Building Bridges of Faith Against Domestic Violence

War and domestic violence: A rapid scoping of the international literature to understand the relationship and to inform responses in the Tigray humanitarian crisis

Authored by: Dr Romina Istratii

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This working paper series is published as part of project dldl/ድልድል, which is dedicated to the development and strengthening of religio-culturally sensitive domestic violence alleviation systems in Ethiopia, Eritrea and the UK. The project is hosted at SOAS University of London, and is funded initially for four years by UK Research and Innovation (UKRI) under the Future Leaders Fellowship "Bridging religious studies, gender & development and public health to address domestic violence: A novel approach for Ethiopia, Eritrea and the UK" (Grant Ref: MR/T043350/1), and supported with a research grant from the Harry Frank Guggenheim Foundation awarded in 2019 under the proposal "Religion, conscience and abusive behaviour: Understanding the role of faith and spirituality in the deterrence of intimate partner violence in rural Ethiopia."

The project seeks to promote a decolonial approach to addressing domestic violence by engaging substantively with the religio-cultural belief systems of domestic violence victims/survivors and perpetrators. It also aims to improve understanding about how religious experience interfaces with gender, material and psychological parameters to facilitate or deter domestic violence in different religious contexts. It will result in new research and intervention approaches working with Ethiopian and Eritrean collaborators, and rural and urban communities, and will apply knowledge from the respective countries to inform approaches towards integrating and better supporting ethnic minority and migrant populations affected by domestic violence in the UK. The project employs research, sensitisation, knowledge exchange and public engagement activities, working collaboratively with partners, stakeholders and communities in the three countries with the aims to:

a) improve preparedness among clergy and seminarians to respond to victims/survivors and perpetrators of domestic violence in their communities;
b) increase religio-cultural sensitivity in non-governmental and state-led domestic violence sectors in the project countries;
c) develop integrated domestic violence support systems that can be sensitive and responsive to religio-culturally diverse populations; and
d) promote reciprocal research partnerships and capacity development for project staff, partners and collaborators.

The project is informed by previous ethnographic investigations of conjugal abuse in the Ethiopian Orthodox community in Tigray region in northern Ethiopia. It intended to develop the evidence base with new research activities and interventions with the clergy in Tigray, as well as to disseminate the evidence and inform approaches to domestic violence in other religious communities of Ethiopia. Unexpectedly, on 4 November 2020 (four days after the official start date of project dldl/ድልድል), a conflict erupted in Tigray region. This raised an urgent need to pay attention to violence experienced in political conflict and related trauma in order to understand the implications for domestic life and family relations in the conflict-affected communities. The current

working paper presents preliminary results from a rapid scoping literature review that was initialised soon after the outbreak of the conflict to identify the state of evidence on the relationship between political violence and domestic violence internationally to deepen the analysis of domestic violence in conflict-ridden Tigray as part of the ongoing work of project dldl/ድልድል, but also to inform current humanitarian approaches in the region.

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War-related violence in Tigray conflict

The compilation of accounts that follows is based as much as possible on official sources of different political or institutional affiliations or direct accounts of victims/survivors, witnesses, doctors and aid workers as reported in news articles and reports. The author acknowledges the controversies that have emerged around some accounts, and recognises that no data can be considered comprehensive at this time when access in the region is limited. The priority of the author is to honour the voices of those who have experienced or witnessed the violence, recognising the importance of validating the experiences of victims/survivors, who can be further traumatised when their abuse is not recognised by the rest of the society. The aim of this section is not to produce a political analysis, but only to understand the forms of war-related violence on the ground in an effort to proactively identify strategies to support victims/survivors and to support the humanitarian response in the region.

In November 2020, a new conflict erupted in Tigray region, northern Ethiopia. The violence has led to extensive displacement and large numbers of people in the region fleeing to Sudan and other areas within Ethiopia. In January 2021, the UN reported that more than 56,000 Ethiopian refugees had fled into neighbouring Sudan since the outbreak of the war, with about 45% being children ('UN warns 2.3 million need aid', 2021), 30% being younger than 18 and 5% older than 60 ('Ethiopians Continue Streaming Into Sudan', 2021). Humanitarian organisations have warned that millions may be facing food insecurity and facing the risk of dying from hunger or of a lack of medical supplies, exacerbated by a limited access to most parts of Tigray hindering humanitarian assistance (Anna, 2021 February 5).

