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Impact of intimate partner violence on the health of women. A case of Hatcliffe Suburb in Harare, Zimbabwe

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Abstract: *The study explored on Intimate Partner Violence (IPV) perpetrated by male spouses, which was noted to be rampant in the global world, including Zimbabwe. The research objectives focused on: identifying factors leading to intimate male partner's violence and proffering strategies that address the factors contributing towards the IPV by male spousal partners in the Hatcliffe suburb of Harare. The beneficiaries of the research include the academia, both female and male spouses, family members and communities, government institutions and the corporate world. The study, which was guided by one of the nursing models, the Ecological Model of Health Promotion, was delimited to the Hatcliffe settlement of Harare. A combination of the positivist philosophy and the interpretivist philosophy was used. The mixed research approach was used. The sample constituted 50 females from sampled households, 5 Ministry of Health officials, and 5 Police officers. Both probability and non-probability sampling methods were used in determining the sample. Data was collected through interview-administered questionnaires. The impact of the IPV was noted to cover various aspects which include scars due to physical abuse, breach of women's rights, psychological effects, and emotional impact. The study findings also noted that various strategies may be used to mitigate the violence, and the strategies included education, awareness and increasing women participants in remedial action. However, the use of hotlines and the use of safe houses were not viewed as effective means due to fear of shame and stigma from society. Mixed views were noted regarding the use of pre-marital counselling as a strategy to mitigate intimate IPV. Some believed pre-marital counselling prepares the woman for what to expect in marriage. However, critics say it does not help, and it may even prepare the ground for abuse by making the woman to be submissive. The other finding was that most of the women expressed that they were not aware of the support services for IPV. School-based programs, community workshops, and public awareness campaigns were also noted to be crucial in mitigating IPV. It was also noted that empowering survivors of IPV with access to resources, support services, legal aid, and shelter options can help them break free from abusive relationships and rebuild their lives. Intervening with perpetrators of IPV through counselling, therapy, and behavior change programs was also noted to be effective in addressing the root causes of violence and prevent reoffending. The study recommended the need for policy makers to design policies and strategies meant to ensure on the safety of woman in intimate relationship, education and awareness programs should be enhanced. The study also recommended that future research need to be of qualitative nature and that they should also include male spouses in their sampling.*

Keywords: *Health of Women, Impact of IPV, Zimbabwe*

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I. Introduction

Relationships are a blessing and fuel our life for survival. Tate, et al, (2019) view love in spousal relationships as one which can reduce stressful situations and anxieties thereby leading to healthy living. However, not all spousal relationships are healthy, some can be toxic with some spouses abusing their partners. Chantler & McCarry (2020) concur with this argument that toxic manipulative spousal relationships have been on the increase, with domestic abuse rising. The World Health Organization (2020) acknowledges the prevalence of unhealthy spousal relationships saying that 1 in 3 women have been physically or sexually abused worldwide. Given this prevalence of domestic violence, globally, concerns on the factors increasing the intimate partner violence (IPV), therefore ignited the researcher to explore more on this phenomenon.

Intimate partner violence (IPV) which is defined as the behavior within an intimate relationship that causes physical, sexual, or psychological harm is a serious public health issue that is often overlooked and underreported. In Zimbabwe, the prevalence of Intimate Partner Violence (IPV) increased from 40.9% in 2010, to 43.1% in 2015. (Mukamana, et al, 2020). In a study in Harare, Shamu, et al, (2016) I noted a high frequency of intimate partner violence during pregnancy and the postnatal phase leading to suicidal tendencies. According to Magezi & Manzanga, (2020) the prevalence of Intimate Partner Violence (IPV) was even exacerbated by the

outbreak of COVID-19 global pandemic. Nationally, Manzanga (2020) opine that the COVID-19 pandemic national lockdown provided a convenient environment for the acceleration of IPV. To sum up on IPV being a public health issue, the Zimbabwe National Statistics Agency & UNICEF, (2019) noted that 40% of women aged 15-49 years experienced physical and / or sexual violence by an intimate partner, including 19% who suffered such violence during the previous 12 months.

SADC countries also face the same trends of IPV affecting females by their male partners. This is evidenced by a study on violence against women in Africa which noted that out of the 13 SADC member states sampled, all the member states reported intimate partner violence being rife in their areas (SADC, 2023). In South Africa, from October 2021 to December 2021, 232 women were murdered through domestic violence. (Statistics South Africa, 2021). In addition to this, Statistics South Africa (2021) reported that one in five women (21%) had experienced physical violence by their male partners. Research further noted that 51% of the South African women are physically beaten by their husbands every 8 minutes. The Southern African Development Community (SADC) Ministers acknowledged the prevalence of IPV through the formulation of the SADC Strategy and Framework for addressing Gender Based Violence (2018-2030). Part 6 of the Southern African Development Community (SADC) Protocol on Gender and Development advocates that member states eliminate Gender–based violence through formulation and adoption of legislation that addresses domestic violence and developing National Plans to end the violence (SADC, 2022).

Intimate partner violence (IPV) is also being experienced in the African continent as evidenced by a third of the women being victims of physical and / or sexual abuse rendered their male spouses. (WHO, 2021) McCloskey, (2016) concurs with this saying that Intimate partner violence (IPV) in sub-Saharan Africa affects 36% of the population. In Morocco, Intimate Partner Violence (IPV) is being noted with more than 50% of women having experienced violence, whilst 45% of women and girls from 15 years up to 49 years had been abused physically and 14% had been abused sexually. (UN Women Global Database on Violence against Women in France, 2020)

In a study among women in Kano in Nigeria, Tanimu, et al, (2016) found out that the prevalence of Intimate Partner Violence (IPV) in the previous 12 months was found to be 36.7% Nigeria, the prevalence of Intimate Partner Violence (IPV) in the previous 12 months was found to be 36.7%. However, Cullen, (2020) argues that even though Intimate Partner Violence (IPV) was rampant in Nigeria and Rwanda, there was underreporting of the issue.

In the Americas, the trend of intimate partner violence as evidenced by 20% of North American women experiencing intimate partner violence (World Bank, 2016), whilst in Latin America, 10 percent to 50 percent of the women were being abused by their male partners. The UN acknowledges the prevalence of IPV in Latin America stating that 27% of the females who were aged between 18 and 69 were exposed to intimate-partner violence at least once in their lifetime from the age of 16 (UN Women Global Database on Violence against Women in Argentina, 2020).

In the Middle East, IPV is also rife with 37% of women in the Arabic countries being abused. Chelala as cited in The Globalist, (2019) concurs with this claiming that an estimated 200,000 women were abused in the region from the year 2014 to 2015.

In the Asia-Pacific region, the same trend of intimate partner violence exists. In Asia alone, in 26.9 percent of the women in Bangladesh were abused in 2018. In India, 21.8% women were abused, with 22% being abused in Thailand, and 46 percent of the women being abused in Afghanistan. (UNFPA Asia-Pacific Region, 2019) In the Pacific region, the rate of intimate partner violence has been high in Fiji with 23.7%, Papua New Guinea (32.9%), Solomon Islands (41.8%) and Samoa with 22.4%. (UNFPA Asia-Pacific Region, 2019).

In Europe, France has one of the highest prevalence IPV rate as evidenced by 142 310 females were murdered and recorded victims of domestic violence in 2019. (UN Women Global Database on Violence against Women in France, 2020). In 2019, in Italy 111 women were murdered by their male spouses or by other members of the family. (Global Database on Violence against Women in Italy, 2020)

The prevalence of domestic violence as noted above is rife in all continents. as evidenced by 20% in the Western Pacific, 22% in developed countries such as Europe, 25% in the Americas, 33% in the African region, 31% in the Mediterranean region, and 33% in the southeast Asia region (WHO, 2024). These appalling global statistics reflect that domestic violence is indeed a global problem. Although the domestic violence affects both women and men, women are disproportionately affected by this form of abuse.

