinants to identify intimate partner and sexual violence from a health service uptake perspective in Malawi? Proxy determinants as reflected in the health service registers proved to be inadequate due to poor reporting and recording, and under-reporting to health services. Under-reporting was influenced by a range of inter-connected barriers to formal help-seeking, including normative attitudes and ineffective responses by both informal and formal sources of support. However, knowledge was generated about the challenges to recording and reporting IPV in this setting.

The study findings suggested a number of key opportunities for improving the health sector response to IPV in Malawi that may be appropriate in this specific context and considered their potential sustainability.

Recommendations

Capacity building for the health sector

Capacity was identified to be the biggest challenge to mounting a more comprehensive response to violence. Health care providers fail to function or appropriately respond to survivors due to lack of knowledge, skills and attitudes. There was a lack of knowledge of the laws, guidelines, policies and frameworks guiding health sector response to violence against women and children. Given the gaps in health care providers knowledge and skills in dealing with psychosocial aspects of violence and their negative attitudes towards survivors of violence this thesis recommend significant investment in capacity building for health workers of different cadres at all levels, starting at the grassroots with Village Health Committees. The health system needs to systematically integrate violence issues in the pre- and in-service curricula for health service training and other related programmes. Pre-service training curricula for health care personnel should also consider including the psychosocial aspects of care. In-service training is also needed in order to address gaps in counselling capacity among staff. While there are good curricula available for some cohorts of health staff, namely family planning and couples counselling on GBV, these need to be used more widely for pre-service training in order to address weaknesses in this area. In addition, GBV training must take into account the challenges in addressing social and cultural norms among health workers, many of whom see violence as 'normal' and some of whom may have experienced it themselves. Capacity development should first focus on specialised One Stop Centres which can function as a learning 'hub' for other sections of the health

sector. These should be adapted to include adult services, including counselling. For populations beyond the reach of such centres there should be point people in facilities with additional training.

Given the gaps in awareness among health workers of basic referral pathways available to them within and beyond the health sector, the thesis recommend the development of a basic and universal referral system with procedures outlined to be put into practice through training and awareness-raising among health workers. It is important that a referral system is integrated into the development of One Stop Centres since these are being established to directly address violence. An additional area of opportunity for building an effective referral system is by making further use of the Social Welfare Officers located within hospitals as there is evidence that they already act as a point of contact between One Stop Centres and other departments within the hospital. It is important too that a referral system includes Health Surveillance Assistants and Village Health Committees since these potentially represent the 'first point of contact' for referral of SGBV in the community. Community-wide effort that establishes linkages between health care settings and community services at this level may extremely be important in meeting the needs of survivors of IPV and ensuring that more survivors and those at risk of IPV are reached by the services. Community resources could be used to meet the psycho-social needs, whereas health care services could be used to address the health-related consequences of partner violence. Therefore community based interventions are required.

Mainstreaming Screening for violence in health services

In relation to the potential for mainstreaming screening for violence in health services in Malawi it is important to emphasise that while this will be a key step in mainstreaming GBV in the health sector and in building a functioning referral system, the thesis recommend that screening be developed in tandem with in-service training procedures that build up sensitivity and capacity among health staff. If screening procedures are implemented separately from in-service training and with no formal referral pathway established, survivors may experience worse trauma through disclosing intimate experiences with no clear benefit or outcome.

This study has found that fewer survivors do report violence in health care services for various reasons including cultural norms, perceptions of IPV as a non-health issue, poor attitude of services providers and personal reasons. Although, identification and reporting IPV by the health sector would offer opportunities to improve estimates of its magnitude, as

well as service provision for survivors and referrals to appropriate services. It is important that before the Malawian health sector engages in universal screening for IPV as stipulated in the Malawi National Health and strategic plan, there is need for an improved response to cases that are already reporting to health services. The intimate nature of questions used to screen for GBV requires that staff fully understand the consequences of establishing whether a woman, man or child has experienced violence. There is need for the health sector to create a task group to oversee the development of tools, policies and protocols for screening violence. Health care providers need to have clear instructions for how to deal with disclosures of violence and a pre-defined and visible referral pathway in order to be able to assist survivors appropriately. There is need to explore ways to implement service integration in areas where 'One Stop Centres' are not feasible due to human, physical infrastructure and financial resource constraints need to be explored. Explore the potential for integrating IPV screening for violence against women and children into already existing programmes such as sexual and reproductive health services, male involvement, youth friendly services, HIV programmes, mental health services and admission and emergency services where service can be integrated at providers' level. Selective screening of IPV at various points of entry such as admissions and emergency department, family planning, STI and ART clinics, mental health services and antenatal clinics may be used while the capacity of the system is being build up. Close attention should be paid to evaluations of screening interventions in comparable contexts.

There is need for a spectrum of health sector interventions – i.e. across the spectrum of severity – need different strategies for more extreme cases and less extreme cases by health sector – e.g. primary prevention in communities can respond to data on less severe/normative end; HIV, STI as screening entry points would respond to the middle (in couples counselling at least couples can still come forward together) and more severe (STI – individuals have demonstrated they can't come as a couple) end – see diagram below

Figure 8.3 illustrating the need for a spectrum of health sector interventions across the spectrum of severity

Less severe/normalised   *Severe/life*
threatening/extreme   -

Primary prevention   *CHCT*   *Screening at STI/mental*

(Community engagement/mass campaigns)   *health services*
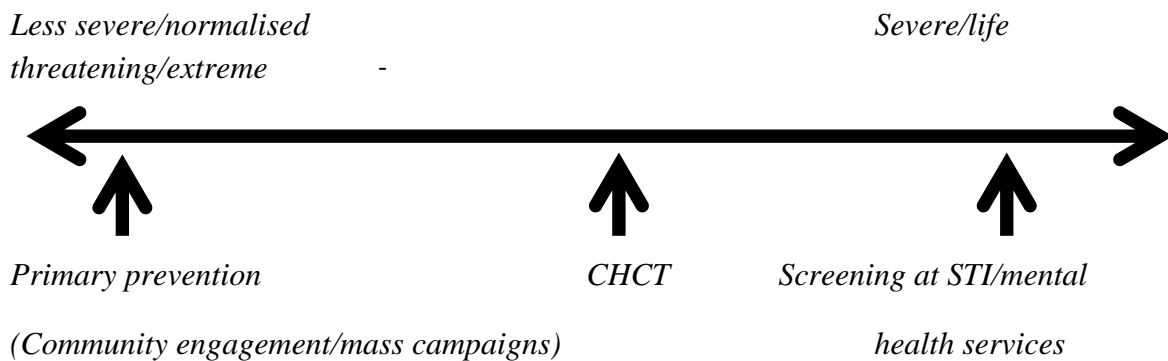
National strategies, policies and coordination of violence activities

In view of confusion over national coordination and responsibilities there is need for the coordination of violence activities to be strengthened and for the Health Sector Strategic Plan (HSSP) to be widely disseminated among health care providers to promote ownership and accountability. The existing strategy documents need to be updated in line with the HSSP and policy ought to be revised so to encourage work across different vertical programmes. At national level responsibility for minimising the public health impact of violence falls under the Non Communicable Disease Directorate. The responsibility for the implementation of a prevention agenda falls under the Ministry of Gender. These two need to work hand-in-hand and develop a joint plan, reporting and close working relationship. Strategies and frameworks should be clearly delineated in function from policies, guidelines and protocols to make it easier for everyone to understand what they should be doing. Policy and planning are the remit of policymakers. This should be led by the policymakers in the Ministries of Gender and Health but with collaborating partners from of a number of other Ministries and institutions including: Ministry of Home Affairs, Ministry of Local Government, and Ministry of Education, Ministry of Youth, Ministry of Justice, civil society organisations and research organisations.

Documentation, Monitoring and evaluation

The health management information system does not contain indicators for monitoring violence cases. Data are needed to describe the magnitude and scope of the problem, monitor trends over time, and identify target populations to focus prevention efforts. Gathering credible baseline and on-going data will advance both prevention and intervention efforts.

Therefore the health system needs to include violence indicators in the Health Management Information System and as indicators in other Ministries. These indicators need to be common across disciplines (health care, criminal justice, social services, development partners etc). There is also need for policies and practices that protect against misuse of data and ensure privacy.

HIV and AIDS programmes

There was a great link between IPV and HIV in this study. The data revealed that IPV interferes with ART and PMTC programmes and disclosure of HIV positive results. There was also an indication that HIV positive status may result into violence and abandonment. Existing couples counselling curricula may provide a useful starting point. Couples HIV Testing and Counselling (CHTC) services offer a potential starting point for developing counselling services for secondary prevention of IPV. Deepening the remit and skills of CHTC providers to explicitly address IPV and gender issues and extending CHTC curricula into mainstream pre-service training should be piloted and evaluated. There would be a need to develop community and health service-based referral mechanisms for couples experiencing IPV to CHTC, since self-referral is likely to be limited, as least until services are established

Preventive activities

Prevention interventions and early identification of violence interventions must underpin the health sector response and be embedded into all aspects of health promotion agenda including community outreaches and school health programmes. There is a need to engage in dialogue with both women and men about understandings of violence in order to carry out primary prevention. Community-wide efforts to establish linkages between health care settings and community services are important. These are specifically required to address community factors condoning violence. Messages need to be tailored to fit specific groups. Specific attention needs to be paid to the needs and preferences of young unmarried people with regard to entry points for prevention of IPV, since their experiences differ from those of older married people and they have very limited avenues of support. IPV prevention programmes are required especially those that address the issues of alcohol. Various strategies such as behavioural couple training and craft methods could be tried in both urban and rural areas and evaluate how these play out in these different social contexts considering that urban

dwellers are often more isolated from social support systems such as *nkhoswe*. Within this collaborative mechanism, community resources such as nkhoswe's, traditional leaders, GBV services and micro financial programmes can be used to address social support services, whereas health care settings could be used to address the health-related consequences of partner violence. In doing so, the health care services can expand its ability in reaching a far much wider population of survivors and individuals at risk of violence since many do not report violence to formal services and if they do, it is a serious condition.

The needs of young people

Young people in Malawi negotiate a complex set of cultural norms as they start to be become sexually active. They are largely unsupported when they face violence in intimate relationships as parents, health care workers and married community members deny their experiences, deepening their vulnerability to a wide range of negative health outcomes including HIV. Gender inequalities suffuse both discourses around sexuality and wider sexual experiences so that young girls have come to expect coerced sex and lack the skills to prevent it or seek help once violence is occurring. Pro-active prevention work with boys and girls in communities is required, but also that health and other services need to develop specific youth-friendly approaches to enable the support required to break the cycles of normative violence amongst youth. The design of IPV programmes should include the experiences of young people as these are often neglected in the main stream violence literature. IPV including life skills programmes should aim to change violent norms around courtship and dating.

Based on the pattern of young people's help seeking behaviour, this study recommends that peer counselling with sufficient training be considered one of the sources of support for young people who experience violence in their relationships. Community programmes that aim at encouraging open communication between young people and parents including significant others should be explored. Community dialogues should also be aim at raising awareness of the impact of adult intimate partner violence on children. The use of modern technology such as telephone text messages, print and electronic as a medium for passing information on violence needs to be encouraged, tried out and evaluated. The ministry of education responsible for primary and secondary education need to re-evaluate the policy on self boarding schools and see how best they can protect young people who stay away from

their parents without jeopardising their opportunities for better education and that violence in young people's relationships should be included as part of child protection measures.

Future research

As the focus group discussions with young people were conducted in Blantyre district alone; the findings cannot be viewed as representing all of Malawi. Since the study focused on perceptions of health services responses to violence, some areas were not explored in depth. For example, we focused on perceptions of violence, so there may be gaps regarding the nature of relationships the participants are engaged in. Although this research identifies limited support from figures of authority, further qualitative study is needed to provide insights into the full range of perceived barriers to support and how these could be transformed to promote resilience among young people. Population based studies are also required.

The use of mass media and modern technology such as use of text messages and podcasts using local voices in local languages can be tried out as a way of passing relevant information to the youth as well as adults and be evaluated for their effectiveness of use with low literacy level individuals.

It was observed the records for a period to enable her draw generalisable conclusions on the quality of documentation in the health facility. A prospective study would be necessary to address the issues of poor reporting, whilst a community-based epidemiological survey would be required to establish true prevalence.

The qualitative findings draw substantially on a limited number of interviews with male and female survivors of IPV, especially with regard to help seeking behaviour and barriers.   The recruitment of these survivors was conducted through a combination of referral from HCWs, NGOs and police and snowballing, introducing both selection and gate keeper bias in the selection of the participants. There is need for conducting a population based study using a randomly selected sample among survivors of IPV. Recruitment of male survivors would also been given a priority since they represent a missing voice in partner violence study.

Population based studies are recommended so as to capture the nature and dynamics of normalised forms of violence.

Since the link between HIV and IPV is contested in some of the literature, there is need to conduct further studies particularly more longitudinal population based studies to strengthen the evidence linking the two epidemics.

Studies on how to deal with alcohol problems as a primary prevention strategy ought to be explored in Malawi. Such studies ought to explore how the effectiveness of the role of significant others such as community leaders and nkhoswe's can play in dealing with problem alcohol. More studies also need to be carried out to establish the best model of alcohol control in Malawi considering the high proportion of the local brewed beer in the country.

With regards to screening for IPV in health care settings, there is need for further studies that can lead to development of selective screening tools for different entry points of the health services.

Studies that explore the link between IPV, alcohol intake and mental health problems are required.

References

1. Violence Prevention Alliance and Education Development Center. *Why invest in violence prevention?* Geneva, Switzerland and Newton, USA: VPA and EDC; 2011.
2. Rutherford A, Kris H. Violence/Intentional Injuries - Epidemiology and Overview. *International Encyclopedia of Public Health*. Oxford: Academic Press; 2008: 500-508.
3. Kimberly AS. *Violence Prevention in Low- and Middle-Income Countries: Finding a Place on the Global Agenda, Workshop Summary*: The National Academies Press; 2008.
4. Krug EG, Mercy JA, Dahlberg LL, Zwi AB. The world report on violence and health. *The Lancet.* 2002;360(9339):1083-1088.
5. Violence Prevention Alliance. *Violence Prevention Alliance: Conceptual framework.* Geneva: World Health Organisation; 2010.
6. Heise LL. *What Works to Prevent Partner Violence? An Evidence Overview Report for the UK Department for International Development* 2011.
7. Colombini M, Mayhew S, Watts C. Health-sector responses to intimate partner violence in low- and middle-income settings: a review of current models, challenges and opportunities. *Bulletin of the World Health Organization.* 2008;86:635-642.
8. Ellsberg M. Violence against women and the Millennium Development Goals: Facilitating women's access to support. *World Report on Women's Health 2006; Women's Right to Health and the Millenium Development Goals; Promoting Partnerships to Improve Access.* 9 2006;94(3):325-332.
9. Butchart A. World Health Organisation Violence and Health Activities : a Global context for UK Action. In: McVeigh C, Hughes K, Lushey C, Bellis MA, eds. *Preventing Violence From Global Perpectives to National Action*. Liverpool; 2005.
10. Watts C, Mayhew S. Reproductive Health Services and Intimate Partner Violence: Shaping a Pragmatic Response in Sub-Saharan Africa. *International Family Planning Perspectives.* 2004;30(4):207-213.
11. Morrison A, Ellsberg M, Bott S. Addressing Gender-Based Violence: A Critical Review of Interventions. *The World Bank Research Observer.* March 20, 2007 2007;22(1):25-51.
12. Mercy JA, Butchart A, Rosenberg ML, Dahlberg L, Harvey A. Preventing violence in developing countries: a framework for action. *International Journal of Injury Control and Safety Promotion.* 2008;15(4):178- 208.
13. Harvey AG-M, C, Butchart, A. *Primary prevention of intimate-partner violence and sexual violence: Background paper for WHO expert meeting.* Geneva: WHO; 2007.
14. Heise LL. *What Works to Prevent Partner Violence? An Evidence Overview.* United Kingdom: DFID; 2011.
15. Walker LE. Who Are the Battered Women? *Frontiers: A Journal of Women Studies.* 1977;2(1):52-57.
16. Johnson MP. Patriarchal Terrorism and Common Couple Violence: Two Forms of Violence against Women. *Journal of Marriage and Family.* 1995;57(2):283-294.
17. Enander V. *Women living violent men: cross roads of emotions, cognition and action*. Goteborg: Department of social work, University of Gothenburg; 2008.
18. Heise L, Ellsberg M, Gottmoeller M. A global overview of gender-based violence. *International Journal of Gynecology & Obstetrics.* 2002;78:S5-S14.
19. Kelly JB, Johnson MP. Differentiation among types of intimate partner violence :research update and implications for interventions. *Family Court Review.* 2008;46(3):476-499.