Reports about sexual violence being used by militant elements in Tigray also started to emerge after the outbreak of the conflict. On 21 January 2021, the United Nations Special Representative of the Secretary-General on Sexual Violence in Conflict, Ms. Pramila Patten, made an official statement about disturbing reports of rape in Tigray, including in the capital Mekelle, which the federal troops had taken control of in the early stages of the military offensive ('United Nations Special Representative', 2021). Following this official statement, a *VOA* news article was published on 22 January 2021, providing specific testimonials by survivors of sexual violence and doctors who treated them ('Choose - I Kill You or Rape You', 2021). In December 2020, a *Guardian* article cited a woman who reportedly fled Tigray with her son after hearing of federal militias raping Tigrayan women on the basis of their ethnicity ('I saw people dying on the road', 2020). A situation report published by the Europe External Programme with Africa on 2 February 2021 spoke, in turn, of "sadistic perpetration of sexual violence", citing specific cases of women and girls who had been raped (EEPA, 2021).

In response to reports about extensive sexual violence and a fear that rape has been perpetuated systematically, the federal government announced in January the establishment of a special task force comprised of members of the Ministry of Health, Ministry of Women, Children and Youth Affairs (MoWCYA), the Ministry of Defence, and the Federal Attorney General to investigate the sexual violence in Mekelle ('Joint Taskforce Established', 2021). The investigations by the task force confirmed "without doubt" the existence of sexual violence, but statements made about the outcomes of the investigations lacked detail in terms of the extent of violence (Anna, 2021 February 12). A report by the Ethiopian Human Rights Commission published in February 2021 was more detailed, mentioning in total 108 rapes in Mekelle, Adigrat, Wukro and Ayder in just the two previous months (Ethiopian Human Rights Commission, n.d.).

A brief by the EEPA Horn Programme on 8 March 2021 reported extensive sexual and gender-based violence (SGBV), citing tens of thousands of women as a conservative estimate of the extent of raping by federal militant elements (EEPA, 2021). The report included the following statement by an aid worker: "Whenever a girl or a woman comes and shares her story, she is speaking for 6, 8 or even 10 other women who were raped in the place she comes from. She is the only one who was able to come and get treatment. This helps you to imagine the scale of the atrocities. So, talking about the official numbers is downscaling the problem." (Ibid). An article by *DW* published on 3 March 2021 mentioned that the hospital in Adigrat had received over 174 rape survivors since the outbreak of the war ('Anger and Collective Trauma, 2021). Numerous sources speak of women being gang-raped and being injured gravely or killed in the assaults (e.g. EEPA, 2021 March 8; 'Anger and Collective Trauma', 2021). A more recent article published by *The Telegraph* spoke of "hundreds of women" rushing to hospitals seeking medical aid and contraception after being raped, citing testimonials that spoke of intentional use of rape by soldiers to impregnate the women, sexually and physically damage them and infect them with HIV (Kassa & Pujol-Mazzini, 2021).

The sexual violence reported extensively in Tigray is not the only form of violence and women and girls are not the sole victims reported. Deaths, injuries and other forms of violence affecting civilian men and children have been extensively documented as well. A report by the Ethiopian Human Rights Commission released in February after investigations were conducted in parts of Tigray in mid and late January reported children being maimed by landmines, bombs or stray bullets (Ethiopian Human Rights Commission, n.d.). The Ayder Hospital treated numerous children, who had been hospitalised for such causes, with one father testifying that his son had lost a leg after being injured by a grenade explosion and due to inability to reach the hospital in time (Ibid, p. 5). The report also referred to the extensive looting of hospitals and medical supplies and ambulances by combatants, resulting in the death of patients in need of urgent medical support. In addition, many internally displaced populations were reported to have witnessed war violence, including the loss of family relatives, which contributed to grave trauma and sadness (Ibid, p. 8).