Zimbabwe is not an exception as the prevalence of domestic violence is also rife in the country. While exact statistics can sometimes be challenging to obtain due to underreporting and data collection limitations, available studies and reports provide valuable insights into the extent of the issue. The Zimbabwe National Statistics Agency (ZIMSTAT, 2015), the Zimbabwe Demographic and Health Survey (ZDHS, 2015) conducted in 2015 revealed that about 1 in 3 women in Zimbabwe have experienced physical violence since the age of 15. This has been echoed in by literature. Rumble et al, (2015), Peta, (2017) and Iman'ishimwe et al, (2020) posit

that about 1 in 4 women have experienced sexual violence at some point in their lives. These numbers highlight the alarming frequency of intimate partner violence in the country.

The high prevalence of Intimate Partner Violence (IPV) indicates problems of lack of awareness and education surrounding the IPV, lack of adequate support services for survivors and legal barriers. Cultural norms and societal attitudes towards the intimate partner violence (IPV) also contribute to the problem. Economic factors can also play a role in perpetuating the intimate partner violence (IPV) within Zimbabwe.

The high prevalence of IPV saw the government enacting the Domestic Violence Act [Chapter 5:16] (Act 14/2006) and the inclusion of the need to protect women from domestic violence in Article 25(b) of the Zimbabwe Constitution. The government further established a National Gender Based Violence Strategy for the period of 2012-2015. Despite these government efforts, IPV continues to rise in Zimbabwe, with a 34% increase in 2015. (Zimbabwe, Domestic Violence, Including Legislation; State Protection and Support Services, June 3, 2015) More than a third of Zimbabwean women aged 15 to 49 have been beaten by partners, and of these 20% were married women, (Zimbabwe Demographic and Health Survey). In their study on gender-based violence in Hatcliffe, Harare, Mukaranga, et al, (2021) noted that 95% of the women surveyed reported experiencing physical violence and 92% had been subjected to spousal rape.

The purpose of the study was to find out the impact of IPV on the health of women in the Hatcliffe suburb of Harare.

II. Methodology

The descriptive research design was used for quantitative data whilst narratives were used for qualitative data as the researcher utilized a mixed method approach

Study Setting

The study was geographically limited to the Hatcliffe suburb in Harare. The suburb is bordered by Domboshava Road to the east and Glen Forest to the north, On the western side is Alpes Road and the southern side is Scam way road. Hatcliffe suburb was selected by virtue of its vulnerability to poverty and the aftermath of Operation Murambatsvina was an area of interest in this study

Sampling and data collection

The target population was females aged 18 years and above who were currently married or in marital relationships, as well as those who had been previously married who were all residents of Hatcliffe suburb. The accessible population was the women who met the inclusion criteria who were available during the period of the study. From the population a sample defined by Creswell (2014) as a subset of the population to which the researcher intends to generalize results. Thus, from the population of 11 568 women, a sample of 52 women was derived using Cochran's formula and basing on the following statistical data:

Population size: 11 568
Confidence level: 85%
Margin of error: 10%
Population Proportion: 50%

The calculated sample was 52, making it 50, when rounded up to the nearest 10. For the sample from The Ministry of Health Officers and 15 police officers, the researcher used the formula of taking a third of the population. Assemagan, (2020) recommend that to determine sample size, 30% of the population can be used as a rule of thumb. Participants were interviewed in a language they could understand, the majority were however, Shona and English speakers. The researcher employed both probability and non-probability sampling methods.

Questionnaires were used to collect data from female respondents from the households selected randomly. The questionnaires were comprised of both fixed and open-ended questions for the questionnaires. The advantages of using questionnaires were that they cover a wider geographical area such as the Hatcliffe suburb. Interview guides, defined as a methodical way of data collection through a question-and-answer session, were also be used to collect data from the respondents such as the health officers from Hatcliffe clinic and the police officers from the Hatcliffe Police Station in the area. The researcher also used observation guides to observe the behavior of the victims of IPV. Permission to carry out the study was sought from The Medical Research Council of Zimbabwe. The researcher obtained informed consent from all participants before conducting interviews. The recruitment of participants who came from diverse backgrounds within the Hatcliffe suburb ensured a comprehensive representation of experience. Data was then collected through the interview administered questionnaires and there was later an analysis of the interview transcripts and focus group narratives to identify recurring themes, attitudes, and perspectives related to IPV in the community. Quantitative data were analyzed using descriptive statistics to identify patterns and relationships among variables. The quantitative data analysis was complemented by qualitative data analysis which included conducting a thematic. Participants' verbatim was highlighted in italics.

III. Results

Table I: Distribution of respondents' sample by gender N= 60

Respondents						
	Males	%	Females	%	Total	%
Female Partners from households	-	-	50	100%	50	100%
Ministry of Health officers	1	20%	4	80%	5	100%
Police Officers	3	60%	2	40%	5	100%
Total	4	7%	56	93%	60	100%

Table I reflects that a total of 56 females (93%) were used in the sample. These consisted of all the 50 females from the sampled households, 20 female partners (100%) were used from the sampled households. Four female health officers and two female police officers were used together with 1 male health officer and 3 male police officers

Table II: Grouped frequency distribution of ages of female partners from households N=50

Age group	No. of Female Partners from households (x)	Midpoint (m)	% Relative frequency	% Cumulative Relative frequency	Frequency X midpoint fm
21-25	2	23	4	4	46
26-30	4	28	8	12	112
31-35	6	33	12	24	198
36-40	10	38	20	44	380
41-45	15	43	30	74	645
46-50	9	48	18	92	432
51-55	4	53	8	100	212
	50		100		fm = 2 025

Arithmetic mean for the grouped data above: $= \frac{\Sigma fm}{n} = \frac{2\,025}{50} = 40.5 = 40$ years

The calculations above show that the average age group of the female partners used in the research sample was 41 years. The youngest females used in the sample were 23 years old and the oldest being 53 years old.

Level of Education	No	%
None	10	20%
Primary	12	24%
Secondary	15	30%
High School	8	16%
Tertiary	5	10%

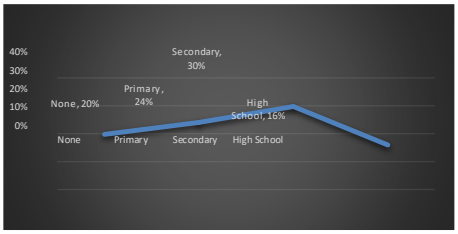

Figure I: Distribution of female partner participants by level of education

The Fig. I above shows that the female partner participants' level of education was of different levels. The level of education was negatively skewed with the majority having completed primary and secondary. The least educated were 20% (10 out of 50) followed by 24 percent (12 out of 50) and then 30% (15 out of 50). Only 16% (8 out of 50) attended High School, with a mere 10% (5 out of 50).