20. Archer J. Sex Differences in Aggression Between Heterosexual Partners: A Meta-Analytic Review. *Psychological Bulletin.* 2000;126(5):651-680.
21. Ospina S. Qualitative Research. *Encyclopedia of Leadership*. London, Thousand Oaks CA, New Delhi: SAGE Publications; 2004.
22. Dempsey MM. What Counts as Domestic Violence? A Conceptual Analysis. *William & Mary Journal of Women and the Law.* 2006;12:301-333.
23. Jewkes R. Intimate partner violence: causes and prevention. *The Lancet.* 2002;359(9315):1423-1429.
24. Akmatov Mk, Mikolajczyk, Rafael T, Labeeb, Shokira, Dhaher, Enas, Khan Mobarak Md. Factors associated with wife beating in Egypt: Analysis of two surveys(1995 and 2005). *Boimed centra Womens Health.* 2008;8(15).
25. Andersson N, Ho-Foster A, Matthis J. National cross sectional study of views on sexual violence and risk of HIV infection and AIDS among South African school pupils. *British Medical Journal.* 2004;329:952 - 954.
26. Andersson N, Ho-Foster A, Mitchell S, Scheepers E, Goldstein S. Risk factors for domestic physical violence: national cross-sectional household surveys in eight southern African countries. *BMC Women's Health.* 2007;7(1):11.
27. Rothman EF, Butchart A, Cerdá M. Intervening with Perpetrators of Intimate Partner Violence: A Global Perspective. In: Department of Injuries and Violence Prevention NDaMH, ed. Geneva: World Health Organization; 2003.
28. Robinson EG. International Perspectives on Violence Against Women -Introduction. *Archives of Women's Mental Health.* 2003; 6:155-156.
29. Pitman T. *The legacy of domestic violence: How the dynamics of abuse continue beyond separation*. Tansmania, University of Tansmania; 2010.
30. Hamby S. The Gender Debate About Intimate Partner Violence: Solutions and Dead Ends. *Psychological Trauma: Theory, Research, Practice, and Policy.* 2009;1(1):24-34.
31. Nixon J, Humphreys C. Marshalling the Evidence: Using Intersectionality in the Domestic Violence Frame. *Social Politics: International Studies in Gender, State & Society.* 2010;17(2):137-158.
32. Gámez AM, Speizer IS. Community-level intimate partner violence and the circumstances of first sex among young women from five African countries. *Reproductive Health.* 2010;7(1).
33. Acosta ML. Collecting evidence for domestic and sexual assault: highlighting violence against women in health care system interventions. *International Journal of Gynecology & Obstetrics.* 2002;78:S99-S104.
34. Johnson M. Langhinrichsen-Rolling's Confirmation of the Feminist Analysis of Intimate Partner Violence: Comment on "Controversies Involving Gender and Intimate Partner Violence in the United States". *Sex Roles.* 2010;62(3):212-219.
35. Feder G, Ramsay J, Dunne D, et al. How far does screening women for domestic (partner) violence in different health-care settings meet criteria for a screening programme? Systematic reviews of nine UK National Screening Committee criteria. *Health Technol Assess.* 2009;13(16):1-156.
36. ECSA-HC. *ECSA Sub- Regional Implementation Framework for Gender -Based Violence Prevention and Control* 2009.
37. Kapur R. The Tragedy of Victimization Rhetoric: Resurrecting the Native Subject in International/Postcolonial Feminist Legal Politics. *Harvard human rights journal.* 2002;15:1.
38. Collins JD. *Understanding Help-Seeking Behavior of Abused Women: A Quantitative Analysis of Domestic Violence Shelter Archives*: BiblioBazaar; 2011.

39.   Platt M, Barton J, Freyd JJ. A Betrayal Trauma Perspective on Domestic Violence. 2009.

40.   Kishor S, Johnson K. *Profiling Domestic Violence - A Multi-Country Study.* Calverton, Maryland: : ORC Macro.; 2004.

41.   United Nations ECE, World Health Organisation. *Violence against women: a statistical overview, challenges and gaps in data collection and methodology and approaches for overcoming them.* Geneva 2005.

42.   Garcia-Moreno C, Jansen HA, Ellsberg M, Heise L, Watts CH. Prevalence of intimate partner violence: findings from the WHO multi-country study on women's health and domestic violence. *The Lancet.* 2006;368(9543):1260-1269.

43.   Devries KM, Kishor S, Johnson H, et al. Intimate partner violence during pregnancy: analysis of prevalence data from 19 countries. *Reproductive Health Matters.* 2010;18:158–170.

44.   Rutherford A. Violence/Intentional Injuries – Epidemiology and Overview. In: Editor-in-Chief: Kris H, ed. *International Encyclopedia of Public Health.* Oxford: Academic Press; 2008: 500-508.

45.   Patel DM. Preventing Violence Against Women and Children: Workshop Summary. Paper presented at: Forum on Global Violence Prevention; Institute of Medicine, 2011.

46.   Shamu S, Abrahams N, Temmerman M, Musekiwa A, Zarowsky C. A Systematic Review of African Studies on Intimate Partner Violence against Pregnant Women: Prevalence and Risk Factors. *PLoS ONE.* 2011;6(3):e17591.

47.   Wagman J, Baumgartner JN, Waszak Geary C, et al. Experiences of Sexual Coercion Among Adolescent Women: Qualitative Findings From Rakai District, Uganda. *Journal of Interpersonal Violence.* 2009;24(12):2073-2095.

48.   Libuku E, Small LF, Wilkinsin W. Exposure to domestic violence during pregnancy: perceptions and coping mechanisms of a vulnerable group. *Health SA Gesondheid.* 2008;13(2):3-13.

49.   Kaye DK. Community Perceptions and Experiences of Domestic Violence and Induced Abortion in Wakiso District, Uganda. *Qualitative   Health Research.* 2006;16(8):1120-1128.

50.   Ameh N, Shittu SO, Abdul MA. Obstetric outcome in pregnant women subjected to domestic violence. *Nigerian Journal Of Clinical Practice.* 2009;12(2):179-181.

51.   Efetie ER, Salami HA. Domestic violence on pregnant women in Abuja, Nigeria. *Journal Of Obstetrics And Gynaecology: The Journal Of The Institute Of Obstetrics And Gynaecology.* 2007;27(4):379-382.

52.   Gyuse ANI, Ushie AP. Pattern of abuse in domestic violence among pregnant women in Jos, Nigeria. *South African Family Practice.* 2009;51(4):343-345.

53.   Hoque ME, Hoque M, Kader SB. Prevalence and experience of domestic violence among rural pregnant women in KwaZulu-Natal, South Africa. *Southern African Journal of Epidemiology & Infection.* 2009;24(4):34-37.

54.   Ntaganira J, Muula A, Masaisa F, Dusabeyezu F, Siziya S, Rudatsikira E. Intimate partner violence among pregnant women in Rwanda. *BMC Women's Health.* 2008;8(1):17.

55.   Umeora OUJ, Dimejesi BI, Ejikeme BN, Egwuatu VE. Pattern and determinants of domestic violence among prenatal clinic attendees in a referral centre, South-east Nigeria. *Journal Of Obstetrics And Gynaecology: The Journal Of The Institute Of Obstetrics And Gynaecology.* 2008;28(8):769-774.

56. Olagbuji B, Ezeanochie M, Ande A, Ekaete E. Trends and determinants of pregnancy-related domestic violence in a referral center in southern Nigeria. *International Journal of Gynecology & Obstetrics.* 2010;108(2):101-103.

57. Okemgbo CN, Omideyi AK, Odimegwu CO. Prevalence, patterns and correlates of domestic violence in selected Igbo communities of Imo State, Nigeria. *African Journal of Reproductive Health.* 2002;6(2):101-114.

58. Obi SN, Ozumba BC. Factors associated with domestic violence in south-east Nigeria. *Journal Of Obstetrics And Gynaecology: The Journal Of The Institute Of Obstetrics And Gynaecology.* 2007;27(1):75-78.

59. Kaye DK, Mirembe FM, Bantebya G, Johansson A, Ekstrom AM. Domestic violence as risk factor for unwanted pregnancy and induced abortion in Mulago Hospital, Kampala, Uganda. *Tropical Medicine & International Health.* 2006;11(1):90-101.

60. Dude A. Spousal Intimate Partner Violence is Associated with HIV and Other STIs Among Married Rwandan Women. *AIDS and Behavior.* 2011;15(1):142-152.

61. El-Bassel N, Gilbert L, Wu E, et al. Intimate partner violence prevalence and HIV risks among women receiving care in emergency departments: Implications for IPV and HIV screening. *Emergency Medicine Journal.* 2007;24(4):255-259.

62. Emusu D, Ivankova N, Jolly P, et al. Experience of sexual violence among women in HIV discordant unions after voluntary HIV counselling and testing: a qualitative critical incident study in Uganda. *AIDS Care: Psychological and Socio-medical Aspects of AIDS/HIV.* 2009;21(11):1363 - 1370.

63. Fonck K, Els L, Kidula N, Ndinya-Achola J, Temmerman M. Increased risk of HIV in women experiencing physical partner violence in Nairobi, Kenya. *AIDS Behav.* 2005;9:335-339. Epub 2005 Oct 2027.

64. Maman S, Campbell J, Sweat MD, Gielen AC. The intersections of HIV and violence: directions for future research and investigations. *Soc Sci Med.* 2000;50:459-478.

65. Managa L, Pengpid S, Peltzer K. Intimate partner violence and HIV risk among women in primary health care delivery services in Vhembe district, South Africa. *Gender & Behaviour.* 2007;5(2):1302-1317.

66. Abrahams N, Jewkes R, Martin LJ, Mathews S, Vetten L, Lombard C. Mortality of women from intimate partner violence in South Africa: a national epidemiological study. *Violence & Victims.* 2009;24(4):546-556.

67. Adinkrah M. Spousal homicides in contemporary Ghana. *Journal of Criminal Justice.* 2008;36(3):209-216.

68. Mathews S, Abrahams N, Jewkes R, Martin LJ, Lombard C, Vetten L. Injury patterns of female homicide victims in South Africa. *Journal of Trauma.* 2009;67(1):168-172.

69. Outwater A, Campbell JC, Webster D, Mgaya E. Homicide death in sub-saharan Africa: A review 1970-2004. *African safety promotion a journal of injury and violence prevention.* 2007;5:31-44.

70. Alio AP, Daley EM, Nana PN, Duan J, Salihu HM. Intimate partner violence and contraception use among women in Sub-Saharan Africa. *International Journal of Gynecology & Obstetrics.* 2009;107(1):35-38.

71. Ezechi O, Gab-Okafor C, Onwujekwe D, Adu R, Amadi E, Herbertson E. Intimate partner violence and correlates in pregnant HIV positive Nigerians. *Archives of Gynecology and Obstetrics.* 2009;280(5):745-752.

72. Ammar NH. Beyond the Shadows: Domestic Spousal Violence in a "Democratizing" Egypt. *Trauma, Violence, & Abuse.* 2006;7(4):244-259.

73. Abiodun FE. Gender Based Violence in Akungba-Akoko of South Western Nigeria: Are Men Victimized? *Fifth African Population Conference.* Arusha Tanzania; 2007: 1-27.

74.   Dienye PO, Gbeneol PK. Domestic Violence Against Men in Primary Care in Nigeria. *American Journal of Men's Health.* 2009;3(4):333-339.

75.   Wubs AG, Aarø LE, Flisher AJ, et al. Dating violence among school students in Tanzania and South Africa: Prevalence and socio-demographic variations. *Scandinavian Journal of Public Health.* 2009;37:75-86.

76.   Bekele AB. *Determinants of sexual violence among Eastern Ethiopian Secondary School Students*. Netherlands; 2012.

77.   Wubs Ag Fau - Aaro LE, Aaro Le Fau - Flisher AJ, Flisher Aj Fau - Bastien S, et al. Dating violence among school students in Tanzania and South Africa: prevalence and socio-demographic variations. *Scandinavian Journal of Public Health* 2009;37:75-86.

78.   Swart L-A, Seedat M, Stevens G, Ricardo I. Violence in adolescents' romantic relationships: findings from a survey amongst school-going youth in a South African community. *Journal of Adolescence.* 2002;25(4):385-395.

79.   Oduro GY, Swartz S, Arnot M. Gender-based violence: Young women's experiences in the slums and streets of three sub-Saharan African cities. *Theory and Research in Education.* November 1, 2012 2012;10(3):275-294.

80.   Heise L, Ellsberg M, Gottemoeller M. Ending violence against women. *Population Reports.* 1999;27(4):44-44.

81.   Hyde-Nolan ME, Julio T. Theoretical basis for family violence. In: Fire RS, Schrager S, eds. *Family violence what health care providers need to know*. United States of America; 2012.

82.   Bowman CG. Theories of domestic violence in the African Context. *Journal of Gender , Social Policy and The Law.* 2003;11(2):847-863.

83.   Macmillan R. Violence and the Life Course: The Consequences of Victimization for Personal and Social Development. *Annual Review Sociology.* 2001;27:1-22.

84.   Enander V. Jekyll and Hyde or "Who is this Guy?"--Battered women's interpretations of their abusive partners as a mirror of opposite discourses. *Women's Studies International Forum.* 2010;33(2):81-90.

85.   Ehrensaft MK, Cohen P, Brown J, Smailes E, Chen H, Johnson JG. Intergenerational Transmission of Partner Violence: A 20-Year Prospective Study. *Journal of Consulting and Clinical Psychology.* 2003;71(4):741-753.

86.   Flood M, Pease B. Factors Influencing Attitudes to Violence Against Women. *Trauma Violence Abuse.* 2009;10(2):125-142.

87.   Williams LM. Understanding Child Abuse and Violence Against Women: A Life Course Perspective. *Journal of Interpersonal Violence.* 2003;18(4):441-451.

88.   Denise AH, Kimberly JS. Intergenerational Transmission of Intimate Partner Violence : A Behavioral Genetic Perspective. *Trauma Violence Abuse.* 2002; 3:210.