The consequences of war-related violence, either through active participation in it as a soldier or experiencing and witnessing it as a civilian, can be devastating and permanent, despite victims/survivors being known to show high levels of resilience. War-time violence is reported to affect the individual mentally, physically and materially, altering a survivor's relationships with

others and subsequently affecting entire communities. Beyond the immediate physical damage, disability and mental health trauma experienced by victims of physical, sexual or other violence, fear, shame and other socio-cultural and environmental parameters can lead both survivors and ex-combatants to be isolated or be unable to reintegrate in society when peace is restored. Moreover, the detrimental and intergenerational effects of war-time violence can coexist with and amplify structural, communal and domestic forms of violence that pre-existed before the conflict (e.g. Østby, 2016). Efforts to assess the consequences of the ongoing war in the region should be based on a grounded understanding of Tigrayan society and the people's religio-cultural beliefs and values, as well as forms of structural, domestic or other violence experienced by its population prior to the war, especially affecting women and girls.

According to statistical evidence, about one in three women in Ethiopia have experienced some form of spousal abuse in their lifetimes, and this includes women in Tigray (CSAE & ICF, 2017, p. 305). While previous research by the author in Aksum found that people considered domestic violence inappropriate and wrong by the standards of their faith and culture, the existence of the problem was not denied, with certain forms of violence (such as sexual coercion in marriage) not being acknowledged generally as a form of abuse and being more likely to be tolerated (Istratii, 2020). It is equally important to note that Tigray is a deeply religious society with the indigenous Ethiopian Orthodox *Täwahədo* Christianity having been formally embraced in the ancient capital of Aksum, to which the majority of Tigray's population adheres (FDRE, 2008, p. 111). Whilst an eclectic and complex tradition, the faith values peace, reciprocity and mutual help as is typically taught by clergy in the countryside (Istratii 2020; 2021). On the other hand, deeply embedded cultural standards, not disconnected from the prevailing religious tradition as lived and understood vernacularly by the people, have included a historical emphasis on women's and girls' virginity and may have fostered attitudes in society that make it difficult to speak about sexual violence and its consequences publicly, which could contribute to victims silencing their experiences and not seeking proper support.

These pre-existing issues should not be assessed in isolation from Tigrayan women's efforts to improve the status of women and to address violence and inequalities affecting women and girls, especially in the period since the liberation struggle against the Derg (Hammond, 1989; Tsehai Berhane-Selassie, 1991; Minale Adugna, 2001; Mjaaland, 2004; Aregawi Berhe, 2004; Burgess, 2013; Krzeczunowicz, 1967). The consequences of the ongoing conflict and strategies to support victims/survivors need to be identified with an understanding of regional history and wider socio-cultural and gender frameworks and available resources locally. For instance, the prevailing faith-inspired values of society that emphasise mutual help and the spiritual support of the clergy, who are generally at the forefront of providing advice and support with family-related problems and life events, could become important resources in rebuilding the society and helping the people of Tigray overcome war-related trauma both collectively and individually. Such an approach would require, however, a careful engagement with the clergy, recognising their historical and current limitations and needs, as discussed in the last section of this working paper.

The aim of the current rapid scoping literature review, which was initialised soon after the outbreak of the war, was to identify the state of evidence on the relationship between political violence and domestic violence internationally in order to deepen the analysis of domestic violence in conflict-ridden Tigray as part of the ongoing work of project dldl/ድልድል, but also to inform current humanitarian approaches in the region. Urgent responses to SGBV and efforts to promote children's protection are currently being led by international humanitarian agencies in coordination with relevant government ministries, as well as organisations working in the region with access and capacity to contribute to the wider humanitarian response. It is hoped that the presentation of this evidence can help international, regional, national and local actors, including women's organisations in Tigray currently working in the warzone to identify how they might better support affected individuals in ways that not only respond to the immediate consequences of war-related violence but also consider previously existing forms of violence and resources to prevent and address further abuse in domestic and communal life post displacement while the conflict is still ongoing and in post-conflict society when peace is, hopefully, restored.