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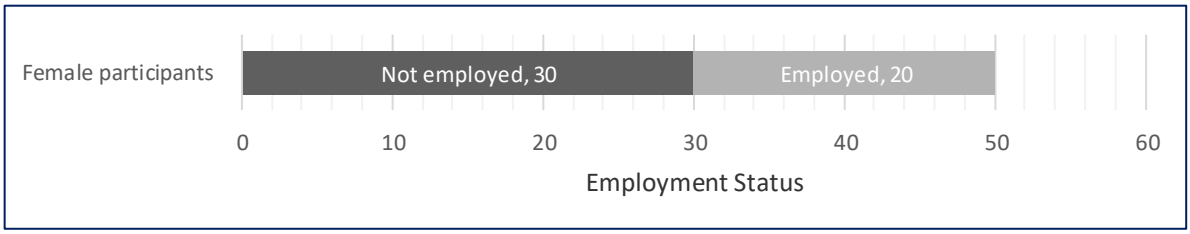

Figure II: Distribution of female partner participants by employment status

The majority, 60% (30 out of 50) of the sampled female participants were not employed, with the remaining 40% (20 out of 50) being employed. Employment status might in a way impact Intimate Partner Violence.

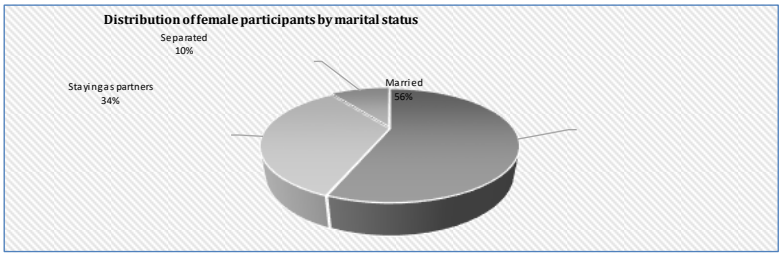

Figure III: Distribution of female partner participants by marital status

Most of the female participants, 56% (28 out of 50) were married, whilst 34% (17 out of 50) were staying as partners. Then, a mere 10% (5 out of 50) had separated. Those who had separated were still able to respond to the data requested citing their experiences during marriage.

Most of the female participants, 70% (35 out of 50) expressed that they were being abused by their male partners. Only 20% (10 out of 50) of the sampled female participants stated that they were not and had never been abused by their intimate partners. Interestingly, the remaining 10% (5 out of 50) were unwilling to disclose whether they were abused or not. However, they were able to respond to some of the questions asked. They said that the direct question on whether they were abused was too personal and thus, they were not comfortable answering it.

Table III: Distribution of female participants' views on the types of abuse experienced N=35

Level of Education	No	%
Physical abuse	16	46%
Sexual abuse	10	29%
Emotional / Psychological	5	14%
Economic abuse	4	11%

Table III shows that the most common type of abuse experienced by women was physical abuse which was highlighted by 46% (16 out of 35) of the women participants. This was followed by both sexual abuse which had 29% and emotional abuse which had 14% (5 out of the 35) participants. Economic abuse was noted to be the least with 11% (4 out of 35).

When asked to describe the experience with their partner that made the women to feel unsafe or harmed, Woman 1 (aged 32) lamented: "*I've lived in Hatcliffe for ten years, and my husband started hitting me after he lost his job. He drinks a lot now. I think the stress and lack of money make him angry. I've had bruises, headaches, and I even miscarried once. I went to the clinic, but I was too ashamed to say what happened. They treated me for the physical injuries, but no one asked about the cause*".

In response to the health issues commonly observed in women who report IPV, Health Personnel 1 (Nurse, 30): "*I see women with injuries—fractures, burns, miscarriages. But many don't say it's IPV*". In response to the question on what gaps or challenges the healthcare system faces when responding to IPV cases, Health Personnel 1 stated that they needed screening tools and counseling services.

34 out of 50 (68%) of the female partners felt that the spouse' age (male or female) can promote chances of abuse on female partners. The remaining 6 out of 50 (12%) and 10 out of 50 (50%) were not sure and disagreed that age contributed to the abuse. All Ministry of Health officials and the two officers asked shared the same view that the age of the spouse contributes to IPV.

30 out of 50 (60%) of the women's intimate partners expressed that the educational status of either of the spouses contributes towards intimate partner violence, whilst 5 out of 50 (10%) were not sure of this. The remaining 15 out of 50 (30%) of the female partners felt that the educational status of the intimate partners did not contribute towards IPV. The views of the women were shared by 60% of the Ministry of Health officials, whilst the remaining 40% (2 out of 5) disagreed. Mixed views were noticed from the police officers. 40% (2 out

of 5) of the police officer felt that the educational status of the spouse promoted IPV, whilst 60% (3 out of 5) disagreed. Education often enhances communication and conflict resolution skills. High educational attainment encourages the development of effective interpersonal skills, helping partners manage disagreement and conflict constructively.

Table IV: Responses by female partners on factors leading to abuse by male intimate partners

Factors	Promote abuse	Not sure	Does not promote abuse	Total
Spouse's age				
Female intimate partners	34	6	10	50
Ministry of Health Officials	5	-	-	5
Police officers	5	-	-	5
Educational Status				
Female intimate partners	30	5	15	50
Ministry of Health Officials	3	-	2	5
Police officers	2	-	3	5
Personality and Emotional status				
Female intimate partners	20	-	-	20
Ministry of Health Officials	1	-	-	5
Police officers	5	-	-	5
Employment & income status				
Female intimate partners	38	12	-	50
Ministry of Health Officials	5	-	-	5
Police officers	5	-	-	5
Socio-cultural factors				
Female intimate partners	40	6	4	50
Ministry of Health Officials	4	-	1	5
Police officers	5	-	-	5
Religion				
Female intimate partners	40	3	7	50
Ministry of Health Officials	5	-	-	5
Police officers	5	-	-	5
Beliefs				
Female intimate partners	32	8	10	50
Ministry of Health officials	3	1	1	5
Police officers	4	-	1	5

All the 50 female spouses who participated in the study felt that the personality of the spouse greatly contributes towards the promotion of intimate partner abuse. Woman 5 (aged 35) said "*I've stopped talking to friends. He checks my phone and accuses me of cheating. Violence is mostly emotional now, but it's worse than physical. I feel worthless. I wish there were support groups here"*

This view was shared by all five health officers. In response to the question on what health issues they commonly observed in women who report IPV, Health Personnel 3 (Counselor, 42): "*Emotional abuse is rampant. Women come in with depression, PTSD, suicidal thoughts. We offer counseling, but stigma and lack of privacy hinder progress. Community education is key".*

38 out of 50 (76%) expressed that the employment status and income status of the spouse promotes the decision to be violent or not. Unemployed spouses were seen to be more likely to be violent as compared to those who were employed or those getting a reasonable income. Woman 4 (aged 29) cried saying "*I was beaten for asking about money. He said I was disrespectful. I've had chronic back pain and anxiety. I went to the police, and they were kind, but they said they couldn't arrest him without evidence. I felt helpless"*

This view was shared by all five health officials. However, 60% (3 out of the 5) police officials shared this view, whilst the remaining 40% (2 out of 5) police officer were uncertain of the response. When asked on how often they receive reports of IPV in Hatcliffe, Police Officer 1 (Male, 45) who opined saying, "*We get many cases, but most women withdraw their complaints. They fear retaliation or have no financial independence. Our hands are tied unless there's clear evidence. We need more training and resources to handle these cases sensitively*"

40 out of 50 (80%) of the women intimate partners expressed that the socio-cultural factors contributed towards intimate partner violence, whilst 12% (6 out of 50) were not sure of this. The remaining 8% (4 out of 50) of the female partners felt that the socio-cultural factors of the intimate partners did not contribute towards intimate partner violence.