89.   Denise A Hines, Saudino KJ. Genetic and Environmental Influences on Intimate Partner Violence: A Preliminary Study. *Violence and Victims.* 2004;19:79-97.

90.   Amirthalingam K. Women's Rights, International Norms, and Domestic Violence: Asian Perspectives. *Human Rights Quarterly.* 2005;27(2):683-708.

91.   Oslon LN, Fine, Mark A;Llyod, Sally A. A Dialectical Approach to Theorising About Aggression Between Intimates. 2002.

92.   Lenton RL. Power versus feminists theories of wife abuse. *Canadian Journal of Criminology.* 1995;37:305-330.

93.   McPhail BA, Busch NB, Kulkarni S, Rice G. An Integrative Feminist Model. *Violence Against Women.* 2007;13(8):817-841.

94.   Johnson KB, Das MB. Spousal violence in bangladesh as reported by men: prevalence and risk factors. *Journal of Interpersonal Violence.* 2009;24(6):977-995.

95.   Straka SM, Montminy L. Family Violence: Through the Lens of Power and Control *Journal of Emotional Abuse.* 2008;8(3):255- 279.

96.   Esplen E, Greig A. Politicising Masculinities: Beyond the Personal. Report on the Politicising Masculinities Symposium. Paper presented at: 15-18 October 2007; Dakar, Senegal,.

97.   Heise LL. Violence against women: an integrated, ecological framework. *Violence Against Women.* 1998;4:262 - 290.

98.   Kanuha VK. Colonization and Violence against Women. Paper presented at: API Institute's National Summit, 2002; Sanfrancisco.

99.   Sitaker M. The Ecology of Intimate Partner Violence: Theorised Impacts on Womens use of Violence. *Journal of Agression, Maltreatment and Trauma.* 2008;15(3).

100.   Riger S, Raja S, Camacho J. The radiating impact of intimate partner violence. *J Interpers Violence.* 2002;17:184 - 205.

101.   Little L, Kaufman Kantor G. Using Ecological Theory to Understand Intimate Partner Violence and Child Maltreatment. *Journal of Community Health Nursing.* 2002;19(3):133-145.

102.   Riger S, Raja S, Camacho J. The Radiating Impact of Intimate Partner Violence. *Journal Interpersonal Violence.* 2002;17(2):184-205.

103.   Morrison A, Ellsberg M, Bott S. Addressing Gender-Based Violence: A Critical Review of Interventions. *World Bank Research Observer.* 2007(1):25-51.

104.   Williams Ac Fau - Bower EJ, Bower Ej Fau - Newton JT, Newton JT. Research in primary dental care Part 6: Data analysis. *British Dental Journal.* 2004;197:67-73.

105.   Gupta J, Silverman JG, Hemenway D, Acevedo-Garcia D, Stein DJ, Williams DR. Physical violence against intimate partners and related exposures to violence among South African men. *CMAJ.* 2008;179(6):535-541.

106.   Abrahams N, Jewkes R. Effects of South African Men's Having Witnessed Abuse of Their Mothers During Childhood on Their Levels of Violence in Adulthood. *American Journal of Public Health.* 2005;95(10):1811-1816.

107.   Jaoko J. Correlates of wife abuse in the Maseno and Nairobi areas of Kenya. *International Social Work.* 2010;53(1):9-18.

108.   Lichter EL, McCloskey LA. The effects of childhood exposure to marital violence on adolescent gender role beliefs and dating violence *Psychology of Women Quarterly.* 2004;28(4):344-357.

109.   Speizer IS. Intimate Partner Violence Attitudes and Experience Among Women and Men in Uganda. *journal of Interpersonal Violence.* 2006(september 15):1-18.

110.   Abrahams N, Jewkes R, Hoffman M, Laubsher R. Sexual violence against intimate partners in Cape Town: prevalence and risk factors reported by men. *Bulletin of the World Health Organization.* 2004;82:330-337.

111.   Jewkes R, Levin J, Penn-Kekana L. Risk factors for domestic violence: findings from a South African cross-sectional study. *Soc Sci Med.* 2002;55(9):1603 - 1617.

112.   Campbell J, Baty ML, Ghandour RM, Stockman JK, Francisco L, Wagman J. The intersection of intimate partner violence against women and HIV/AIDS: a review. *International Journal of Injury Control and Safety Promotion.* 2008;15(4):221 - 231.

113.   Dunkle K, Jewkes RK, Nduna M, et al. Perpetration of partner violence and HIV risk behaviour among young men in the rural Eastern Cape, South Africa. *AIDS.* 2006;20(16):2107-2114

114.   Dunkle KL, Jewkes RK, Brown HC, Gray GE, McIntryre JA, Harlow SnD. Gender-based violence, relationship power, and risk of HIV infection in women attending antenatal clinics in South Africa. *The Lancet.* 2004;363(9419):1415-1421.

115. Jewkes R, Levin JB, Penn-Kekana LA. Gender inequalities, intimate partner violence and HIV preventive practices: findings of a South African cross-sectional study. *Social Science & Medicine.* 2003;56(1):125-134.

116. Fonck K, Els L, Kidula N, Ndinya-Achola J, Temmerman M. Increased Risk of HIV in Women Experiencing Physical Partner Violence in Nairobi, Kenya. *AIDS and Behavior.* 2005;9(3):335-339.

117. Van der Straten A, King R, Grinstead O, Vittinghoff E, Serufilira A, Allen S. Sexual coercion, physical violence and HIV infection among women in steady relationships in Kigali, Rwanda. *AIDS Behaviour.* 1998;2:61 - 73.

118. Townsend L, Jewkes R, Mathews C, et al. HIV Risk Behaviours and their Relationship to Intimate Partner Violence (IPV) Among Men Who Have Multiple Female Sexual Partners in Cape Town, South Africa. *AIDS and Behavior.* 2010.

119. Gupta J. History of sex trafficking, recent experiences of violence, and HIV vulnerability among female sex workers in coastal Andhra Pradesh, India. *International Journal of Gynecology and Obstetrics.* 2011.

120. Gupta G. How men's power over women fuels the HIV epidemic. *British Medical Journal.* 2002;324:183-184.

121. Silverman JG, Decker MR, Saggurti N, Balaiah D, Raj A. Intimate Partner Violence and HIV Infection Among Married Indian Women. *JAMA.* 2008;300(6):703-710.

122. Jewkes RK, Dunkle K, Nduna M, Shai N. Intimate partner violence, relationship power inequity, and incidence of HIV infection in young women in South Africa: a cohort study. *The Lancet.* 2010;376(9734):41-48.

123. Dunkle K, Jewkes RK, Brown HC, Gray GE, McIntryre JA, Harlow SD. Gender-based violence, relationship power, and risk of HIV infection in women attending antenatal clinics in South Africa. *The Lancet.* 2004;363(9419):1415-1421.

124. Decker MR, Seage GR, Hemenway D, Gupta J, Raj A, Silverman JG. Intimate partner violence perpetration, standard and gendered STI/HIV risk behaviour, and STI/HIV diagnosis among a clinic-based sample of men. *Sexually Transmitted Infections.* 2009;85(7):555-560.

125. Decker MR, Seage GRI, Hemenway D, et al. Intimate Partner Violence Functions as Both a Risk Marker and Risk Factor for Women's HIV Infection: Findings From Indian Husband-Wife Dyads. *Journal of Acquired Immune Deficiency Syndromes.* 2009;51(5).

126. Raj A, Reed E, Welles SL, Santana MC, Silverman JG. Intimate Partner Violence Perpetration, Risky Sexual Behavior, and STI/HIV Diagnosis Among Heterosexual African American Men. *American Journal of Men's Health.* 2008;2(3):291-295.

127. Luke N, Kurz KM. *Cross-generational and Transactional Sexual Relations in Sub-Saharan Africa: Prevalence of Behavior and Implications for Negotiating Safer Sexual Practices*: PSI, ICRW,; 2002.

128. Kaler A. My Girlfriends Could Fill A Yanu-Yanu Bus. *Demographic Research Special Collections.* 2003;1:349-372.

129. Diop-Sidibé N, Campbell JC, Becker S. Domestic violence against women in Egypt--wife beating and health outcomes. *Social Science & Medicine.* 2006;62(5):1260-1277.

130. Alio AP, Nana PN, Salihu HM. Spousal violence and potentially preventable single and recurrent spontaneous fetal loss in an African setting: cross-sectional study. *The Lancet.* 2009;373(9660):318-324.

131. Diop-Sidibe N, Campbell JC, Becker S. Domestic Violence against Women in Egypt -- Wife Beating and Health Outcomes. *Social Science & Medicine.* Mar 2006;62(5):1260-1277.

132. Oyedokun AO. Domestic violence and constrained contraceptive choices in selected areas of Osun State, Nigeria. *Sexual and Relationship Therapy.* Nov 2008;23(4):305-323.

133. Ogunjuyigbe P, Akinlo A, Oni G. Violence against Women as a Factor in Unmet Need for Contraception in Southwest Nigeria. *Journal of Family Violence.* 2010;25(2):123-130.

134. Ogunjuyigbe PO, Akinlo A, Ebigbola JA. Violence Against Women: An Examination of Men's Attitudes and Perceptions About Wife Beating and Contraceptive Use. *Journal of Asian and African Studies.* 2005;40(3):219-229.

135. World Health Organization. Intimate partner violence during pregnancy: fact sheet. Geneva 27 Switzerland: Department of Reproductive Health and Research; 2011.

136. García-Moreno C, Jansen H, Ellsberg M, Heise L, Watts C. *WHO multi-country study on women's health and domestic violence against women: initial results on prevalence, health outcomes and women's responses. .* Geneva: World Health Organization 2005.

137. Devries KM, Kishor S, Johnson H, et al. Intimate partner violence during pregnancy: prevalence data from 19 countries. *Reproductive Health Matters.* 2010;18:1-13.

138. Ezechi O, Kalu B, Ezechi L, Nwokoro C, Ndububa V, Okeke G. Prevalence and pattern of domestic violence against pregnant Nigerian women. *Journal of Obstetrics & Gynaecology.* 2004;24(6):652-656.

139. Fawole AO, Hunyinbok KI, Ibitola O. Prevalence of violence against pregnant women in Abeokuta, Nigeria. *Australian and New Zealand Journal of Obstetrics and Gynaecology.* 2008;48(4):405-414.

140. Ezechi Oc Fau - Kalu BK, Kalu Bk Fau - Ezechi LO, Ezechi Lo Fau - Nwokoro CA, Nwokoro Ca Fau - Ndububa VI, Ndububa Vi Fau - Okeke GCE, Okeke GC. Prevalence and pattern of domestic violence against pregnant Nigerian women. (0144-3615 (Print)).

141. Kaye D. *Domestic violence during pregnancy in Uganda* [Dissertation/Thesis], Karolinska Institutet; 2006.

142. Amoakohene MI. Violence against Women in Ghana: A Look at Women's Perceptions and Review of Policy and Social Responses. *Social Science & Medicine.* Dec 2004;59(11):2373-2385.

143. Moore A. Types of Violence against Women and Factors Influencing Intimate Partner Violence in Togo (West Africa). *Journal of Family Violence.* 2008;23(8):777-783.

144. Jewkes R, Levin J, Penn-Kekana L. Risk factors for domestic violence: findings from a South African cross-sectional study. *Social Science & Medicine.* 2002;55(9):1603-1617.

145. Koenig M, Lutalo T, Zhao F, et al. Domestic violence in rural Uganda: evidence from a community-based study. *Bull World Health Organ.* 2003;81:53 - 60.

146. Karamagi C, Tumwine J, Tylleskar T, Heggenhougen K. Intimate partner violence against women in eastern Uganda: implications for HIV prevention. *BMC Public Health.* 2006;6(1):284.

147. Okenwa LE, Lawoko S, Jansson B. Exposure to intimate partner violence amongst women of reproductive age in lagos, nigeria: Prevalence and predictors. *Journal of Family Violence.* 2009;24(7):517-530.

148. Simister J. Domestic Violence and Female Genital Mutilation in Kenya: Effects of Ethnicity and Education. *Journal of Family Violence.* 2010;25(3):247-257.

149. Djamba YK, Kimuna SR. Intimate Partner Violence among Married Women in Kenya. *Journal of Asian and African Studies.* 2008;43:457-470.

150. Vyas S, Watts C. How does economic empowerment affect women's risk of intimate partner violence in low and middle income countries? A systematic review of published evidence. *Journal of International Development.* 2009;21(5):577-602.

151. McCloskey LA, Williams, Corrine, Larsen, Ulla. Gender Inequality and Intimate Partner Violence Among Women in Moshi, Tanzania. *International Family Planning Perspectives.* 2005;31(3):124-130.

152. Jewkes RK, Levin J, Penn-Kekana L. Risk factors for domestic violence:findings from a South African cross-sectional study. *Soc Sci Med.* 2002;55:1603-1617.

153. Abuya BA, Onsomu EO, Moore D, Piper CN. Association between education and domestic violence among women being offered an HIV test in urban and rural areas in Kenyamore. *Journal of Interpersonal Violence.* 2012:1-17.

154. Strebel A, Crawford M, Shefer T, et al. Social constructions of gender roles, gender-based violence and HIV/AIDS in two communities of the Western Cape, South Africa. *Sahara J: Journal of Social Aspects of HIV/AIDS/Journal de Aspects Sociaux du VIH/SIDA.* Nov 2006;3(3):516-528.

155. Koenig MA, Lutalo T, Zhao F, et al. Coercive sex in rural Uganda: Prevalence and associated risk factors. *Social Science & Medicine.* 2004;58(4):787-798.

156. Zablotska I, Gray R, Koenig M, et al. Alcohol Use, Intimate Partner Violence, Sexual Coercion and HIV among Women Aged 15–24 in Rakai, Uganda. *AIDS and Behavior.* 2009;13(2):225-233.

157. Ntaganira J, Muula A, Siziya S, Stoskopf C, Rudatsikira E. Factors associated with intimate partner violence among pregnant rural women in Rwanda. *Rural and Remote Health* 2009;9:1153.

158. Ranney ML, Odero W, Mello MJ, Waxman M, Fife RS. Injuries from interpersonal violence presenting to a rural health center in Western Kenya: characteristics and correlates. *Injury Prevention.* 2009;15(1):36-40.

159. Frank YW, Z. Jennifer Huang, Julia A. DiGangi, Estina E. Thompson, and Brian D. Smith. Gender Differences in Intimate Partner Violence on Substance Abuse, Sexual Risks, and Depression among a Sample of South Africans in CapeTown, South Africa. *AIDS Education and Prevention.* 2006;20(1):56-64.

160. Kalichman S, Simbayi L, Kaufman M, Cain D, Jooste S. Alcohol Use and Sexual Risks for HIV/AIDS in Sub-Saharan Africa: Systematic Review of Empirical Findings. *Prevention Science.* 2007;8(2):141-151.

161. Abbey A, Clinton AM, McAuslan P, Zawacki T, Buck PO. Alcohol-Involved Rapes: Are They More Violent? *Psychology of Women Quarterly.* 2002;26(2):99-109.

162. Abbey A, Clinton-Sherrod AM, McAuslan P, Zawacki T, Buck PO. The Relationship Between the Quantity of Alcohol Consumed and the Severity of Sexual Assaults Committed by College Men. *Journal of Interpersonal Violence.* 2003;18(7):813-833.