Literature review protocol

As previously stated, thus rapid scoping review aimed to understand the state of the evidence around the relationship between war and domestic violence at the international level to inform the work of project dldl/ድልድል in the region and also current humanitarian responses to the Tigray conflict. The specific objectives of the scoping review were to identify:

a) key conceptual issues around the relationship between war and domestic violence;
b) types of studies and research conducted before;
c) main areas of agreements and disagreement;
d) and gaps in the evidence or directions for future research.

The review also sought to explore linkages with culture-specific religious and other beliefs and parameters, where these were identified, in line with this project's objective to address domestic violence with sensitivity to the local communities' valued religio-cultural systems.

The review was conducted by the author with the support of a colleague in Ethiopia (who opted to remain anonymous) under the following distribution of labour: the author drafted the review protocol; both reviewers proceeded to refine the exclusion/inclusion criteria; the second reviewer identified and collected relevant studies by running searches on Google, Google scholar, BMJ, APA PsychNet and the Lancet. The author complemented these studies by running searches on EBSCO. An Ethiopia-specific search in Amharic was also attempted by the Ethiopia-based scholar. Due to a scarcity of studies specifically addressing the relationship war violence-domestic violence, efforts were made by the second reviewer to contact specialists at Addis Ababa University and other research institutes in the country to identify additional pertinent sources. Unfortunately, this did not yield extensive results in the limited time available and thus the presentation on Ethiopia-specific evidence has been omitted from the current synthesis.

For the search of studies, a combination of keyword terms was used, namely: war and domestic violence, war and family relations, war and spouse violence, war and intimate partner violence, political conflict and domestic violence, political conflict and family relations, political conflict and spousal violence, domestic violence in war zones, domestic violence in post-conflict areas, women and terrorism, post-conflict family relations, domestic violence in post-conflict communities, intimate partner violence during war, gender-based violence in war zones, the impact of war on family relations, violence against women in conflict areas, effects of war on women. The search was limited to sources in English.

The exclusion/inclusion criteria were dictated by the objectives of the review. Political violence was understood as any violence committed, experienced or witnessed during a war or conflict. Domestic violence, for the purposes of this paper, was defined as violence committed by adult family members, with a primary focus on spouses and intimate partners. While the study was limited to adult violence so as to exclude parent-child or child-parent violence (which would merit a specialised review in itself), we use the word 'adult' very loosely recognising that under-age

marriages in Ethiopia are extensive and that victimised spouses, intimate partners or other individuals considered 'adults' in the home can be 'children' by state law or international definition. Since we were interested in understanding long-term implications and war trauma, studies and papers that referred to post-conflict, displaced and refugee populations were also included. To make the review more feasible, we restricted the search to studies published since 2000, although certain studies that were considered seminal published prior to 2000 were screened to produce the report.

Excluded were studies that referred to gang violence, crime or other environmental shocks that did not comprise war or conflict (although terrorism was included). The review also excluded feminist analyses of sexual and gender-based violence if no connections were made with domestic forms of violence. Nonetheless, relevant studies on sexual and gender-based violence were reviewed by the author for the purposes of adding theoretical depth to the analysis.

Table 1: Inclusion/Exclusion criteria

Included studies	Excluded studies
All studies that referred to political violence, war or conflict, including global terrorism	Studies that referred to gang violence, crime or other environmental shocks that did not comprise war or conflict
All studies that referred to post-conflict, displaced and refugee populations	Studies on SGBV in conflict, post-conflict and displaced contexts that did not establish direct links with domestic violence
Studies published since 2000, although some earlier seminal studies were reviewed	Studies prior to 2000, except certain seminal studies
Studies that could be retrieved on the Internet (through original publisher or PDF copy provided online or by the authors directly)	Studies that could not be retrieved directly from the Internet due to limited time or inability to contact the author

In total, the reviewers' searches resulted in an initial list of 193 items. The author screened all the titles and abstracts against the initial exclusion/inclusion criteria, excluding also any duplicates. This resulted in 143 studies, which included 33 studies on sexual and gender-based violence that applied a feminist analysis to the issue. All studies were then read in full by the reviewers. In the process of the full screening, 37 additional studies were identified from bibliography lists, which were also read in full. By the end of the screening, 64 studies were included as directly relevant to the review to be used in the synthesis of the working paper. Numerous additional studies that were found relevant could not be retrieved in the short period of the rapid scoping review.