In respond to the question on what they thought caused their partner to act violently, Woman 3 (aged 40) who said "*I think it's the culture. Men are raised to believe they own women. My husband says I must obey him or face consequences. I've had broken ribs and internal bleeding. The clinic helped, but I had to lie about how I got injured. I fear losing my children if I speak out*"

80% (4 out of 5) of the Ministry of Health officials felt that the socio-cultural factors led to domestic violence, whilst only 20% (1 out of 5) of the health officers disagreed. Even the police officers shared the sane the same feelings, with all the five officers expressing that the socio-cultural factors of the couple contributed towards intimate partner violence.

The majority, 80% (40 out of 50) of the women intimate partners expressed that the religion of the spouses greatly contributed towards the promotion of intimate partner violence. This sentiment was shared by all the 5 Health officials and by the 5 police officers.

70% (35 out of 50) of the women partners felt that beliefs promote violence on women, whilst 20% (10 out of 50) felt that beliefs have no impact on violence. The remaining 10% (5 out of 50) were not certain of their decisions. Mixed responses were also noted as evidenced by 60% (3 out of 5) of the health officers shared the same view that religion impacts on intimate partner violence. However, the remaining 40% (2 out of 5) disagreed. All the five police officers were also convinced that beliefs contributed to IPV.

When asked to identify how the above highlighted factors influence intimate partner violence, the participants' views were as follows:

Table V: Women partners' perceptions on the effects of intimate partner violence

	Views on the effects of Intimate partner violence			
	Scars due to physical abuse	Breach of woman rights	Psychologically affected	Emotional / Stress
Women partners	✓✓✓✓✓✓✓✓✓✓ ✓✓✓✓✓✓✓✓✓✓ ✓✓✓✓✓✓✓✓✓✓ ✓✓✓✓✓	✓✓✓✓✓✓✓✓✓✓ ✓✓✓✓✓✓✓✓✓✓ ✓✓✓✓✓	✓✓✓✓✓✓✓✓✓✓ ✓✓✓✓✓✓✓✓✓✓ ✓✓✓✓✓✓✓✓✓✓	✓✓✓✓✓ ✓✓✓✓✓ ✓✓✓✓✓ ✓✓✓✓✓
Total (20)	**35**	25	30	20
%	**75%**	50%	70%	40%

Table V shows that 35 out of 50 (70%) of the women partners expressed that scars of IPV were common among women. Half of the women partners, 25 out of 50 (50%) said they were concerned that the IPV was eroding the rights of women. Seventy percent of the women state that IPV led to psychological effects, whilst 40 percent felt that the IPV led to emotional and stressful conditions.

Health officials share the same sentiments saying scars were much easier to see due to physical violence by intimate partners, as compared to psychological and / or emotional effects. Even the police officers also shared the same views stating that intimate partner violence (IPV) cases being reported were easier to pursue when there was evidence of physical abuse.

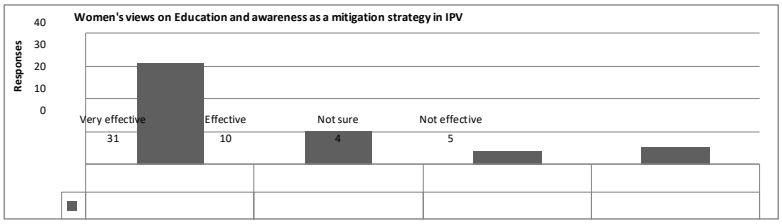

Figure IV: Responses on education and awareness as a mitigation strategy

The majority, 31 out of 50 (62%) of the women partners felt that using education and awareness was a very effective means to mitigate intimate partner violence. 10 out of 50 (20%) felt it was effective, with 4 out of 50 (8%) saying they were not sure. The remaining 5 out of 50 (10%) disagreed with the view that education and awareness were an effective strategy. In addition, the five health officers considered education and awareness as a very effective mitigation strategy. The five police officers felt the strategy was effective.

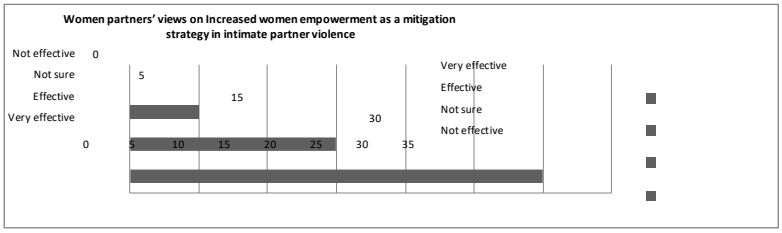

Figure V: Responses on increased women empowerment as a mitigation strategy

Most of the women, 30 out of 50 (70%) felt that increasing women empowerment was a very effective means to mitigate intimate partner violence. Fifteen out of 50 (30%) felt it was effective, with 5 out of 50 (5%) not being sure. The five health officers and all the police officers believed that increasing women empowerment is a very effective mitigation strategy towards intimate partner violence.

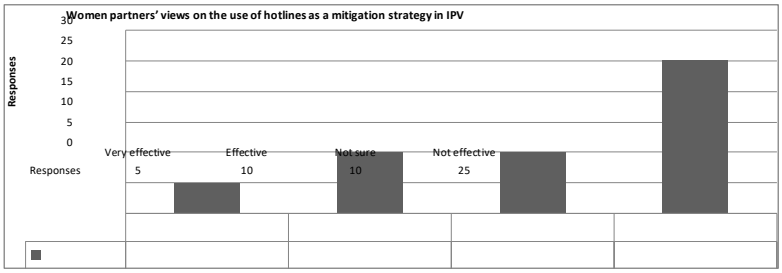

Figure VI: Responses on the use of hotlines as a mitigation strategy

The use of hotlines was seen as not being effective by half of the women partners., that is 25 out of 50 (50%). Only 5 out of 50 (10%) felt that the hotlines were very effective with 10 out of 50 (20%) believing that they were effective. The remaining 10 out of 50 (20%) were not certain. However, the five health officers and five police officers felt that the use of hotlines was simply effective in mitigating intimate partner violence.
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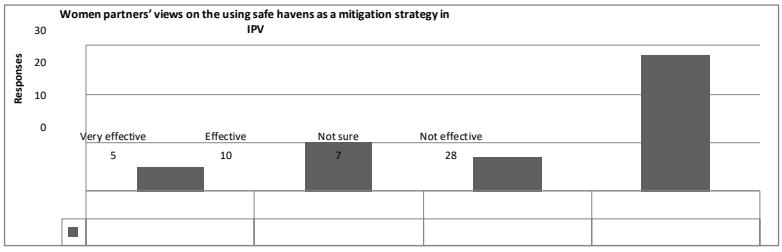

Figure VII: Responses to the use of safe havens (safe homes) in high density suburbs

Most of the women partners, 29 out of 50 (56%) expressed that the use of safe havens or safe homes was an ineffective mitigation strategy. Only 5 out of 50 (10%) felt that the safe havens were very effective with 10 out of 50 (20%) believing that they were effective. The remaining 7 out of 50 (14%) were not certain. Interestingly, all the health officers and the police officers also shared the same views that safe havens were an ineffective mitigation strategy in dealing with intimate partner violence.

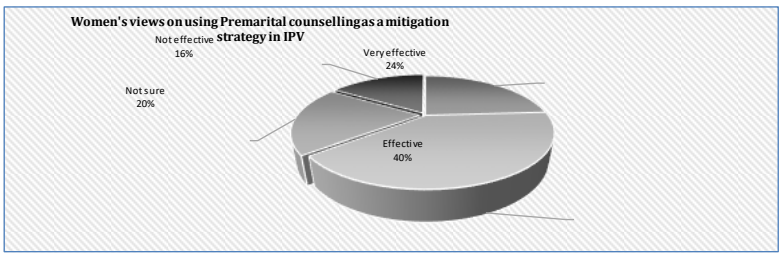

Figure VIII: Responses to the use of pre-marital counselling in mitigating domestic violence

Mixed views were noted with regards to the use of pre-marital counselling as a strategy to mitigate intimate partner violence. Twelve out of 50 of the women partners, (24%) expressed that the use of pre-marital counselling was a very effective strategy, whilst 20 out of 50 (40%) felt that it was an effective strategy. However, 8 out of 50 (16%) felt that pre-marital counselling was not an effective strategy in dealing with intimate partner violence. The remaining 10 out of 50 (20%) were not certain of their decisions.