163. Kantor G, Straus M. Substance abuse as a precipitant of wife abuse victimizations. *American Journal Drug Alcohol Abuse.* 1989;15(2):173 - 189.

164. Choi SY, Ting KF. Wife beating in South Africa: an imbalance theory of resources and power. *Journal Interpersonal Violence.* 2008;23(6):834-852.

165. Mann JR, Takyi BK. Autonomy, dependence or culture: Examining the impact of resources and socio-cultural processes on attitudes towards intimate partner violence in Ghana, Africa. *Journal of Family Violence.* 2009;24(5):323-335.

166. Mutiso MM, Chessa SR, Chesire MA, Kemboi L. Factors Leading to Domestic Violence in Low-Income Residential Areas in Kenya: A Case Study of Low-income Residential Areas in Kisumu City. *Journal of Emerging Trends in Educational Research and Policy Studies (JETERAPS).* 2010;2:65-75.

167. Lawoko S, Dalal K, Jiayou L, Jansson B. Social inequalities in intimate partner violence: a study of women in Kenya. *Violence Victims.* 2007;22(6):773-784.

168. Pelser E, Gondwe L, Mayamba C, Mhango T, Phiri W, Burton P. Intimate Partner Violence : Results from a National Gender-Based Violence Study in Malawi. Pretoria, South Africa: Crime & Justice Statistical Division National Statistical Office; 2005: 1-34.

169. Fawole OI. Economic Violence To Women and Girls: Is It Receiving the Necessary Attention? *Trauma, Violence, & Abuse.* July 1, 2008 2008;9(3):167-177.

170. Hollander D. Women in Some Sub-Saharan African Countries Are More Likely than Men to Justify Wife Beating. *International Family Planning Perspectives.* 2005;31(3):153-154.

171. Alio A, Salihu H, Nana P, Clayton H, Mbah A, Marty P. Association between intimate partner violence and induced abortion in Cameroon. *International Journal of Gynecology and Obstetrics.* 2011;112:83-87.

172. Hindin M. Understanding women's attitudes towards wife abuse in a non-western society. *Bulletin of the World Health Organisation.* 2003;81:501 - 508.

173. Oyediran K, Isiugo-Abanihe U. Perceptions of Nigerian women on domestic violence: Evidence from 2003 Nigeria Demographic and Health Survey. *African Journal of Reproductive Health.* 2005;9:38 - 53.

174. Rani M, Bonu S, Diop-Sidibe N. An Empirical Investigation of Attitudes towards Wife-Beating among Men and Women in Seven Sub-Saharan African Countries. *African Journal of Reproductive Health.* 2004;8(3):116-136.

175. Uthman O, Lawoko S, Moradi T. Factors associated with attitudes towards intimate partner violence against women: a comparative analysis of 17 sub-Saharan countries. *BMC International Health Human Rights.* 2009;9:14.

176. Uthman O, Lawoko S, Moradi T. Sex disparities in attitudes towards intimate partner violence against women in sub-Saharan Africa: a socio-ecological analysis. *BMC Public Health.* 2010;10(1):223.

177. Waltermaurer E. Public Justification of Intimate Partner Violence: A Review of the Literature. *Trauma, Violence, & Abuse.* 2012:1-9.

178. Yount KM, Halim N, Hynes M, Hillman ER. Response effects to attitudinal questions about domestic violence against women: A comparative perspective. *Social Science Research.* 2011;40(3):873-884.

179. Hindin MJ. Understanding women's attitudes towards wife beating in Zimbabwe. *Bulletin World Health Organisation.* 2003;81(7):501-508.

180. Olufunmilayo F, Adedibu, L; Aderonmu, Fawole , Adeniran O. Intimate Partner Abuse: Wife Beating among Civil Servants in Ibadan, Nigeria *African Journal of Reproductive Health.* 2005;9(2):54-64.

181. Koenig MA, Lutalo T, Zhao F, et al. Domestic violence in rural Uganda: evidence from a community-based study. *Bulletin of the World Health Organisation.* 2003;81:53-60.

182. Abrahams N, Jewkes R, Laubscher R, Hoffman M. Intimate partner violence: prevalence and risk factors for men in Cape Town, South Africa. *Violence Victims.* 2006;21(2):247-264.

183. Hindin MJ, Kishor Sunita, Ansara Donna L. *Intimate partner violence among 10 DHS countries: predictors and helath outcomes.* Claverton, MD USA: Macro International Inc; 2008.

184. Antai D, Antai J. Collective violence and attitudes of women toward intimate partner violence: Evidence from the Niger Delta. *BMC International Health and Human Rights.* 2009;9(1):12.

185. Waldrop AE, Resick PA. Coping Among Adult Female Victims of Domestic Violence. *Journal of Family Violence,.* 2004;19:291-302.

186. Mitchell R, Hodson C. Coping with domestic violence: Social support and psychological health among battered women. *American Journal of Community Psychology.* 1983;11(6):629-654.

187. Mitchell MD, Hargrove GL, Collins MH, Thompson MP, Reddick TL, Kaslow NJ. Coping Variables That Mediate the Relation Between Intimate Partner Violence and Mental Health Outcomes Among Low-Income, African American Women. *Journal of Clinical Psychology.* 2006;62:1503–1520.

188. Carver CS, Scheier MF, Weintraub JK. Assessing Coping Strategies: A Theoretically Based Approach. *Journal of Personality and Social Psychology.* 1989;56:267-283.

189. Carlson BE. A Stress and Coping Approach to Intervention with Abused Women. *Family Relations.* 1997;46(3):291-298.

190. Kearney MH. Enduring love: A grounded formal theory of women's experience of domestic violence. *Research in Nursing & Health.* 2001;24(4):270-282.

191. Kaye DK, Ekström AM, Johansson A, Bantebya G, Mirembe FM. Escaping the triple trap: Coping strategies of pregnant adolescent survivors of domestic violence in Mulago hospital, Uganda. *Scand J Public Health.* 2007;35(2):180-186.

192. Myors K, Johnson M, Langdon R. Coping Styles of Pregnant Adolescents. *Public Health Nursing.* 2001;18(1):24-32.

193. Meyer S. Trends ans Issues in Criminal Justice:Responding to intimate partner violence victimisation: Effective options for help-seeking. Australia; 2010.

194. Fanslow JL, Robinson EM. Help-seeking behaviors and reasons for help seeking reported by a representative sample of women victims of intimate partner violence in New Zealand. *Journal of Interpersonal Violence.* 2010;25(5):929-951.

195. Kaukinen C. The help-seeking decisions of violent crime victims: An examination of the direct and conditional effects of gender and the victim-offender relationship. *Journal of Interpersonal Violence.* 2002;17:432-456.

196. Ragusa AT. Rural Australian Women's Legal Help Seeking for Intimate Partner Violence: Women Intimate Partner Violence Victim Survivors' Perceptions of Criminal Justice Support Services. *Journal of Interpersonal Violence.* 2012.

197. Djikanović B, Lo Fo Wong S, Jansen HAFM, et al. Help-seeking behaviour of Serbian women who experienced intimate partner violence. *Family Practice.* 2012;29(2):189-195.

198. Zungu LI, Salawu AO, Ogunbanjo GA. *Reported intimate partner violence amongst women attending a public hospital in Botswana.* Vol 2; 2010.

199. Chatzifotiou S, Dobash R. Seeking Informal Support: Marital Violence Against Women in Greece. *Violence Against Women.* 2001;7(9):1024-1050.

200. Kaukinen C. The Help-Seeking Strategies of Female Violent-Crime Victims: The Direct and Conditional Effects of Race and the Victim-Offender Relationship. *Journal of Interpersonal Violence.* 2004;19:967-990.

201. Robinson L, Spilsbury K. Systematic review of the perceptions and experiences of accessing health services by adult victims of domestic violence. *Health & Social Care in the Community.* 2008;16(1):16-30.

202. Coker AL, Derrick C, Lumpkin JL, Aldrich TE, Oldendick R. Help-seeking for intimate partner violence and forced sex in South Carolina. *American Journal of Preventive Medicine.* 2000;19(4):316-320.

203. Fugate M, Landis L, Riordan K, Naureckas S, Engel B. Barriers to Domestic Violence Help Seeking: Implications for Intervention. *Violence Against Women.* 2005;11(3):290-310.

204. Naved RT, Persson LA. Factors associated with spousal physical violence against women in Bangladesh. *Studies in Family Planning.* 2005;36:289-300.

205. Zink T, Jacobson C, Regan S, Pabst S. Hidden victims: the healthcare needs and experiences of older women in abusive relationships. *Journal of Women's Health.* 2004;13:898-908.

206. Rodriguez M, Sheldon W, Bauer H, Perez-Stable E. The factors associated with disclosure of intimate partner abuse to clinicians. *Journal of Family Practitioner.* 2001;50:338 - 344.

207. Chang JC, Cluss PA, Ranieri L, et al. Health care interventions for intimate partner violence: What women want. *Women's Health Issues.* 2005;15:21-30.

208. Gracia E. Unreported cases of domestic violence against women: towards an epidemiology of social silence, tolerance, and inhibition. *Journal of Epidemiology and Community Health.* July 1, 2004 2004;58(7):536-537.

209. Gregory A, Ramsay J, Agnew-Davies R, et al. Primary care Identification and Referral to Improve Safety of women experiencing domestic violence (IRIS): protocol for a pragmatic cluster randomised controlled trial. *BMC Public Health.* 2010;10:7.

210. Gerber M, Wittenberg E, Ganz M, Williams C, McCloskey L. Intimate Partner Violence Exposure and Change in Women's Physical Symptoms Over Time. *Journal of General Internal Medicine.* 2008;23(1):64-69.

211. Campbell J. Health consequences of intimate partner violence. *Lancet.* 2002;359:1331 - 1336.

212. Heise L, Germain A, Pitanguy J. *Violence against Women: The Hidden Health Burden.* Washington, D.C: World Bank; 1994.

213. Fanslow JL, Norton RN, Spinola CG. Indicators of assault-related injuries among women presenting to the emergency department. *Annals of Emergency Medicine.* 1998;32(3 I):341-348.

214. Antai D. Traumatic physical health consequences of intimate partner violence against women: what is the role of community-level factors? *BMC Women's Health.* 2011;11(1):56.

215. Seers K, Toye F. What is quality in qualitative health research? *Evidence Based Nursing.* 2012;15(1).

216. Elnashar AM, El-Dien Ibrahim M, Eldesoky MM, Aly OM, El-Sayd Mohamed Hassan M. Sexual abuse experienced by married Egyptian women. *International Journal of Gynecology & Obstetrics.* 2007;99(3):216-220.

217. Monaze EMAK, Ekram M. *Domestic Violence High in Egypt, Affecting Women's Reproductive Health.* Washington: Population Reference Bureau; 2010.

218. Peterman A, Johnson K. Incontinence and trauma: Sexual violence, female genital cutting and proxy measures of gynecological fistula. *Social Science & Medicine.* 2009;68(5):971-979.

219. Dunkle KL, Jewkes R. Effective HIV prevention requires gender-transformative work with men. *Sexually Transmitted Infections.* 2007;83(3):173-174.

220. Maman S, Campbell J, Sweat MD, Gielen AC. The intersections of HIV and violence: directions for future research and interventions. *Social Science & Medicine.* 2000;50(4):459-478.

221. Kiarie JN, Farquhar C, Richardson BA, et al. Domestic violence and prevention of mother-to-child transmission of HIV-1. *AIDS.* 2006;20(13):1763-1769.

222. Kaye DK. Gender inequality and domestic violence: implications for human immunodeficiency virus (HIV) prevention. *African Health Sciences.* 2004;4(1):67-70.

223. Kitzinger J. Qualitative Research: Introducing focus groups. *British Medical Journal.* 1995;311(7000):299-302.

224. Flexner WA, JE L, CP M. Discovering what the health consumer really wants,. *Health Care Manage Review.* 1977; 1:43-49.
225. Sandelowski M. Focus on qualitative methods. Notes on Transcription. *Research in Nursing & Health.* 1994;17(4):311-314.
226. Dickson-Swift V, James EL, Kippen S, Liamputtong P. Doing sensitive research: what challenges do qualitative researchers face? *Qualitative Research.* 2007;7(3):327-353.
227. Flexner Wa Fau - McLaughlin CP, McLaughlin Cp Fau - Littlefield JE, Littlefield JE. Discovering what the health consumer really wants. *Health care management review.* 1977:43-49.
228. Patton M. *Qualitative evaluation and research methods*. Beverly Hills, CA; 1990.
229. Schoeman J Fau - Grove DV, Grove Dv Fau - Odendaal HJ, Odendaal HJ. Are domestic violence and the excessive use of alcohol risk factors for preterm birth? (0142-6338 (Print)).
230. Rosen D, Seng J, Tolman R, Mallinger G. Intimate partner violence, depression, and posttraumatic stress disorder as additional predictors of low birth weight infants among low-income mothers. *Journal Interpersonal Violence.* 2007;22:1305 - 1314.
231. Ellsberg M, Jansen HA, Heise L, Watts CH, Garcia-Moreno C. Intimate partner violence and women's physical and mental health in the WHO multi-country study on women's health and domestic violence: an observational study. *Lancet.* 2008;371(9619):1165-1172.
232. Gelaye B, Arnold D, Williams MA, Goshu M, Berhane Y. Depressive Symptoms Among Female College Students Experiencing Gender-Based Violence in Awassa, Ethiopia. *Journal of Interpersonal Violence.* 2009;24(3):464-481.
233. Deyessa N, Berhane Y, Alem A, et al. Intimate partner violence and depression among women in rural Ethiopia: A cross-sectional study. *Clinical Practice and Epidemiology in Mental Health.* 2009;5(8).
234. Tadegge AD. The mental health consequences of intimate partner violence against women in Agaro Town, southwest Ethiopia. *Tropical doctor.* 2008;38(4):228-229.
235. FAO. Marketing research and information systems. (Marketing and Agribusiness Texts - 4): Chapter 5: Personal Interviews. 1997.
236. England KVL. Getting Personal: Reflexivity, Positionality, and Feminist Research. *The Professional Geographer.* 1994;46(1):80-89.
237. Dahlberg LL, JA. M. History of violence as a public health issue. *AMA Virtual Mentor.* 2009;11:167-172.
238. Morraco KE, Runyan CW, Dull L. Violence against women : synthesis of research for public health policy makers. USA. National Institute of Justice 2003.
239. WHO. *Expert meeting on heath care responses to violence agaisnt women* Geneva 17-19 March,2009 2010.
240. Krug EG, James MA, Dahlberg LL, Zwi AB. The World report on violence and health. *Lancet.* 2002;360:1083-1088.
241. Mercy JA, Rosenberg ML, Powell KE, Broome CV, Roper WL. Public health policy for preventing violence. *Health Aff.* 1993;12(4):7-29.
242. Pronyk PM, Hargreaves JR, Kim JC, et al. Effect of a structural intervention for the prevention of intimate-partner violence and HIV in rural South Africa: a cluster randomised trial. *The Lancet.* 2006;368(9551):1973-1983.
243. Coker A. Preventing Intimate Partner Violence How We Will Rise to This Challenge. *American Journal of Preventive Medicine.* 2006;30(6):528-529.
244. WHO. *Expert meeting on health sector responses to violence against women.* Geneva 2009.

245.   World Health Organization, London School of Hygiene and Tropical Medicine. Preventing intimate partner and sexual violence against women: taking action and generating evidence. Geneva, World Health Organization; 2010.