In order to extrapolate the data collected from the screened studies in a systematic manner, a charting map was used that identified the following characteristics for each of the studies: a) context of study (conflict, post-conflict, displaced, refugee camp), b) country, c) years of conflict, b) affected population under study, d) mechanism relating war violence or trauma to domestic violence, d) limitations of study design, e) major contribution of study to the literature, e) gaps in

the evidence or needs for further research and implications. For theoretical, empirical, sociological or legal studies that applied a feminist/gender-based violence analytical framework to war violence and predominantly conceptualised IPV under the larger category of SGBV a simplified version of this charting map was used.

Lastly, it is important to note that while the paper was authored solely by the author, the second reviewer supported the synthesis of some of the studies presented under the sections on SGBV in refugee contexts and on family violence. These were reviewed by the author and again summarised in her own words. In synthesising the evidence, the reviewers were cautious to paraphrase all works in their own words, to the best of their ability, and to attribute all the studies to their original authors accurately. Any errors are unintended and should be brought to the attention of the author for correction. The paper will remain in draft mode for a month's time after first publication to allow for feedback to be received, which will be incorporated in the paper at the discretion of the author.

War and domestic violence: Understanding the relationship

While the relationship between war violence and domestic violence received limited attention historically, this changed in recent decades and new evidence has emerged that suggests direct associations between exposure to political violence and an increased likelihood of victims/survivors and perpetrators experiencing or resorting to violence in the domestic sphere. The reviewed studies pointed to roughly four types of studies: a) studies that explored the relationship of war and IPV within military and civilian populations, b) studies that referred to sexual and gender-based violence (SGBV), including IPV, in refugee camps, displaced contexts and migrant communities, c) studies that applied a gender-sensitive or feminist lens to conflict and post-conflict violence, and d) studies that examined the consequences of war on family violence and children's wellbeing.

Overall, the evidence reviewed revealed a multi-dimensional mechanism connecting political violence and domestic violence, such as through mental health trauma affecting victims/survivors, direct effects on the behaviour of soldiers, veterans and civilian ex-combatants, socio-cultural influences and normative frameworks contributing to the further abuse of war survivors, or the breakdown of structures, support systems and community solidarity that would otherwise be available to victims of domestic or other forms of violence in peace time. Feminist perspectives on the relationship distinguish themselves by seeing violence as a continuum, with war-related SGBV thought to be exacerbated by pre-existing socio-cultural ideals of sexuality and honour, the breakdown of law and order fostering impunity, and the militarisation of the private sphere in post-conflict contexts (Olujic, 1998; Davies & True, 2015; Ahmad & Anctil Avoine, 2018). Moreover, conflict-related violence is seen as interlinked with SGBV during flight from a conflict zone and in post displacement contexts, justifying an understanding of violence as a continuous threat (Krause, 2015).

Studies involving military populations consistently reported a higher frequency of IPV in military populations in contrast to civilian populations. Numerous aetiologies were proposed or established to explain this higher frequency. Service men and women and veterans were reported to be more likely to be affected by war trauma, including by Posttraumatic Stress Disorder (PTSD), which consequently influenced relationships with intimate partners and other family members. Service personnel and veterans often manifested a reduced ability to adjust feelings and emotions in marital relationships, as well as hyper-sensitivity as a result of stressors faced in combat. The reviewed studies suggested that standard treatment programmes for IPV perpetrators may be ineffective for military populations if they do not take into account and address war trauma (Love et al., 2015). Moreover, there may be need for pre-deployment and post-deployment specific programmes to support service personnel with stage-specific stressors and prevent relationship problems that can foster IPV (Schmaling et al., 2011).