The health officers also suggested that the strategies for mitigation can be carried out at different levels which might include individual level, family level, community level and at national level. Appropriate strategies may be used that suit the level of assistance in the mitigation of intimate partner violence

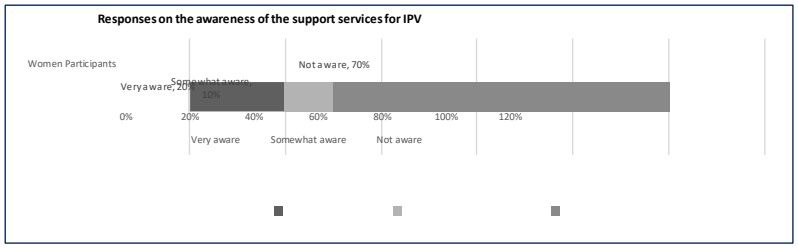

Figure IX: Responses to the awareness of the support services available for individuals experiencing intimate partner violence in Hatcliffe

When asked whether they were aware of the support services available for individuals experiencing intimate partner violence in Hatcliffe, most of the women, 70% (35 out of 50) expressed that they were not aware of the support services for IPV. Only 20% (10 out of 50) pointed out that they were aware of the support services provided for those exposed to IPV. However, the remaining 10% (5 out of 50) expressed that they were somewhat aware of the support services. Woman 5 lamented that even if she wanted to sought help, her spouse never allowed her to do so. He made it clear that if she sought help from others, she would have to be married by them.

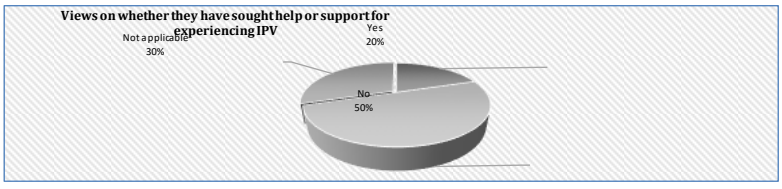

Figure 4.11 Views on whether they have sought help or support for experiencing IPV

Most of the female participants, 50% (25 out of 50) pointed out that they never sought any support for the abuse they were experiencing. Whilst only 20% (10 out of 50) mentioned that they were seeking support on the issue. The remaining 30% (15 out of 50) said this was not applicable to them since they never experienced the IPV.

In response to the question on how they support the women exposed to IPV, the health personnel unanimously agreed that community involvement was needed to fight against intimate partner violence. The officers stated that the community involvement may include community awareness campaigns, training

community members, establishing support groups or collaborations with local organizations. The police officer shared the same sentiments saying that the community involvement may additionally include community dialogue sessions, the creation of crisis response teams and the use of art and media campaigns. Community involvement will, thus, create a supportive environment that values safety, equality, and respect for all residents of Hatcliffe.

Besides the strategies discussed above, the health officers and the police officers expressed the need for other strategies which include early intervention, where signs of IPV can be identified early and providing intervention and support to individuals and families at risk. Empowering survivors of IPV with access to resources, support services, legal aid, and shelter options has also been noted to help them break free from abusive relationships and rebuild their lives.

The health officials also mentioned that intervening with the perpetrators of IPV through counselling, therapy, and behavior change programs can help address the root causes of violence and prevent reoffending. Offering support for anger management, communication skills, and healthy relationship dynamics is also key. The police pointed out the need for those being exposed to get legal protection, enacting and enforcing laws and policies that protect survivors of IPV, prosecute perpetrators, and providing access to justice and support services are critical. This includes restraining orders, emergency shelters, and legal aid for survivors seeking redress. Police Officer 2 (Female, 38) said that "*Some officers still view IPV as a private matter. We need to change that mindset. Victims need safe shelters and legal aid. Right now, we mostly refer them to NGOs, but they're overwhelmed"*

One of the nurses recommended utilizing technology, such as mobile apps, online resources, and helplines, to provide information, support, and emergency assistance to individuals experiencing IPV can be crucial, especially in reaching those in remote or isolated areas. Another nurse pointed out the need for cross-sector collaboration which might include health, education, justice, social services, and civil society. This can strengthen the response to IPV. By working together, different stakeholders can share resources, expertise, and best practices to address this complex issue comprehension.

IV. Discussion

70% (35 out of 50) of the respondents acknowledged that females were abused by their intimate partners. Sharp-Jeffs (2015) agree with this saying that females become victims of intimate partner abuse. However, Walker et al. (2020) also argues that there are women who are also perpetrators, abusing men. This can be a research topic on its own.

The participants noted that the abuse of women came in various forms. However, the most common type of abuse experienced by women was noted to be physical abuse followed both sexual abuse and emotional abuse. The least abuse noted was economic abuse.

34 out of 50 (68%) of the female partners felt that the spouse' age (male or female) can promote chances of abuse on female partners. This view concurs with the literature of Salari & Sillito (2016) which argues that the age of the spouses contributes more to intimate partner violence. Younger couples have been involved in more abuse than the elderly.

The age gap has also been noted to be a contributing factor. The age of spouses is a significant factor influencing the dynamics and prevalence of intimate partner violence (IPV). Research shows that age can interact with various social, psychological, and economic factors, affecting the likelihood of IPV occurrence. Torrisi, (2023) acknowledges this saying that younger individuals, particularly women, are at a heightened risk for intimate partner violence (IPV) compared to older age groups. This vulnerability can be attributed to lack of relationship experience and emotional immaturity. Prasad & Periyan (2019) share the same sentiments saying that young adults may be more prone to engage in unhealthy relationship behaviors due to a lack of maturity and conflict resolution skills. This results in adolescents and young adults often finding themselves in relationships characterized by jealousy and possessiveness, which can lead to violence.

67% (34 out of 50) of the female participants felt that the spouse' age (male or female) can promote chances of abuse on female partners. Thus, significant age disparities between partners can also contribute to intimate partner violence (IPV). Research by Cooper, et al, (2021) suggests that greater age gaps, particularly when younger partners are involved, can lead to power imbalances. An older partner may exert more control or dominance, creating conditions that facilitate abusive behavior. The traditional stereotypes associated with older male partners dominating younger female partners can lead to increased risk for IPV.

Furthermore, as couples age, relationship dynamics often evolve. Research indicates that older partners may have better conflict resolution skills and emotional regulation, which can decrease the likelihood of IPV This implies that the older spouses gain more maturity and conflict resolution strategies which may bused to address partner violence. A study by Madison et al, (2024) found that couples in midlife or older tend to have lower rates of IPV due to increased maturity and stability in their relationships. However, it is important to note that when IPV does occur in older couples, it can manifest in different forms, such as psychological or financial

abuse.

Besides age, the educational level of the spouses or partners have been noted to be influencing the abuse. This has been noted by 30 out of 50 (60%) of the respondents. Banyard et al, (2020) states that the academic level correlates with intimate partner violence. The higher the academic level, the lower the chances of violence being perpetrated. Higher levels of education are generally associated with greater economic opportunities and financial independence, which can empower individuals, especially women, to leave abusive relationships. A study by Song & Kim, (2024) found that women increased educational attainment correlated with a decreased likelihood of experiencing IPV.