246.   Rabin RF, Jennings JM, Campbell JC, Bair-Merritt MH. Intimate Partner Violence Screening Tools: A Systematic Review. *American Journal of Preventive Medicine.* 2009;36(5):439-445.

247.   Nelson H, Nygren P, McInerney Y, Klein J. Screening women and elderly adults for family and intimate partner violence: a review of the evidence for the U.S. Preventive Services Task Force. *Annals of Internal Medicine.* 2004;140:387 - 396.

248.   MacMillan HL, Wathen CN, Jamieson E, et al. Screening for Intimate Partner Violence in Health Care Settings: A Randomized Trial. *Journal of American Medical Association.* 2009;302(5):493-501.

249.   Ramsay J, Richardson J, Carter Y, Davidson L, Feder G. Should health professionals screen women for domestic violence? systematic review. *British Medical Journal.* 2002;325:314.

250.   Wathen C, MacMillan H. Prevention of violence against women: recommendation statement from the Canadian Task Force on Preventive Health Care. *Canadian Medical Association Journal.* 2003;169(6):582 - 584.

251.   Phelan MB. Screening for intimate partner violence in medical settings. *Trauma Violence Abus.* 2007;8(2):199-213.

252.   Klevens J, Saltzman LE. The Controversy on Screening for Intimate Partner Violence: A Question of Semantics? *Journal of Women's Health.* 2009;18:143-145.

253.   Bass DM, Anetzberger GJ, Ejaz FK, Nagpaul K. Screening Tools and Referral Protocol for Stopping Abuse Against Older Ohioans: A Guide for Service Providers. *J Elder Abuse Negl.* 2001;13(2):23-38.

254.   Shakil A, Donald S, Sinacore JM, Krepcho M. Validation of the HITS domestic violence screening tool with males. *Family Medicine.* 2005;37(3):193-198.

255.   Williams GB, Dou M, Leal CC. Violence Against Pregnant Women. *Lifelines.* 2003;7(4):348-354.

256.   Punukollu M. Domestic violence: Screening made practical. *The Journal of Family Practice.* 2003;52(7):537-543.

257.   Christofides N Fau - Jewkes R, Jewkes R. Acceptability of universal screening for intimate partner violence in voluntary HIV testing and counseling services in South Africa and service implications. *AIDS Care.* 2010;22:279-285.

258.   John IA, Lawoko S, Oluwatosin A. *Acceptance of screening for Intimate Partner Violence, actual screening and satisfaction with care amongst female clients visiting a health facility in Kano, Nigeria.* Vol 3; 2011.

259.   Wall KM, Kilembe W, Nizam A, et al. Promotion of couples' voluntary HIV counselling and testing in Lusaka, Zambia by influence network leaders and agents. *British Medical Journal Open.* 2012;2(5).

260.   Kaye DK, Mirembe F, Bantebya G. Perceptions of health care providers in Mulago hospital on prevention and management of domestic violence *African Health Sciences.* 2005;5(4):315-318

261.   Ganga D, Scott S. *Cultural "Insiders" and the Issue of Positionality in Qualitative Migration Research: Moving "Across" and Moving "Along" Researcher-Participant Divides.* Vol 7; 2006.

262.   Adeyemi AB, Irinoye OO, Oladimeji BY, et al. Preparedness for management and prevention of violence against women by Nigerian health professionals. *Journal of Family Violence.* 2008;23(8):719-725.

263. Jacobs T, Jewkes R. Vezimfilho: a model for health sector response to gender violence in South Africa. *International Journal of Gynecology & Obstetrics.* 2002;78(1):S51-S56.

264. Chibber K, Krishnan S. Confronting intimate partner violence: a global health priority. *Mount Sinai Journal of Medicine.* 2012(1931-7581).

265. A D, Kohler HP. The impact of HIV testing on subjective expectations and risky behavior in Malawi. *Demography.* 2012;49:1011-1036.

266. Waalen J, Goodwin MM, Spitz AM, Petersen R, Saltzman LE. Screening for intimate partner violence by health care providers: Barriers and interventions. *American Journal of Preventive Medicine.* 2000;19(4):230-237.

267. García-Moreno C. Dilemmas and opportunities for an appropriate health-service response to violence against women. *Lancet.* 2002;359:1509-1514.

268. Christofides Nj Fau - Jewkes RK, Jewkes Rk Fau - Webster N, Webster N Fau - Penn-Kekana L, Penn-Kekana L Fau - Abrahams N, Abrahams N Fau - Martin LJ, Martin LJ. "Other patients are really in need of medical attention"--the quality of health services for rape survivors in South Africa. *Bulletin of the World Health Organisation.* 2005;83(495-502).

269. Kim J, Motsei M. "Women enjoy punishment": attitudes and experiences of gender-based violence among PHC nurses in rural South Africa. *Social Science & Medicine.* 2002;54(8):1243-1254.

270. Kilonzo N, Theobald SJ, Nyamato E, et al. Delivering post-rape care services: Kenya's experience in developing integrated services. *Bulletin of the World Health Organization.* 2009;87(7):555-559.

271. Colombini M, Siti hA, Watts C, Mayhew S. One stop crisis centres : A policy analysis of the Malaysian response to intimate partner violence *Health research policy and systems* 2011;9.

272. Kilonzo N, Ndunga N, Nthamburi N, et al. Sexual violence legislation in sub-Saharan Africa: the need for strengthened medico-legal linkages. *Reproductive health matters.* 2009;17(34):10-19.

273. Dahlber LLK, E.G. (2002). . Violence - a global public health problem. In: Krug EG, Dahlber LL, Mercy JA, ZWI AB, Lozano R. World report on violence and health. Geneva: World Health Organization; 2002. p. 1-22. .

274. Theobald S, Elsey H, Tolhurst R. Gender Mainstreaming and Sector-wide Approaches in Health: Key Areas for Debate. *Journal of Health and Managemant , Special edition on gender and health.* 2002;4:119-133.

275. Velzeboer. M. M, Ellsberg C, Alcas, Garcia-Moren C. *Violence against Women: The Health Sector Responds.* Washington, D.C: Pan American Health Organization.; 2003.

276. Derbyshire H. *Gender Manual: A Practical Guide for Development Policy Makers and Practitioners.* In: DFID Social Develpoment Division, ed; 2002.

277. Gremillion DH. Should physicians be required to report domestic violence. *North Carolina medical journal* 1997;58:320-322.

278. Sachs CJ. Should physicians be required to report domestic violence to the police? For: mandatory reporting is worthy of support. *the western journal of medicine* 2000;173:225.

279. Sachs CJ. Mandatory Reporting of Injuries Inflicted by Intimate Partner Violence. *American Medical Association Journal of Ethics.* 2007;9:842-845.

280. Rodriguez MA, McLoughlin E, Bauer HM, Paredes V, Grumbach K. Mandatory Reporting of Intimate Partner Violence to Police: Views of Physicians in California. *American Journal of Public Health.* 1999;89:575-579.

281. Rodríguez Ma MENGCJC. Mandatory reporting of domestic violence injuries to the police: What do emergency department patients think? *JAMA.* 2001;286:580-583.

282. Malecha AT, Lemmey D, McFarlane J, et al. Mandatory Reporting of Intimate Partner Violence: Safety or Retaliatory Abuse for Women? *Journal of Women's Health & Gender-Based Medicine.* 2000;9 75-78.

283. Sikkema K, Neufeld S, Hansen N, et al. Integrating HIV Prevention into Services for Abused Women in South Africa. *AIDS and Behavior.* 2010;14(2):431-439.

284. Fritz K, Gregowski A, Glenshaw M, et al. Addressing the Impact of Alcohol on the Prevention, Care, and Treatment of HIV in Southern and Eastern Africa: Research, Programming, and Next Steps-Report on a PEPFAR Technical Consultation. *USAID's AIDS Support and Technical Assistance Resources.* Vol Task Order 1. Held in Windhoek, Namibia, : AIDSTAR-One; 2012.

285. Hartmann M Fau - Gilles K, Gilles K Fau - Shattuck D, Shattuck D Fau - Kerner B, Kerner B Fau - Guest G, Guest G. Changes in couples' communication as a result of a male-involvement family planning intervention. *Journal of Health Communication.* 2012;17:802-819.

286. Becker S, Mlay R, Schwandt H, Lyamuya E. Comparing Couples' and Individual Voluntary Counseling and Testing for HIV at Antenatal Clinics in Tanzania: A Randomized Trial. *AIDS and Behavior.* 2010;14(3):558-566.

287. Ghanotakis E, Peacock D, Wilcher R. *The importance of addressing gender inequality in efforts to end vertical transmission of HIV*; 2012.

288. Semrau K, Kuhn L, Vwalika C, et al. Women in couples antenatal HIV counseling and testing are not more likely to report adverse social events. *AIDS.* 2005;19(6):603-609.

289. Farquhar C, Kiarie JN, Richardson BA, et al. Antenatal Couple Counseling Increases Uptake of Interventions to Prevent HIV-1 Transmission. *Journal of Acquired Immune Deficiency Syndromes.* 2004;37(5):1620-1626.

290. Katz Da Fau - Kiarie JN, Kiarie Jn Fau - John-Stewart GC, John-Stewart Gc Fau - Richardson BA, Richardson Ba Fau - John FN, John Fn Fau - Farquhar C, Farquhar C. Male perspectives on incorporating men into antenatal HIV counseling and testing. *PLoS One* 2009;4(11).

291. Arbuckle J, Olson L, Howard M, Brillman J, Anctil C, Sklar D. Safe at Home? Domestic Violence and Other Homicides Among Women in New Mexico. *Annals of Emergency Medicine.* 1996;27(2):210-215.

292. GOM. Gender and Development Index 2011. Zomba Ministry of Gender, Children and Community Development and the National Statistical Office.; 2012.

293. Lowe Morna C, Glenwright D, Makaya Magarangoma M. *SADC Gender Protocol Barometer 2010 Malawi.* Lilongwe: Malawi Human Rights Resource Centre; 2010.

294. Kayambazinthu E. The langauge planning situation of Malawi. *Journal of multilingual and Multicultural Development* 1998;5:369-439.

295. National Statistical Office (NSO). *2008 Population and Housing Census Results.* ZOMBA National Statistical Office 2008.

296. National Statistical Office. Integrated Household Survey 2004-2005. Zomba National Statistical Office; 2005.

297. National Statistical Office (NSO), Macro I. *Malawi Demographic and Health Survey 2010.* Zomba, Malawi, and Calverton, Maryland, USA: NSO and ICF Macro; 2011.

298. Ministry of Development Planning and Cooperation. RAPID: Population and Development in Malawi. In: Population Unit MoDPaC, ed. Lilongwe, Malawi:; 2010.

299. Tsoka MG, Chinangwa S. *Baseline Survey for the Community Mobilization against Gender Based Violence, HIV and AIDS" Project in Kanengo Policing Area.* Lilongwe: Malawi Human Rights Resource Centre; 2007.

300. CHRR. *Community safety & empowerment programme: report on community perspetives on gender based violence in Malawi : a survey of knowledge attitudes and practices.* Lilongwe, Malawi: Centre for Human Rights and Rehabitation; 2005.

301. UNDP. *Human Development Report 2011 Sustainability and Equity: A Better Future for All.* 1 UN Plaza, New York, NY 10017, USA: United Nations Development Programme; 2011.

302. Kalipeni E, Ghosh J. Women in Chinsapo, Malawi: vulnerability and risk to HIV/AIDS. *Journal of Social Aspects of HIV/AIDS.* 2005;2:320-332.

303. Ellis F, Kutengule M, Nyasulu A. Livelihoods and Rural Poverty Reduction in Malawi. *World Development.* 2003;31(9):1495-1510.

304. Lele U. Structural adjustment, agricultural development and the poor: Some lessons from the Malawian experience *World Development.* 1990;18:1207-1219.

305. Mlenga E. Place of Residence and Sexual Behavior: Evolving norms? ; 2012.

306. UN-HABITAT. Malawi: Blantyre urban Profile. 2011.

307. Riley L. The political economy of urban food security in Blantyre, Malawi. *The Africa Institute Occasional Paper Series Vol. 1, Iss.2, June 2012*: The University of west Ontario; 2012.

308. united nations Human Settlements Programme (un-HaBitat). *Malawi:Blantyre urban Profile.* Kenya 2011.

309. FAO. Malawi Country Profile Gender Inequalities in Rural Employment in Malawi An Overview. In: Gender EaREDoF, ed. Rome, Italy: FAO; 2011.

310. Maluwa-Banda D. *Gender Sensitive educational Policy and Practice: The Case of Malawi.* Zomba UNESCO; 2003.

311. GOM. Health Sector Strategic Plan (HSSP) 2011-2016 Moving towards equity and quality. In: Health Mo, ed. Lilongwe: Ministry of Health 2011.

312. Population Reference Bureau. Malawi PoPulation Data Sheet. 2012.

313. Munthali A, Zulu EM, Madise N, et al. *Adolescent Sexual and Reproductive Health in Malawi:Results from the 2004 National Survey of Adolescents.* New York Guttmacher Institute; 2006.

314. Undie Cc Fau - Crichton J, Crichton J Fau - Zulu E, Zulu E. Metaphors we love by: Conceptualizations of sex among young people in Malawi. *African Journal of Reproductive Health.* 2008;11:221-235.

315. WHOSIS. Malawi Health profile. Global Health Observatory (GHO). ; 2010.

316. Rico E, Fenn B, Abramsky T, Watts C. Associations between maternal experiences of intimate partner violence and child nutrition and mortality: findings from Demographic and Health Surveys in Egypt, Honduras, Kenya, Malawi and Rwanda. *Journal of Epidemiology and Community Health.* 2011;65:360-367.

317. Office of the President and Cabinet. National HIV and AIDS Strategic Plan 2012-2016. Lilongwe: Office of the President and Cabinet; 2011.

318. GOM. 2012 Global AIDS Response Progress Report: Malawi Country Report for 2010 and 2011. Lilongwe: Office of President and Cabinet; 2012.

319. Aarnio P, Olsson P, Chimbiri A, Kulmala T. Male involvement in antenatal HIV counseling and testing: exploring men's perceptions in rural Malawi. *AIDS Care.* 2009;21:1537-1546.

320. Muula AS, Kataika E. 'Assessment of equity in the uptake of anti-retrovirals in Malawi,' EQUINET Discussion Paper Series 58. . University of Cape Town, Harare:

Regional network for Equity in Health in East and southern Africa, (EQUINET)/ Health Economics Unit:

; 2008.

321. Makwiza I, Nyirenda L, Bongololo G, Rene L, Theobald S. Monitoring equity and health systems in the provision of antiretroviral therapy (ART): Malawi country report EQUINET Discussion Paper Number 24. 2005.

322. Mwambene L. *Divorce in matrilineal Customary Law marriage in Malawi: A comparative analysis with the patrilineal Customary Law marriage in South Africa*: Faculty of Law

University of Western Cape; 2005.

323. Saur M, Semu L, Ndau Hauya S. *Nkhanza Listening to peoples voices: A base line study of gender based violence " nkhanza" in three districts of Malawi.* Zomba: GTZ, Ministry of Gender and Community Services; 2003.

324. Mtika MM, Doctor HV. "Matriliny, patriliny, and wealth flows in rural Malawi,". *African Sociological Review.* 2002;6:71-97.

325. Segal ES. Gender and Ethnicity in Banda's Malaëi. *Women's Activism for Gender Equality in Africa.* 2008;6.

326. White S. *Malawi: Country Gender Profile.* Blantyre: Women and Law in Southern Africa Research and education trust-Malawi.; 2007.

327. MHRC. *Cultural Practices and their Impact on the Enjoyment of Human Rights, Particularly the Rights of Women and Children in Malawi.* Lilongwe: MHRC; 2011.

328. National Statistical Office (NSO), Macro I. *Malawi Demographic and Health Survey 2004.* Calverton, Maryland: NSO and ORC Macro.; 2005.

329. Harling G, Msisha W, Subramanian SV. No Association between HIV and Intimate Partner Violence among Women in 10 Developing Countries. *PLoS ONE.* 2010;5(12):e14257.

330. Alio AP, Clayton HB, Garba M, Mbah AK, Daley E, Salihu HM. Spousal Concordance in Attitudes Toward Violence and Reported Physical Abuse in African Couples. *Journal of Interpersonal Violence.* September 1, 2011 2011;26(14):2790-2810.

331. Bazargan-Hejazi S Fau - Medeiros S, Medeiros S Fau - Mohammadi R, Mohammadi R Fau - Lin J, Lin J Fau - Dalal K, Dalal K. Patterns of Intimate Partner Violence: a study of female victims in Malawi. *Journal of Injury and Violence Research.* 2013;1:38-50.

332. Johnson K. Incontinence in Malawi: Analysis of a proxy measure of vaginal fistula in a national survey. *International Journal of Gynecology & Obstetrics.* 2007;99, Supplement 1:S122-S129.

333. Rani M, Bonu S, Diop-Sidibé N. An Empirical Investigation of Attitudes towards Wife-Beating among Men and Women in Seven Sub-Saharan African Countries. *African Journal of Reproductive Health.* 2004;8:116-136.

334. Barkvoll B. *A quantitative study examining the association between intimate partner violence in Malawi and the gender order.* Norway, University of Oslo, ; 2009.

335. Kathewera-Banda M, Gomile-Chidyaonga F, Hendriks S, Kachika T, Mitole Z, White S. Sexual violence and women's vulnerability to HIV transmission in Malawi: a rights issue. *International Social Science Journal.* 2005:649-660.

336. Pelser E, Gondwe L, Mayamba C, Mhango T, Phiri W, Burton P. *Intimate partner violence: Results from a national gender based violence study in Malawi.*: Crime & Justice Statstical Division, National Statstical Office,; 2005.

337.   Chasweka R, Chimwaza A, Maluwa A, Odland JO. Magnitude of domestic violence against Pregnant women in Malawi. *Journal of Research in Nursing and Midwifery.* 2012;2:17-21.

338.   Kayuni HM. The Challenge of Studying Sexual Harassment in Higher Education: An Experience from the University of Malawi's Chancellor College. *Journal of International Women's Studies.* 2009;11:83-99.

339.   Moore Am Fau - Awusabo-Asare K, Awusabo-Asare K Fau - Madise N, Madise N Fau - John-Langba J, John-Langba J Fau - Kumi-Kyereme A, Kumi-Kyereme A. Coerced first sex among adolescent girls in sub-Saharan Africa: prevalence and context. *African Journal of Reproductive Health* 2007;11:62-82.

340.   Phiri I, Semu L, Nankhuni F, Madise N. *Violence against women in educational institutions : the case of sexual harassment and Rape on Chancellor College Campus.* Zomba 1994.

341.   Kvam MH, Braathen SH. "I thought . . . maybe this is my chance": Sexual Abuse Against Girls and Women With Disabilities in Malawi. *Sexual Abuse: A Journal of Research and Treatment.* 2008;20(1):5-24.

342.   Bisika T. Do Social and Cultural Factors Perpetuate Gender based violence in Malawi? *Gender & Behaviour.* 2008:1884-1896.

343.   Mkandawire-Valhmu L, Stevens PE. Applying a Feminist Approach to Health and Human Rights Research in Malawi: A Study of Violence in the Lives of Female Domestic Workers. *Advances in Nursing Science.* 2007;30(3):278-289

344.   Mandal M Fau - Hindin MJ, Hindin MJ. Men's Controlling Behaviors and Women's Experiences of Physical Violence in Malawi. *Maternal and Child Health Journal.* 2012.

345.   Braathen SH. *Substance Use and Gender Based Violence in a Malawian Context – Pilot Project 2.* Oslo 2008. SINTEF A6189.

346.   NATIONAL STATISTICAL OFFICE (NSO) & MACRO I. Malawi Demographic and Health Survey 2004. Calverton, Maryland:: NSO and ORC Macro.; 2005.

347.   National Statistical Office (NSO) and ICF Macro. Malawi Demographic and Health Survey 2010. Zomba, Malawi, and Calverton, Maryland, USA: NSO and ICF Macro.; 2011.

348.   Underwood C, Skinner J, Osman N, Schwandt H. Structural determinants of adolescent girls' vulnerability to HIV: views from community members in Botswana, Malawi, and Mozambique *Social Science & Medicine.* 2011;73:343-350.

349.   Baird S, Garfein R, McIntosh C, Ozler B. Effect of a cash transfer programme for schooling on prevalence of HIV and herpes simplex type 2 in Malawi: a cluster randomised trial. *Lancet.* 2012;379:1320-1329.

350.   Tolhurst R, Theobald S, Kayira E, et al. [`]I don't want all my babies to go to the grave': perceptions of preterm birth in Southern Malawi. *Midwifery.* 2008;24(1):83-98.

351.   GOM. A Joint Programme of Work for a Health Sector Wide Approach (SWAp) [2004 - 2010]. In: Department of Planning Ministry of Health, ed. Lilongwe; 2004.

352.   Tolhurst RJ. *Involving dostrict level fieldworkers in participatory research: possibilities and constraints as an approach to gender main streaming in health.* Liverpool, University of Liverpool; 2004.

353.   Banda HT, Bongololo GT, Ng'ombe J, Makwiza I. *Regional network for Equity in Health in east and southern Africa (EQUINET)* Malawi: REACH Trust Malawi, Malawi Health Equity Network 2006.

354.   Pearson M. *DFID impact evaluation of the Sector Wide Approach, Malawi.* Malawi 2010.

355. GOM. Malawi Health Information System: National Policy and Strategy. Lilongwe: Ministry of Health,; 2003.

356. Crotty M. *Introduction: The research process. In The foundations of social research: Meaning and perspective in the research process (Vol. The foundations of social research*. Thousand Oaks, CA: : Sage Publications.; 1998.

357. Creswell J. *Qualitative Inquiry and Research Design: Chosing Among Five Approaches 2nd Edition.* Thousand Oaks:: Sage Publications.; 2007.

358. Kilonzo N. *The Practical and Policy Requirements for Implementing Post Rape Care Services in Resource Limited Settings*. Liverpool School of Tropical Medicine, University of Liverpool; 2007.

359. Maxwell JA. Designing a Qualitative Study. *Qualitative Research Design: An Interactive Approach*: Copyrightby SAGE; 2005.

360. Carr U. The strengths and weaknesses of quantitative and qualitative research: what method for nursing? *Journal of Advanced Nursing* 1994;20,:716-721.

361. Draper AK. The principles and application of qualitative research. *Proceedings of the Nutrition Society*. 2004;63(04):641-646.

362. Aarnio P Fau - Olsson P, Olsson P Fau - Chimbiri A, Chimbiri A Fau - Kulmala T, Kulmala T. Male involvement in antenatal HIV counseling and testing: exploring men's perceptions in rural Malawi. *AIDS Care.* 2009;21.

363. Small SA. Action-Oriented Research: Models and Methods. *Journal of Marriage and Family.* 1995;57(4):941-955.

364. Ambert A-M, Adler PA, Adler P, Detzner DF. Understanding and Evaluating Qualitative Research *Journal of Marriage and Family.* 1995;57:879-893.

365. Shapiro M, Setterlund D, Cragg C. Capturing the Complexity of Women's Experiences: A Mixed-Method Approach to Studying Incontinence in Older Women. *Affilia.* 2003;18(1):21-33.

366. Lee RM. *Doing Research on Sensitive topics*. London: Sage; 1993.

367. Bradley EH, Curry LA, Devers KJ. Qualitative Data Analysis for Health Services Research: Developing Taxonomy, Themes, and Theory. *Health Research and Educational Trust.* 2007:1758-1771.

368. Wilson K, Silberberg M, Brown A, Yaggy S. Health needs and barriers to healthcare of women who have experienced intimate partner violence. *J Womens Health (Larchmt).* 2007;16:1485 - 1498.

369. Mercer T. *Gender Needs Assessment for Blantyre City, Malawi* 2010.

370. Dzamalala CP, Milner DA, Liomba NG. Suicide in Blantyre, Malawi (2000-2003). *Journal of Clinical Forensic Medicine.* 2006;13(2):65-69.

371. Centre for Human Rights and Rehabilitation. *Alternative Report for the Review of Republic of Malawi by the Human Rights Committee.* Lilongwe: Centre for Human Rights and Rehabilitation; 2011.

372. WHO. Preventing violence and reducing its impact: How development agencies can help. Geneva: Violence prevention alliance; 2008: 1-49.

373. Bott S, Morrison, Andrew Robert and Ellsberg, Mary. *Preventing and Responding to Gender-Based Violence in Middle and Low-Income Countries: A Global Review and Analysis* World Bank 2005.

374. Djikanovic B, Celik H, Simic S, Matejic B, Cucic V. Health professionals' perceptions of intimate partner violence against women in Serbia: Opportunities and barriers for response improvement. *Patient Education and Counseling.* 2010;80(1):88-93.

375. Linhorst DM. A Review of the Use and Potential of Focus Groups in Social Work Research. *Qualitative Social Work.* 2002;1(2):208-228.

376. Gerbert B, Abercrombie P, Caspers N, Love C, Bronstone A. How Health Care Providers Help Battered Women: The Survivor's Perspective. *Women & Health.* 1999;29(3):115 - 135.

377. Hathaway JE, Willis, Georgianna and Zimmer, Bonnie. Listening to Survivors' Voices: Addressing Partner Abuse in the Health Care Setting *Violence Against Women.* 2002;8:687-716.

378. Basch CE. Focus Group Interview: An Underutilized Research Technique for Improving Theory and Practice in Health Education. *Health Education & Behavior.* 1987;14(4):411-448.

379. Pope C, Ziebland S, Mays N. Qualitative research in health care: Analysing qualitative data. *BMJ.* 2000;320(7227):114-116.

380. Mkandawire-Valhmu L Fau - Stevens PE, Stevens PE. The critical value of focus group discussions in research with women living with HIV in Malawi. *Qualitative Health Research.* 2010;20::684-696.

381. Mkandawire-Valhmu L. "Suffering in Thought": An Analysis of the Mental Health Needs of Female Domestic Workers Living with Violence in Malawi. *Issues in Mental Health Nursing.* 2010;31(2):112-118.

382. Mkandawire-Valhmu L, Rodriguez R, Ammar N, Nemoto K. Surviving Life as a Woman: A Critical Ethnography of Violence in the Lives of Female Domestic Workers in Malawi. *Health care for women international.* 2009;30(9):783 - 801.

383. Chernesky RH, Grube B. Examining the HIV/AIDS case management process. *Health & Social Work.* 2000;25:243-253.

384. Tough A. Oral culture, written records and understanding the twentieth-century colonial archive. The significance of understanding from within. *Archival Science.* 2012;12(3):245-265.

385. Theobald S, Nyirenda L, Tulloch O, et al. Sharing experiences and dilemmas of conducting focus group discussions on HIV and tuberculosis in resource-poor settings. *International Health.* 2011;3(1):7-14.

386. Mkandawire-Valhmu L, Stevens PE. The Critical Value of Focus Group Discussions in Research With Women Living With HIV in Malawi. *Qualitative Health Research.* 2010;20(5):684-696.

387. Munoz-Rivas Mj Fau - Grana JL, Grana Jl Fau - O'Leary KD, O'Leary Kd Fau - Gonzalez MP, Gonzalez MP. Prevalence and predictors of sexual aggression in dating relationships of adolescents and young adults. *Psicothema.* 2009;21:234-240.

388. Densombe M. *Research guide for small scale research projects*. England Open university press; 2007.

389. Allmark P, Boote J, Chambers E, et al. Ethical issues in the use of in-depth interviews: literature review and discussion. *Research Ethics Review.* 2009;5(2):48-54.

390. Gremler DD. The Critical Incident Technique in Service Research. *Journal of Service Research.* 2004;7(1):65-89.

391. Epi info. The division of surveillance and epidemiology Atlanta, USA: Centers for Disease control and Prevention,; 2002.

392. Pope C, Mays N, eds. *Qualitative research in health care.* Vol 3rd edition. Oxford: Blackwell publishing company; 2006.

393. Lacey A, Luff D. Qualitative Research Analysis. The NIHR RDS for teh East Midlands/Yorkshire and the Humber. 2007.

394. Rabiee F. Focus-group interview and data analysis. *Proceedings of the Nutrition Society.* 2004;63(04):655-660.

395.   Krueger RA, Casey MA. *Focus Group A Practical Guide for Applied Reseach.* 3rd Edition ed. London: Sage Publications 2000.

396.   Tolich M. Internal Confidentiality: When Confidentiality Assurances Fail Relational Informants. *Qualitative Sociology.* 2004;27(1):101-106.

397.   Tolich M. The Principle of Caveat Emptor: Confidentiality and Informed Consent as Endemic Ethical Dilemmas in Focus Group Research. *Journal of Bioethical Inquiry.* 2009;6(1):99-108.

398.   WHO. Putting women first: ethical and safety recommendations for research on domestic violence against women (WHO/FCH/GWH/01.1). 2001.

399.   Head E. The ethics and implications of paying participants in qualitative research. *International Journal of Social Research Methodology.* 2009;12(4):335 - 344.

400.   Grant RW, Sugarman J. Ethics in Human Subjects Research: Do Incentives Matter? *Journal of Medicine and Philosophy.* 2004;29(6):717-738.

401.   Shenton AK. Strategies for ensuring trustworthiness in qualitative research projects. *Education for Information* 2004 22:63-75 63.

402.   Lincoln Y, Guba E. *Naturalistic Inquiry*. Newbury Park, CA: Sage Publications; 1985.

403.   Mathison S. Why Triangulate? *Educational Reseacrher.* 1988:13-17.

404.   Golafshani N. Understanding Reliability and Validity in Qualitative Research. *The Qualitative Report.* 2003;8:597-607.

405.   Ellsberg M, Heise L. Bearing witness: ethics in domestic violence research. *The Lancet.* 2002;359(9317):1599-1604.

406.   McCorkel JA, Myers K. What Difference Does Difference Make? Position and Privilege in the Field. *Qualitative Sociology.* 2003;26:199-231.

407.   United Nations. CEDAW Convention on all Elimination of all forms of Violence against Women. In: Division for the advancement of women Department of Economic and Social Affairs, ed; 1979.

408.   United Nations. Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women. In: Division for the advancement of women Department of Economic and Social Affairs, ed; 2000.

409.   United Nations. World Conference on Human Rights Vienna Declaration and Programme of Action. In: Outcomes on Human Rights, ed; 1993.