60% of the female participants felt that educational attainment often shapes attitudes towards relationships and violence. Research by Erten & Keskin, (2022) suggests that individuals with higher levels of education are typically more aware of their rights and the resources available for victims of violence. They are also less likely to endorse traditional gender roles that can contribute to aggressive behaviors. Education can also often enhance communication and conflict resolution skills. High educational attainment encourages the development of effective interpersonal skills, helping partners manage disagreement and conflict constructively. A study by Heard et al, (2019) indicates that educated couples are more likely to engage in healthy conflict resolution strategies, thus reducing the likelihood of IPV occurrences.

Thus, the research findings which reflected that 60% of the female participants felt that the spouse's educational level impacted on IPV, was in line with literature. The research findings on the contribution of the educational level of spouses in IPV dynamics has also been noted by the research published by the World Health Organization, (2013) which emphasizes that educated women are less likely to accept violence as a norm in relationships and are more likely to seek help when violence occurs. Educated women are also often more informed about legal protections and social services available to them, empowering them to escape abusive environments. Furthermore, a study by Walsh, et al, (2020) indicate that lower education levels in men correlate with higher rates of IPV perpetration. Thus, high educational attainment is generally associated with reduced risk of involvement in IPV as both victims and perpetrators, while lower levels of education correlate with increased vulnerability and aggression.

All the 50 female participants stated that personality and emotional status of spouses greatly contribute to the intimate partner abuse. Individuals with aggressive personality traits are more likely to engage in violent behavior in intimate relationships. Salari & Sillito (2016) state that spouses who are not emotionally stable or male partners who have a personality of being violent are likely to be very abusive in the relationship. However, personality and emotions may be triggered by other various factors.

A study by Stinson et al, (2018) highlights the correlation between narcissistic traits and IPV. Individuals who exhibit high levels of narcissism often have a distorted self-image and may feel entitled, which can manifest as controlling or abusive behavior toward their partners.

According to a study by Blais et al, (2018), emotional instability, often linked with borderline personality traits, is associated with heightened risks of IPV perpetration. Individuals displaying these traits may struggle with emotional regulation, leading to impulsive and violent reactions during conflicts. In addition to this, the emotional states of spouses can significantly influence the occurrence of IPV. Research indicates that depression and anxiety can impair judgment and lead to frustration, which may increase the likelihood of violent behavior. A study by Collison & Lynam, (2021) found that individuals with heightened anxiety and depression were more prone to conflicts that could escalate into violence.

The respondents also highlighted that the employment and income status of the partners are also a contributory factor. This has been noted by 76% of the participants who expressed that the employment status and income status of the spouse promotes the decision to be violent or not. Economic difficulties, such as unemployment or low income, can lead to increased stress within relationships, which may escalate tensions and contribute to violent behavior. A study by Tur-Prats, (2021) highlights that economic stress can create feelings of inadequacy and frustration in partners, leading to aggressive behaviors. Tur-Prats, (2021) also found that when men face job loss or economic hardship, their perceived loss of masculinity can lead to compensatory aggression, resulting in heightened risks of IPV. Conversely, when women are employed and financially independent, this can sometimes disrupt traditional power dynamics, potentially leading to violence from male partners who feel threatened.

Kutin, et al, (2017) postulated that the economic status of the partners may influence the abuse. The unemployed males, married to employed spouses, may see the men filled with anger, hatred and jealousy which might lead to abuse. The women, in some cases may also trigger the abuse by looking down upon their unemployed men. Thus, while the employment of women has been associated with increased financial independence and empowerment, it can also generate conflict.

Income disparities within relationships can also exacerbate power imbalances, potentially leading to IPV. According to a study by Lutz et al, (2017), couples with significant disparities in income levels were more likely to experience violence, particularly when the lower-income partner is a woman. The partners with higher

incomes may exert control over financial resources, increasing the potential for violence when the lower-income partner attempts to assert independence.

Socio-cultural factors, religion and beliefs have been seen to contribute to intimate partner abuse. This has been noted by 80% of the research respondents of this study. The findings imply that cultural norms surrounding masculinity and femininity can profoundly affect the prevalence of IPV. For instance, traditional gender roles dictate that men should be dominant and women submissive, creating an environment where violence is tolerated or even condoned in the name of maintaining control. A study by Mshweshwe, (2020) indicates that cultural beliefs about male authority and female inferiority significantly correlate with levels of violence against women. This means that cultures that acknowledge male dominancy often uphold the notion that men have the right to discipline their partners, contributing to a higher incidence of IPV. Salari & Sillito, (2016) support this saying that intimate partner violence may be triggered by the patriarchal system which view the man as the head of the family who makes decisions he like. Some religions like Apostolic increase abuse through child marriages. Thus, socio-cultural factors significantly contribute to the incidence and perpetuation of intimate partner violence.

In addition to this, the socialization process within families and communities dictate attitudes toward violence and gender relations. According to a study by Stiller, et al, (2022), children who witness IPV are more likely to accept violence as a means of conflict resolution in their adult relationships. This cyclical pattern perpetuates the prevalence of IPV across generations. The impact of the IPV was noted to cover various aspects which include scars due to physical abuse, breach of women rights, psychological effects and emotional or stress impact. Of these, scars were noted to be common followed by psychological effects. Ahinkorah, et al, (2018) concur with this saying that violence against women is a common form of human rights violation.

The respondents noted that various strategies may be used to mitigate the violence. One of them is education and awareness. 62% of the female participants expressed that education and awareness play critical roles in mitigating intimate partner violence (IPV) by empowering individuals, altering perceptions and norms, and providing essential information on rights and resources. Education provides knowledge and skills that empower individuals, particularly women, to make informed choices about their relationships. According to a study by Chennells & Weissman (2016), women with higher education levels reported greater agency in their personal lives and were more likely to recognize signs of unhealthy relationships, which can help them avoid IPV. Educational programs can also effectively challenge and change societal attitudes and norms surrounding gender roles and violence. The WHO (2010) report on violence prevention emphasizes that educational interventions can shift the acceptance of violence in relationships by promoting gender equality. When women are educated about their rights and the services available to them, they are more likely to seek help and support when facing IPV. This awareness builds resilience and encourages victims to act against abusive behaviors.

Education programs that teach conflict resolution, communication, and emotional intelligence skills are effective in reducing IPV. According to a review by Hohman et al, (2016), educational workshops that focus on healthy relationship skills have been shown to reduce aggression and improve relationship dynamics among participants. School-based education about healthy relationships, consent, and IPV awareness can also be crucial in preventing violence before it occurs. The Centers for Disease Control and Prevention (CDC, 2016), states that school programs that promote respect and equality among students can reduce the incidence of IPV.

62% of the female participants rated education and awareness as a good strategy to mitigate intimate partner violence. This view is shared by Miller & McCaw, (2019) saying that role of education and awareness is critical in the prevention of intimate partner violence. However, education and awareness will be more effective when used on participants with a reasonable educational level than those who are illiterate. Thus, education and awareness are critical components in the fight against intimate partner violence. By empowering individuals, changing societal norms, informing victims of their rights, and fostering skills for healthy relationships, IPV can be mitigated.