410.   UNFPA. Master Plans for Development: Summary of the ICPD Programme of Action. 1994.

411.   Organization of African Unity. African Charter on Human and Peoples' Rights ("Banjul Charter"). In: http://www.unhcr.org/refworld/docid/3ae6b3630.htm, ed: CAB/LEG/67/3 rev. 5, 21 I.L.M. 58 (1982); 1981.

412.   SADC. SADC Protocol on Gender and Development 2008.

413.   Internation Criminal Court. Prevent Genocide International. In: Rome Statute of The International Criminal Court, ed.

414.   United Nations. International Covenant on Civil and Political Rights. In: Office of the United Nations High Commissioner on Human Rights, ed; 1966.

415.   United Nations. International Covenant on Economic, Social and Cultural Rights In: Office of the United Nations High Commissioner on Human Rights, ed; 1976.

416.   SADC. Protocol on health in South African Development Community. 1999.

417.   GOM. Pre-service Education Family Planning Reference Guide (2010) Ministry of health, IntraHealth International.; 2010.

418.   GOM. Guidelines for Provision of Comprehensive services for survivors of physical and sexual violence at Health Facilities in Malawi(One-Stop Centres) Revised Edition 2012,. In: Ministry of Health, ed. Lilongwe; 2012.

419. Cammack D. *Peri-urban governance and the delivery of public goods in Malawi 2009-11* Overseas Development Institute; 2012.

420. Bonoma TV. Case research in marketing: Opportunities problems, and a process. *Journal of Marketing Research.* 1985;22:199-208.

421. Garcia-Moreno C, Jansen H, Ellsberg M, Heise L, Watts C. Prevalence of intimate partner violence: findings from the WHO multi-country study on women's health and domestic violence. *Lancet.* 2006;368(9543):1260 - 1269.

422. Giridhar N. *The global spread of domestic violence legislation : causes and effects*, New york university; 2012.

423. Whitaker DJ, Lutzker JR. *Preventing partner violence: Research and evidence-based intervention strategies*. Washington, DC, US: American Psychological Association; 2009.

424. Welbourn A. Stepping Stones: A training package in HIV/AIDS, communication and relationship skills. London: Strategies for Hope; 1995.

425. Shen AC-T. Cultural Barriers to Help-Seeking Among Taiwanese Female Victims of Dating Violence. *Journal of Interpersonal Violence.* 2011;26(7):1343-1365.

426. Black BM, Tolman RM, Callahan M, Saunders DG, Weisz AN. When Will Adolescents Tell Someone About Dating Violence Victimization? *Violence Against Women.* 2008;14(7):741-758.

427. Moses Vernonxious Madalitso Chamba. *Evaluation Study on Implementation of Life Skills Programme in Public Secondary Schools in Malawi: South Eastern Educational Division (SEED)*. Malawi: College of Medicine, UNIVERSITY OF MALAWI; 2009.

428. CHIRWA G.W. *A case study of challenges facing the implementation of life skills education in primary schools in the Zomba district of Malawi*. Johannesburg University of the Witwatersrand; 2009.

429. Saltzman L, Fanslow J, McMahon P, Shelley G. Intimate partner violence surveillance: Uniform definitions and recommended data elements. *Atlanta, GA: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control.* 2002.

430. Colombini M, Mayhew S, Ali SH, Shuib R, Watts C. "I feel it is not enough..." Health providers' perspectives on services for victims of intimate partner violence in Malaysia. *BMC Health Services Research.* 2013;13(1):65.

431. Plichta S. The effects of woman abuse on health care utilization and health status: A literature review. *Women's Health Issues.* 1992;2(3):154-163.

432. Hartmann M, Gilles K, Shattuck D, Kerner B, Guest G. Changes in Couples' Communication as a Result of a Male-Involvement Family Planning Intervention. *Journal of Health Communication.* 2012;17(7):802-819.

433. Chipeta Ek Fau - Chimwaza W, Chimwaza W Fau - Kalilani-Phiri L, Kalilani-Phiri L. Contraceptive knowledge, beliefs and attitudes in rural Malawi: misinformation, misbeliefs and misperceptions. *Malawi Medical Journal.* 2010;2(31-41).

434. Gubrium A. "I've Lost My Mojo, Baby". *Sex Res Soc Policy.* 2011/12/01 2011;8(4):321-334.

435. Mason K Fau - Lynam P, Lynam P. Not for women only: child-spacing clubs for Malawian men. *AVSC News.* 1992;30.

436. Kululanga LI, Sundby J, Malata A, Chirwa E. Striving to promote male involvement in maternal health care in rural and urban settings in Malawi - a qualitative study. *Reprod Health.* 2011;8:36.

437. Angotti N, Dionne KY, Gaydosh L. An offer you can't refuse? provider-initiated HIV testing in antenatal clinics in rural Malawi. *Health Policy Plan.* 2011;26(4):307 - 315.

438. Vernooij E Fau - Hardon A, Hardon A. 'What mother wouldn't want to save her baby?' HIV testing and counselling practices in a rural Ugandan antenatal clinic. *International Journal for Research, Intervention and Care.* 2013(1464-5351).

439. Levy JM. Women's expectations of treatment and care after an antenatal HIV diagnosis in Lilongwe, Malawi. *Reproductive health matters.* 2009;17(33):152-161.

440. Robinson A, Cook D. Understanding Victim Retraction in Cases of Domestic Violence: Specialist Courts, Government Policy, and Victim-Centred Justice. *Contemporary Justice Review.* 2006;9(2):189-213.

441. Brown LB, Miller WC, Kamanga G, et al. HIV partner notification is effective and feasible in sub-Saharan Africa: opportunities for HIV treatment and prevention. *Journal of Acquired Immune Deficiency Syndrome.* 2011;56(5):437 - 442.

442. Rasch V, Silberschmidt M, McHumvu Y, Mmary V. Adolescent girls with illegally induced abortion Dar es Salaam: The discrepancy between sexual behaviour and lack of access to contraception. *Reproductive Health Matters.* 2000;8(15):52-62.

443. Silverman JG, Raj A, Clements K. Dating Violence and Associated Sexual Risk and Pregnancy Among Adolescent Girls in the United States. *Pediatrics.* 2004;114(2):e220-e225.

444. Stöckl H, Filippi V, Watts C, Mbwambo JKK. Induced abortion, pregnancy loss and intimate partner violence in Tanzania: A population based study. *BMC Pregnancy and Childbirth.* 2012;12.

445. Wingood GM, DiClemente RJ, McCree DH, Harrington K, Davies SL. Dating Violence and the Sexual Health of Black Adolescent Females. *Pediatrics.* 2001;107(5):e72.

446. Levandowski BA, Kalilani-Phiri L, Kachale F, Awah P, Kangaude G, Mhango C. Investigating social consequences of unwanted pregnancy and unsafe abortion in Malawi: The role of stigma. *International journal of gynaecology and obstetrics: the official organ of the International Federation of Gynaecology and Obstetrics.* 2012;118:S167-S171.

447. Jackson E, Ronald Johnson B, Gebreselassie H, Kangaude GD, Mhango C. A strategic assessment of unsafe abortion in Malawi. *Reproductive Health Matters.* 2011;19:133–143.

448. Poulin M. Sex, money, and premarital partnerships in southern Malawi. *Social Science and Medicine.* 2007;65(2383-2393).

449. Brear M, Bessarab D. Perspectives on intimate partner violence in Swaziland amongst 18–29-year-old men undergoing medical circumcision. *Culture, Health & Sexuality.* 2011;14(1):31-43.

450. Glasier A, Gülmezoglu AM, Schmid GP, Moreno CG, Van Look PFA. Sexual and reproductive health: a matter of life and death. *The Lancet.* 2006;368(9547):1595-1607.

451. Guedes A, Bott S, Guezmes A, Helzner JF. Gender based violence Human rights and the health sector: Lessons from Latin America. *Health and human rights.* 2002;6:177-193.

452. Colombini M, Mayhew S, Ali S, Shuib R, Watts C. An integrated health sector response to violence against women in Malaysia: lessons for supporting scale up. *BMC Public Health.* 2012;12(1):548.

453. McCollum Ee Fau - Stith SM, Stith SM. Couples treatment for interpersonal violence: a review of outcome research literature and current clinical practices. *Violence & Victims.* 2008;23:187-201.

454. Malera G. Adolescent Girls Leadership Initiative (AGALI), training notes. 2011.

455. Murray C. Young People's Help-Seeking: An alternative model. *Childhood.* November 1, 2005 2005;12(4):479-494.

456. Davidson Ll Fau - Grisso JA, Grisso Ja Fau - Garcia-Moreno C, Garcia-Moreno C Fau - Garcia J, Garcia J Fau - King VJ, King Vj Fau - Marchant S, Marchant S. Training programs for healthcare professionals in domestic violence. *Journal of Womens Health Gender Based Medicine.* 2001;10:953-969.

457. Pualani Enos V, Linden JA, Tieszen L, Bernstein J, Brown J. *An Intervention to Improve Documentation of Intimate Partner Violence in Medical Records.* US: U.S. Department of Justice; 2004.

458. Sprague S, Madden K, Simunovic N, et al. Barriers to Screening for Intimate Partner Violence. *Women & Health.* 2012;52(6):587-605.

459. Undie C-C, Maternowska MC, Mak'anyengo M, Birungi H, Keesbury J, Askew I. *Routine screening for intimate partner violence in public health care settings in Kenya: An assessment of acceptability.* Nairobi, Kenya: APHIA II OR Project in Kenya/ Population Council; 2012.

460. Elsey H, Tolhurst R, Theobald S. Mainstreaming HIV/AIDS in development sectors: Have we learnt the lessons from gender mainstreaming? *AIDS Care.* 2005;17(8):988-998.

461. Kilonzo N, Taegtmeyer M, Molyneux C, Kibaru J, Kimonji V, Theobald S. Engendering health sector responses to sexual violence and HIV in Kenya: Results of a qualitative study. *AIDS Care.* 2008;20(2):188-190.

462. MOH. National Sexual and Reproductive and Rights (SRHR) Policy. Lilongwe; 2009.

463. Becker S Fau - Mlay R, Mlay R Fau - Schwandt HM, Schwandt Hm Fau - Lyamuya E, Lyamuya E. Comparing couples' and individual voluntary counseling and testing for HIV at antenatal clinics in Tanzania: a randomized trial. *AIDS and Behavior.* 1573-3254

464. Ghanotakis E Fau - Peacock D, Peacock D Fau - Wilcher R, Wilcher R. The importance of addressing gender inequality in efforts to end vertical transmission of HIV. *Journal of Acquired Immune Deficiency Syndromes.* 1758-2652

465. Farquhar C Fau - Kiarie JN, Kiarie Jn Fau - Richardson BA, Richardson Ba Fau - Kabura MN, et al. Antenatal couple counseling increases uptake of interventions to prevent HIV-1 transmission. *Journal of Acquired Immune Deficiency Syndromes.* 1525-4135

466. Katz Da Fau - Kiarie JN, Kiarie Jn Fau - John-Stewart GC, John-Stewart Gc Fau - Richardson BA, Richardson Ba Fau - John FN, John Fn Fau - Farquhar C, Farquhar C. Male perspectives on incorporating men into antenatal HIV counseling and testing. *PLOS one.* 1932-6203

467. Sikkema Kj Fau - Neufeld SA, Neufeld Sa Fau - Hansen NB, Hansen Nb Fau - Mohlahlane R, et al. Integrating HIV prevention into services for abused women in South Africa. *AIDS and Behavior.* 1573-3254.

468. AID U. Addressing the impact of alcohol on the prevention, care, and treatment of HIV in Southern and Eastern Africa: Research, programming, and next steps. Windhoek, Namibia, April 12-14, 2011.: PEPFAR technical consultation 2011.

Annexes

Annex 1: Proforma- records review forms

Date: DD/MM/YY No: | | Age: | | Dept: | | Marital status: | | Location: | | Home district: | | Sex : M   F

This form is used to collect data from registers. Please ensure that all data is entered correctly Do not enter patients' names.   Use of codes recommended

Indicators	
Rape	[ ] yes [ ]No [ ] N/A
Human bites	[ ] yes [ ]No [ ] N/A
Delayed presentation	[ ] yes [ ]No [ ] N/A
Story not compatible	[ ] yes [ ]No [ ] N/A
Overt Suicide	[ ] yes [ ]No [ ] N/A
Femicide	[ ] yes [ ]No [ ] N/A
Lacerations or abrasions	[ ] yes [ ]No [ ] N/A
Burns	[ ] yes [ ]No [ ] N/A
Ear injuries	[ ] yes [ ]No [ ] N/A
Pelvic inflammatory diseases	[ ] yes [ ]No [ ] N/A
STIs	[ ] yes [ ]No [ ] N/A
HIV	[ ] yes [ ]No [ ] N/A
Unsafe abortion	[ ] yes [ ]No [ ] N/A
Premature labour	[ ] yes [ ]No [ ] N/A
Deliberate self harm	[ ] yes [ ]No [ ] N/A
Facial injuries	[ ] yes [ ]No [ ] N/A
Maternal mortality	[ ] yes [ ]No [ ] N/A
Fractures	[ ] yes [ ]No [ ] N/A
Drug and Alcohol abuse	[ ] yes [ ]No [ ] N/A
Depression and anxiety	[ ] yes [ ]No [ ] N/A
Low birth weight	[ ] yes [ ]No [ ] N/A
Miscarriage	[ ] yes [ ]No [ ] N/A
Abdominal and thoracic injuries	[ ] yes [ ]No [ ] N/A
Assault	[ ] yes [ ]No [ ] N/A
Sexual abuse	[ ] yes [ ]No [ ] N/A
Special comments	

Annex 2: General Key informant interviews guide

Key Informant code   :

Key Informant Title   :

Key Informant Category   :

Address   :

Email address   :

Phone   :

Interview Date   :

Interview Location   :

Interviewers Name   :

Introduction

The interviewer will introduce her/him self and explain the purpose of the discussion. She will explain that the discussion will focus on health care services available for IPV clients, their perceptions of IPV and their role in violence prevention and experiences of providing care to survivors male or female and linkages with other service providers.

Knowledge and Attitudes

What do you understand by the word violence?

What about intimate partner violence?

Probes:

In what kind of relationship does this type of violence occur?

Does it include violence occurring in a non- marital relationship?

How do you differentiate it from non-partner violence? What is rape?

In what kind of relationships does rape occur? Can rape occur in intimate relationships? How, why or why not

What does the law say about IPV and rape in Marriage?

Probes:

What do you think about that?

Why do you think IPV happens?

How do people resolve conflicts in marriage?

How could you differentiate between violence and misunderstandings in the family?

Role of your organisation in violence prevention?
Would you please tell me more about your role in violence prevention and service provision?
Probes :

What motivated you to engage in such type of work?
How do you find your job?
Who do you provide service to?
Which organisations do you work with?
Who supports your work?
Which areas do you provide services?
What else are you willing to do?
What would hinder you from accomplishing your goals?
What are the challenges you face on daily basis?
What are the opportunities you meet?

The Role of Health Care Services in gender based violence prevention intimate partner prevention

What is the relationship between IPV and health?

What in your perception is the role of health care services in intimate partner violence prevention?

Probes:

Why should health care providers be involved in violence prevention?

What are some of the ways in which health care providers could work in violence prevention?

What do you think are the areas in which health care services does well in addressing the needs of IPV survivors?

Where are they not doing well?

What makes them not function well?

What are the challenges the health care system is meeting in addressing the needs of IPV survivors?

Would survivors   freely disclose to health care providers of their experience of IPV

What would promote the disclosure?

What would hinder survivors' disclosure?

From your perspectives which are the services that are needed most by the community

Would you please tell me more about your experience of collaborating with other organisatons?

How do you think these can be improved?

Explain any concerns or ideas you have about the health care services

What are the opportunities for provision /improvement of care?

What should be done?

Do you have any suggestions?

Probes:

Is there anything that you wished was asked

Is there anything that you would like to tell or ask us?

[a] key informant guidelines for justice system

What is the legal definition of IPV?

How is rape defined in the law?

What is the magnitude of IPV in legal services?

What are the procedures for reporting IPV and rape?

Probes:

Are they similar? How and why and why not

What is the procedure for prosecution?

What are the challenges you face in discharging justice

Is the current system efficient? Are there any changes you wish were done? What are they and how do you wish they should be implemented

What are the opportunities for helping victims of violence?

What is the response of the government to issues of IPV?

Probes:

What about political will?

Why do you think so?

[b] Key informant guidelines with the police

What is the legal definition of IPV?

How is rape defined in the law?

Why do you think intimate partner violence occur?

How big is this problem in the country?

Probes:

How is it manifesting in the legal services?

What impact does it have on the legal services?

What do you think are the consequence of IPV?

What are the procedures for reporting IPV and rape?

Probes:

Are they similar? How and why and why not?

What is the role of the police in IPV prevention?

How many cases of IPV have you seen over the past year and past month?

What is the role of victim support unit in domestic violence unit?

Do you think the unit is achieving its mandate?

Probes:

What are the challenges?

What are the opportunities?

Do you think it is important for women to come and report problems in their marriages to the police?

Probes:

Who is supposed to handle this?

What would you have preferred to be done?

Why do you think this should be the case?

Do you refer your cases to other organisations?

Probes:

Which ones?

Why do you refer them to those organisations?

Which violence victims do you refer to the hospital?

Why do you refer them to them to the hospital?

Why do you not refer the others to the hospital?

[c] Key informant guidelines with other domestic violence services offering counselling and support services

What support do you get to help with the running of your organisation?

Where do you get this support from?

Which organisations offer support for domestic violence services

Who does the counselling?

Where were these counsellors trained?

Do you think this support is adequate?

What is your opinion about the efforts of violence prevention on the district?

Do you think these services are well coordinated why and why not?

What can be done to improve the services?

Are survivors of domestic violence given adequate support?

[d] key informant guidelines with research, policy and education institutions and health policy

What is your role in IPV prevention? What are you currently doing? What more are you willing to do?

What are the opportunities for health service to improve its service delivery to families?

What can the health services do to encourage survivors of IPV to seek help?

What can staff do to encourage women to tell them when they have problems?

Are there any particular services that would help women?

What are the policies, procedures or protocols that are in place in dealing with IPV?

Probes:

What do these policies mention regarding the role of health services?

How is the health care sector positioned in these policies?

What support can you offer to promote care and support for IPV?

Should the health care service be involved? How, why and to what extent

Annex 3: Question guide for focus group discussions/in-depth interviews for health care providers (English)

I.D Number.....…................. Date of FGD/IDI ....Place of FGD/IDI...........................

District...................................T/A...............................Name of Facility.............................

Male / Female participant...... .Name of the interviewer/ moderator..

Name of the recorder / note taker....................................Number of participants. ....

Introduction

The moderator/interviewer will introduce her/him self and explain the purpose of the discussion. She will explain that the discussion will focus on health care services available for IPV clients, their perceptions of IPV and their experiences of providing care to survivors male or female.

Knowledge and Attitudes

What do you understand by the word violence?

What about intimate partner violence?

In what kind of relationship does this type of violence occur?

Does it include violence occurring in a non- marital relationship?

How do you differentiate it from non-partner violence?

What is rape?

In what kind of relationship does rape occur? Can rape occur in intimate relationships? How, why or why not

What does the law say about IPV and rape in Marriage? What do you think about that? Why do you think IPV happens?

How do people resolve conflicts in marriage?

How could you differentiate between violence and misunderstandings in the family?

Perceptions of the Magnitude IPV in Health Care Services

Why should health care providers be involved in violence prevention? What is the relationship between IPV and health?

How big is the problem of IPV in health care services?

Probe: How often do you see such patients in your departments?

Does it match the magnitude of the problem in the community?

In what state do IPV survivors report to the hospital?

Where do they come from? How do you recognise IPV?

Do you have any process or protocol to help you identify or screen for IPV

Can you describe the process in which IPV is disclosed? What do you do first?

What other policies are available to deal with IPV?

What are the standard guidelines or procedures for victims of IPV, how do I get a copy?

The Role of Health Services in Violence Prevention

What in your perception is the role of health care services in IPV prevention? Care? Support?

What are some of the ways in which health care providers could work in violence prevention?

What do you think are the areas in which health care services does well in addressing the needs of IPV survivors?

Where are they not doing well?

What makes them not function well?

What are the challenges the health care system is meeting in addressing the needs of IPV survivors?

Would survivors of IPV freely disclose to health care providers of their experience of IPV? Why/ why not?

What would promote the disclosure?

What would hinder victims to disclosure?

From your perspectives which are the services that are needed most by the community?

Please explain any concerns or ideas you have about the health care services

What are the opportunities for provision /improvement of care?

Tell Me More about Your Experiences of Treating Victims of Domestic Violence (If Cases Cited Follow It Up)

What services do you offer to such patients?

Was there anything that could have been done to (or done for?) the clients?

What makes providing care to such patients easy?

What makes it difficult?

If a patient comes and complains that has been raped by her/his partner /boy friend what would you do?

Collaboration

What services /resources and programmes are available for abused people in the community?

Have you referred clients to such agencies?

What are your experiences with those agencies? Are they helpful?

What services you feel are necessary but are not available

Do you have any suggestions? Let's talk more about the referral system within and outside the hospital? Let us draw a simple flow chart indicating the flow of such clients

Opportunities and Barriers

What can be done to improve health services to domestic violence victims?

Annex 4: Critical incident interviews survivors of violence
I.D Number.....…................. Date of IDI ....Place of FGD/IDI...........................

District..................................Urban/Rural ..T/A................................Name of Facility.............................

Male / Female participant...... .Name of the interviewer/ ....

Number of interview. ....

Introduction

The interviewer will introduce her/him self and explain the purpose of the discussion. She will explain that the discussion will focus on health care services available for IPV clients, their perceptions of IPV and their experience of seeking care and their perception of the role of health services in violence prevention. The participant will be informed that the focus will be on the last time she/he sought care.

Knowledge and attitudes

How would you define a harmonious relationship? What makes a relationship unharmonius? What can go wrong in a relationship?

What do you understand by the word violence? What about intimate partner violence? What are the different types of violence? What do you call them?

What kinds of violence can occur in different types of relationships?

How related is violence between people who are married and people in sexual relationships? What makes them similar or different?

What about violence against women? What about violence against men? How similar or different they are? How do you differentiate them?

How do you differentiate it from non-partner violence?

What is rape? In what knd of relationships does rape occur?

Can rape occur in intimate relationships? How, why or why not

What does the law say about IPV and rape in Marriage? What do you think about that?

Why do you think IPV happens? What kinds of things promote it? What kinds of things prevent it? How do you differentiate violence from conflict in a relationship? How are conflicts resolved in relationships?

Does IPV have any effect on the person experiencing it? What kinds of effects (checklist: health, including mental health and emotional well-being, divorce, ostracism or by family if action is taken, effects on livelihood/ability to work, effects on relationships including children, others)

Last incident

Let's talk about the last time you accessed care/services for intimate partner violence

What was the problem?

What did you do? Where did you go?

When did this happen?

What was the matter last time it happened? What do you think was the cause?

Who did you first talk to about it? Why?

Were there others? Who? Why?

What did you do first? Who did you go to? Why? What happened?

What did you do next? How long was it before you did this? What prompted you to seek help? Was this the first time to seek help? Where else did you seek help? How easy was it for you to get help you needed? For how long did you wait before seeking help?

What kind of help was sought first? Who did you contact? Why them?

What helped you to seek help? Did you face any barriers? Were these expected? Why? How did you overcome them?

Please you tell me more about your experience of seeking help? What is your general impression about the services being provided? How were you treated? Did you disclose voluntarily or were they encouraged to do so? What kind of treatment were they given? Did they get a referral? Where?

Do you think these services are well able to help women who have experienced domestic violence? Why and why not?

What other services in the community help survivors of domestic violence?

Was there something you thought about doing but you could not? What was that for IPV and health related condition

Magnitude/Help Seeking Behaviours

How often have you experienced violence in your relationships? Since when? What action did you take? What was the cause? Did you seek help? What kind of help? How easy or difficult is it to disclosure abuse within a relationship? Why? Would you tell me more of your experiences of disclosing violence? To whom did you disclose? What was their reaction? What this what you expected? How?

Where did you go to seek help for intimate partner violence?

When did you decide to seek help? What prompted you to seek help?

IPV and Health/Services

How do you describe your health status since you started experiencing IPV? How has this impacted on your life? What about your reproductive health

What made you to seek help? Health problem or violence

Why did you decide seek health services to help with domestic violence at that time?

How the service providers did came to learn about your experience of IPV? How easy was it to disclose intimate violence to health workers?

Is there anything within the health services which made it easy to talk about your experience?

Was is difficult or embarrassing to disclose abuse? If so, how /why?

How did the service provider respond to your disclosure? What did s/he say and do? How did you feel about that?

What treatment did you get? How did you feel about that?

Did you get a referral? If so, where to? How did you feel about that?

Did you take up the referral? When? Why/why not?

What happened when you took up the referral?

Was there anything about your contact with these health services which made it easy or less hard to talk about your experience?

Was there anything about your contact with these health services which made it difficult or embarrassing to talk about your experience?

Did you have any concerns about the way the health service looked after you or women you know with the same problems?

What about the waiting time to get help? Did this help or hinder you from seeking help? In what way?

Are there other reasons that would prohibit people from using health care services?

Is it necessary for health care services to be engaged in issues of intimate partner violence? How? In what way

Do you know anyone else in a similar problem as yourself?

What help did they seek? What their experiences were like?

What sort of help should health services provide to survivors of IPV?

Opportunities for Health Service

What else do you think could help people with IPV issues?

What are the opportunities for the Health Service to improve its service delivery to survivors of violence?

What can the Health Service do to encourage people to seek help? What can health care providers do to encourage women to tell them when they have problems?

Are there any particular services that would help people experiencing violence?

Satisfaction with Existing Services

Can you tell me, your feelings or perceptions of the way the Health care Service looked after you or women you know with the similar problems?

Was there anything about your contact with the Health Service which made it easy or less hard to talk about your experience?

Annex 5: Fgds for community members

I.D Number.....…................. Date of FGD ....Place of FGD............................

District....................................T/A................................Name of Facility.............................

Male / Female FGD Name of the interviewer/ moderator...

Name of the recorder / note taker.....................................Number of participants.

Introduction

The interviewer will introduce her/him self and explain the purpose of the discussion. She will explain that the discussion will focus on health care services available for IPV clients, their perceptions of IPV and their perceptions of the role of health services in violence prevention and community referral systems and linkages with other service providers.

Knowledge and Attitudes

How would you define a harmonious relationship? What makes a relationship unharmonius? What can go wrong in a relationship?

What do you understand by the word violence? What about intimate partner violence

What are the different types of violence? What do you call them?

What about violence against women? What about violence against men how do see them?

What kinds of violence can occur in different types of relationships?

How related is violence between people who are married and people in sexual relationships

What makes them similar or different?

How do you differentiate it from non-partner violence?

What is rape? In what kind of relationships does rape occur?

Can rape occur in intimate relationships? How, why or why not

What does the law say about IPV and rape in Marriage? What do you think about that?

Why do you think IPV happens? What kinds of things promote it? What kinds of things prevent it?

Does IPV have any effect on the person experiencing it? What kinds of effects (checklist: health, including mental health and emotional well-being, divorce, ostracism or by family if action is taken, effects on livelihood/ability to work, effects on relationships including children, others)

Magnitude/Help Seeking Behaviour

How common is IPV in this area and the neighbouring communities? Who is commonly affected with it? Men? Women? Why do you think this is the case? What triggers violence? What actions should the individuals take in case of IPV? How easy or difficult is it for the person experiencing violence to tell someone else about it? Why? Who could they most easily tell? Where do people go to seek help for intimate partner violence?

When do people decide to seek help?

What would prompt a survivor to seek help? How easy is it to get help? What are the things that enable people to seek help? What might stop them from seeking help?

What kind of help does the survivor get?

Please you tell me what services are available in your community for men and women who experience IPV?

What is your opinion of the services they provide to people who have experienced IPV?

Do you think these services are able to help people who have experienced IPV ?

What other services in the community help people who are experiencing IPV ?

Are there any services you know of which help children who may live in a home where there is intimate partner violence?

IPV and health/services

For what reasons do survivors go to health services for help with domestic violence?

How easy is it to disclose intimate violence to health workers? What can health care services do to promote disclosure of IPV? What might make it difficult to disclose abuse?

What do you think about the way the health services approach survivors of intimate partner violence? What is the relationship between intimate partner violence and health?

Opportunities for Health Service

Is there a need for survivors of IPV to seek health care services?

What could be done to encourage survivors tell health care providers when they have problems?

What are the opportunities for the Health Service to improve its service delivery to survivors of IPV? Are there any particular services that would help survivors?

What sort of help should health services provide to survivors of IPV? What else do you think could help survivors?

Annex 6: Community members English Dummy Topic Guide

I.D Number......…................... Date of FGD ....Place of FGD...........................

District...................................T/A................................Name of Facility.............................

Male / Female FGD.......Name of the moderator..

Name of the recorder / note taker....................................Number of participants. ....

Introduction

The moderator will introduce her/him self and explain the purpose of the discussion. She will explain that the dummy guide is a safety measure. The researcher will switch to this guide so where interrupted suddenly or where somebody insists to see the content of discussion. The questions in the dummy guide are not related to violence but will focus on health care needs and services available for pregnant mothers and young people, particularly pertaining to family planning pregnancy and childbirth.

Pregnancy and childbirth

ANC
- Do women in this community attend antenatal clinic?
- Approximately when do most women begin their ANC clinic?
- What services do they receive during the ANC visit?
- In your opinion are these services usually available?
- Why are these ANC services important?

Birth preparedness
- What preparations do women make in readiness for delivery? *(probe for deliberate savings, plans for transport, payment in instalments to the facility, organisation through women groups,)*
- How do you perceive the role of a partner / spouse in the process of pregnancy, childbirth and birth preparedness? *(probe for the men's roles and responsibilities, what the community expects men to do)*

Linkages between the community and health facility

- How can you describe the relationship between the facilities and the community?

- Do you have an established community health committee? What is the function of these committees? (probe for advantages and disadvantages)

- Do we have community health workers in this area and what is their role?

- What measures should be put in place to improve the relationship between the community and the facility

Community referral system

- When a woman gets a complication during pregnancy and childbirth, how is such a woman assisted while in the community? *(who does the referral,)*

- What problems / challenges do these women experience? (*probe for transport availability and payment)*

- What initiatives exist in this community that facilitate referral to the nearest health facility?

- What else can be done and by whom to improve referral at both the community and the health facility leveI