70% (30 out of 50) of the women participants also pointed out that increasing women empowerment was generally an effective means to mitigate intimate partner violence. This implies that giving the women skills in which they can be working or being self-employed reduces the chances of them being financially and economically abused. A study by Kim et al, (2007) found that women with their own income are less likely to experience IPV because financial independence allows them to leave abusive relationships and reduces their reliance on partners for economic support. Economic empowerment also promotes shared power and reduces the likelihood of control and violence. Empowering women to have decision-making power within the household is also essential for combating IPV. Studies indicate that when women have a say in decisions regarding finances, family planning, and daily activities, the incidence of IPV decreases (Ebrahim & Atteraya, 2019) Thus, women's empowerment plays a pivotal role in mitigating intimate partner violence. Empowered women are better equipped to resist and combat IPV. (Kutin, et al, 2017) However, even those economically rich may still be involved in intimate partner abuse.

Interestingly, 50% (25 out of 50) of the female respondents felt that the use of hotlines was not an

effective means. The argument was that the hotlines were only effective in the short-run, or as an immediate solution to end physical abuse. However, for married women to constantly phone reporting the abuse was seen as belittling the use of elderly people in the families of the spouses. McCleary-Sills et al, (2016) agree to this saying that fear of shame and stigma reduces the chances of the women reporting the abuse through hotlines. Hotlines were also noted to provide physical support that might be critical in certain situations. Some victims may require in-person assistance for safety planning or emotional support. Research suggests that while hotlines can provide critical information, they are not a substitute for comprehensive, in-person services (Dunn, 2019).

The other disadvantage noted was that not all victims have equal access to phones or the ability to make calls without arousing suspicion from their abusers. (Meyer et al., 2021). A study by Nurius et al, (2018) also noted that lack of cultural competency among hotline staff could deter individuals from using these critical services. However, Padian et al, (2018) highlights that timely interventions through hotlines can facilitate safety planning and empower victims to make informed decisions about their situations. Hotlines also offer an anonymous platform that allows victims to voice their concerns without fear of judgment or retaliation, thereby encouraging individuals to reach out who might not otherwise do so.

56% (29 out of 50) of the respondents also expressed that the use of safe havens or safe homes was an ineffective mitigation strategy for intimate partner violence. The respondents questioned the significance of the abused women finding refuge at the safe havens instead of going to relatives of the man or woman.

Although safe havens provide space free from immediate danger. Research suggests that the provision of a secure environment is critical for the mental and physical well-being of IPV victims. (Giordano et al, (2020) most respondents did not applaud them. The limited availability of safe havens has been noted by literature. Research by Campbell et al, (2020) indicates that the lack of adequately funded shelters can severely restrict survivors' options, leading them to remain in violent situations. Some victims may experience social stigma associated with utilizing the safe havens which can deter them from seeking help. A qualitative study by Peterman et al, (2021) highlighted that cultural stigma about domestic violence may pressure some individuals to avoid shelters despite the immediate need for safe refuge.

However, despite not being appreciated, the safe havens often serve as hubs for essential services, including counselling and legal aid for the IPV victims. (Tweed & Ehlers, 2021). The safe havens also provided a safe place for empowering residents by providing them with resources and tools to regain independence. A study by Leth & Lentz (2020) found that shelters that emphasized empowerment strategies significantly improved the IPV victim's self-efficacy and confidence in making future decisions.

To enhance the effectiveness of safe havens, it is therefore crucial for policymakers and service providers to address these limitations. This can include increasing funding for shelters, promoting awareness campaigns to reduce stigma, and developing robust transition programs that provide continued support after leaving a haven. Additionally, collaboration between shelters, community organizations, and government entities can create a stronger network of resources, ensuring that victims have access to the help they need in the aftermath of IPV.

Continued research is also essential to evaluate the effectiveness of safe havens in various contexts and identify best practices for supporting victims of intimate partner violence effectively.

Mixed views were noted with regards to the use of pre-marital counselling as a strategy to mitigate intimate partner violence. 64% (32 out of 50) believed pre-marital counselling prepares the woman on what to expect in marriage, whilst 15% (8 out of 50) disagreed. The remaining 20% (10 out of 50) were not certain of their decisions. Premarital counselling is designed to help couples prepare for marriage by discussing key issues, enhancing communication, and building skills necessary for a successful partnership. While its primary aim is to strengthen marital relationships, premarital counselling can also be a preventative measure against intimate partner violence (IPV)

Premarital counselling enhances communication skills. It helps couples learn constructive communication techniques, which can lead to better conflict resolution. A study by Markman et al, (2018) highlights that couples who undergo premarital counselling exhibit improved conflict management skills, potentially reducing the likelihood of escalating tensions that could lead to violence. The counselling sessions can also educate couples about the signs of IPV and unhealthy relationship dynamics. Educating partners about power dynamics and emotional abuse can empower them to recognize problematic behaviors early. Premarital counselling can also encourage couples to establish shared values and goals. Achieving alignment in core beliefs can create a stronger bond and reduce potential friction points. Research by Doss et al, (2020) indicates that couples who engage in this goal-setting process are less likely to encounter issues that lead to IPV, as they are more likely to work collaboratively toward shared objectives. It can also provide a space for individuals to identify and address concerns about their partner's behaviors. A study by Cummings et al, (2019) found that open discussions during counselling often lead to the recognition of red flags, allowing partners to reconsider the relationship dynamics before entering marriage.

However, critics say it does not help and it may even prepare ground for abuse by making the woman to be submissive. Many premarital counselling programs prioritize topics such as financial planning, communication, and intimacy, sometimes neglecting the specific dynamics of IPV. As highlighted by Reddy & Siriraj, (2021), if counsellors lack training in recognizing and addressing IPV, essential topics may be overlooked, affecting the programs. The other limitation is that the effectiveness of premarital counselling relies heavily on the active participation and openness of both partners (Toomey et al, 2019). Wadsworth & Markman, (2020), indicate that within certain cultural contexts, discussions around IPV may be met with resistance or denial, which can hinder the effectiveness of premarital counselling.

When asked whether they were aware of the support services available for individuals experiencing intimate partner violence in Hatcliffe, most of the women, 70% (35 out of 50) expressed that they were not aware of the support services for the IPV. Only a few, 10% of the respondents were aware of the support services. This ignorance of available support services to mitigate intimate partner violence (IPV) poses a significant barrier for victims seeking help. This lack of awareness can stem from various factors, including social stigma, cultural background, and inadequate education systems. Many people hesitate to seek support due to the stigma associated with being a victim of IPV. A study by Houghton et al, (2020) found that individuals often feel ashamed of their situation, leading to reluctance in reaching out for help. This stigma can prevent them from accessing local resources, making them less likely to know about support services available to them. The lack of support could have been due to cultural beliefs. Research by Cousins et al, (2021) indicates that in communities where traditional gender roles prevail, victims may be less aware of services due to cultural norms that discourage speaking out. For instance, some cultural backgrounds view domestic issues as private matters that should not involve external intervention.

Limited education about IPV can contribute to ignorance about support services. Miller & Smith, (2019) state that many educational programs fail to address IPV comprehensively, leaving individuals unaware of the signs of abuse, thus perpetuating the cycles of violence.

A study by O'Leary et al, (2020) found that many victims may stay in abusive relationships longer because they are unaware of the options available to escape. This delay can exacerbate mental and physical health issues associated with abuse. In addition to this, the victims who are unaware of support services may feel isolated, believing they are alone in their experiences. This isolation can worsen their mental health and feelings of hopelessness. As identified in a study by Johnson et al, (2022), the lack of awareness can lead to a downward spiral, where victims become more trapped in their situations due to misinformation or lack of knowledge about resources.

Thus, without access to support services, victims may continue to be victimized and may also be less empowered to leave abusive relationships. The work of Greenfield & Smith, (2018) highlights that victims who are unaware of shelters, hotlines, or legal assistance often succumb to prolonged incidents of violence because their options remain unclear or unobtainable.

All the five Ministry of Health officers as well as all the 5 Police officers sampled expressed that community involvement was a necessity in addressing IPV. This can be done through school-based programs, community workshops, and public awareness campaigns in changing societal norms and attitudes. Thus, the role of community involvement in mitigating intimate partner violence (IPV) is a multifaceted one, and research has demonstrated varying degrees of effectiveness. Community-led education programs can significantly diminish the stigma surrounding IPV and increase awareness.

According to the World Health Organization (WHO), community interventions that educate individuals about healthy relationships can empower victims to seek help (WHO, 2013).

Local organizations can also provide crucial resources like shelters, legal aid, and counselling services. Research by Decker et al, (2016) highlights how shifting community attitudes can lead to decreased tolerance for IPV, ultimately reducing its prevalence.

However, not all community programs are effective uniformly. Fisher et al, (2020) states that since community interventions might be culturally sensitive, they must therefore be tailored to specific community dynamics. Some victims may also distrust community programs, especially in communities where there are historical tensions with law enforcement or social services. A study by Gilchrist et al, (2015) found that victims from marginalized backgrounds often fear that reaching out for help will lead to criminalization rather than support, highlighting the importance of building trust.

Community involvement plays a crucial role in combating intimate partner violence, with numerous studies supporting its potential for creating change. Effective strategies focus on awareness, resource availability, norm change, and bystander intervention. However, challenges such as cultural insensitivity, trust issues, resource limitations, and sustainability must be addressed for community involvement to be fully effective. Tailored, well-supported community initiatives have the potential to significantly mitigate IPV, making them an essential component of a broader strategy to combat violence in intimate relationships.

In addition to this, all the five Health Officers and all the 5 Police Officers felt that early intervention

strategy can also be important in mitigating IPV. Identifying signs of IPV early and providing intervention and support to individuals and families at risk can prevent escalation of violence. Health professionals, social workers, and educators can be trained to recognize the warning signs and offer appropriate assistance.

The early intervention strategies can play a critical role in mitigating intimate partner violence (IPV). These strategies aim to identify risk factors, provide education, support, and resources to those at risk, and offer interventions before violence escalates. Parker et al, (2017) argue that programs that educate individuals on the dynamics of IPV, healthy relationship practices can reduce violence. This implies that when individuals are informed about the healthy norms of relationships, they are less likely to engage in abusive behaviors.

However, while early interventions have notable benefits, several challenges can hinder their effectiveness: Victims may be reluctant to seek help due to fear of repercussions, social stigma, or a lack of trust in authorities. Research shows that cultural and societal barriers can prevent individuals from accessing necessary services (Cattaneo & Goodman, 2015). Addressing these barriers is crucial for intervention efficacy.

Furthermore, professionals involved in IPV interventions may lack adequate training to recognize signs of abuse or respond appropriately. Studies suggest that without proper training in trauma-informed care, first responders may inadvertently exacerbate the situation or fail to provide necessary support (Macy et al, 2015). Limited funding and resources can also restrict the reach and effectiveness of early intervention programs. Many programs are under-resourced, which can lead to burnout among staff and a lack of comprehensive services (Koss et al, 2014). Ensuring sustainable funding is critical for long-term success. Early interventions also require collaboration among various sectors, including healthcare, law enforcement, and social services. Poor coordination among these entities can result in fragmented care and support, reducing the overall effectiveness of intervention strategies (Davis et al, 2020).

Thus, early intervention strategies have the potential to significantly mitigate intimate partner violence through risk identification, education, resource accessibility, and community engagement. However, their effectiveness can be compromised by factors such as stigma, insufficient training, resource limitations, lack of coordination, and variability in responses. All the 5 Health Officials and all the 5 Police Officers also noted that empowering survivors of IPV with access to resources, support services, legal aid, and shelter options can help them break free from abusive relationships and rebuild their lives.

Intervening with perpetrators of IPV through counselling, therapy, and behavior change programs was also noted to be effective in addressing the root causes of violence and prevent reoffending. The need for legal protection was also seen to be effective in mitigating IPV. Enacting and enforcing laws and policies that protect survivors of IPV, prosecute perpetrators, and provide access to justice and support services are critical. This includes restraining orders, emergency shelters, and legal aid for survivors seeking redress.

This view is supported by literature which also noted that empowering survivors can enhance their sense of agency and self-efficacy, enabling them to make informed choices about their lives. Research indicates that when survivors actively participate in decision-making, it fosters resilience. For example, a study by Firestone, (2023) highlighted that empowerment programs led to increased self-esteem and reduced feelings of helplessness among survivors. Empowerment strategies also often involve providing survivors with access to resources such as legal assistance, financial support, and housing. According to Sullivan & Goodman, (2019) these resources are crucial for helping survivors leave abusive relationships and rebuild their lives. Access to economic resources, for instance, is correlated with reduced vulnerability to IPV. Empowerment initiatives also create support networks which are essential for survivors dealing with the repercussions of IPV. Sullivan & Goodman, (2019) acknowledge this saying that survivors with strong social support systems were more likely to engage in help-seeking behavior.

While empowerment initiatives can lead to positive outcomes, there are also potential challenges and limitations. Empowerment efforts may encourage survivors to recount their experiences, and this can inadvertently lead to re-traumatization. Cramer et al, (2020) found that some empowerment programs, particularly those relying heavily on survivor narratives, could trigger past trauma, leading to increased anxiety and distress. Some empowerment programs may fail to address the economic disparities that limit survivors' options. Holcomb et al, (2017) pointed out that even with empowerment strategies in place, survivors who lack financial resources may still find themselves trapped in abusive relationships, regardless of their empowerment efforts.

Providing specialized training for healthcare providers, law enforcement officers, social workers, and other professionals on identifying, responding to, and supporting survivors of IPV was also seen to be essential. Furthermore, the participants pointed out that utilizing technology, such as mobile apps, online resources, and helplines, to provide information, support, and emergency assistance to individuals experiencing IPV can be crucial, especially in reaching those in remote or isolated areas. It was also noted that Cross-sector collaboration would also be an effective means to address IPV. Collaborating across sectors, including health, education, justice, social services, and civil society, can strengthen the response to IPV. By working together, different

stakeholders can share resources, expertise, and best practices to address this complex issue comprehensively. Thus, by implementing a multifaceted approach that combines community involvement, education, empowerment, intervention, legal protections, and collaboration across sectors, stakeholders can work together to mitigate IPV and create safer, healthier, and more equitable communities

Recommendations

1. There is need for the policy makers to design policies and strategies meant to ensure on the safety of woman in intimate relationships. The existing policies seem not to protect the women from being abused by their intimate partners.
2. Intensifying education and awareness programmes are a necessity to conscientize stakeholders on the need to safeguard women being abused by intimate partners. Carrying out education and awareness programmes with the females enlighten them about the abuse they face from their partners. This will also empower the women on strategies to deal with the violence; The education and awareness programs can be done by the Ministry of Health in conjunction with the police and this can be funded by donor agents that support women empowerment.
3. It is also recommended that future research need to be of qualitative nature which will allow the respondents to express their feelings, emotions and attitudes on the intimate partner violent.
4. It is further recommended that: future research may be done focusing specifically on district, provincial and national levels with regards to intimate partner violence.
5. Further research is recommended which should target the involvement of intimate males as part of the sample. The involvement of males would add more value to the research findings since responses will not be biased in terms of gender.

AUTHOR DISCLOSURE

The authors declare that there is no conflict of interest arising from this publication

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