Studies involving civilian populations also found higher odds of IPV with exposure to or participation in conflict-related violence. Studies reporting prevalence rates also found associations between intensity of violence and odds of IPV. Numerous mechanisms were suggested to explain the relationship between war violence and IPV. Some authors argued that violence can render men powerless who might aim to re-assert their power by using abuse with partners. Moreover, violence can foster humiliation, stress, mental ill-health (e.g. depression, PTSD) and substance and alcohol abuse in men that can manifest as aggression. Additionally, economic policies related to occupation can result in household financial stress and dysfunctional families (Al-Krenawi et al., 2007). Other causal mechanisms may be a higher normalisation of violence for both men and women (Gutierrez and Gallegos, 2016), a higher manifestation of violence as a consequence of conflict-related stress, and a victim's heightened hesitation to leave an abusive environment in fear of losing the protection it offers (Noe & Rieckmann, 2013). IPV frequency following conflict might be mediated also by changes in the sex ratio, with the decline in the number of men to women contributing to a decrease in women's decision-making power in relation to spouse selection and marriage and subsequently increased IPV (La Mattina, 2012).

As an especially pernicious form of war violence, sexual violence (rape, sex slavery, forced marriage, or other) experienced during conflict can cause physical disability, health problems, unwanted pregnancies and dysregulated affect in females, interfering with healthy intimate relationships in post-conflict times (Josse, 2010). Moreover, exposure to war-related SGBV may make women and girls more vulnerable to prostitution, sexual exploitation and human trafficking (Handrahan, 2004). In many societies, especially those that place emphasis on pre-marital virginity, rape victims may face challenges to be accepted as brides, or may be divorced if already married (Manjoo & McRaith, 2011). Where women previously acted as combatants, stigmatisation may make their re-integration difficult (Ayub et al., 2009). Re-integration can be further challenged as a result of many women's lack of education and inability to find employment, poverty, marginalisation (victims or children born as a result of rape casted out) or context-specific socio-cultural normative standards (Annan & Brier, 2010).

Studies occurring in refugee camps and displaced contexts reported high levels of IPV and other forms of violence, evidencing clear associations with war-related violence and suggesting a continuum of violence as feminist analyses propose. IPV among refugees, internally displaced populations and migrant families was described to be the result of emotional distress, changes in gender roles, shifts in family power structures and male unemployment in post-conflict time (Meffert & Marmar, 2009). IPV victims were also reported to be reluctant to leave their abusive husbands, to report the abuse and to use humanitarian services. Reasons included perceived and experienced stigma, reliance on social/economic/security support from husbands, lack of awareness of services, and fear of the risk children being kidnaped while mothers sought services (Al-Natour et al., 2019; Wirtz et al., 2013; Horn, 2010). Other studies spoke of women feeling abandoned and isolated in the aftermath of war-related violence, which was also associated with under-age marriages in refugee camps (Newbury & Baldwin, 2000).

Lastly, studies on war violence and family violence, focusing on children's wellbeing, provide sufficient evidence to suggest that violence against children in post-conflict is often an extension of political violence and a consequence of domestic violence perpetrated by family members (Catani, Schauer, et al., 2008; Catani et al., 2009; Rees et al., 2015). Witnessing IPV interferes with parenting skills, which can result in child abuse and affect children's psychological state and wellbeing, but may also affect children's development and their behaviour in future adult relationships (e.g. via attachment styles) (Dalgaard et al., 2020; Saile et al., 2014, 2016). This should be assessed in conjunction with the generally established understanding that children who experience or witness IPV are at a higher likelihood of either perpetrating violence or being abused in their adult lives. On the other hand, a study with veterans who had been deployed to Iraq and Afghanistan found a significant relationship between PTSD symptoms (flashbacks, numbing, anger, being physically reactive to a reminder, and being on guard/hyper-vigilant) and perpetration of violence against children (Sullivan & Elbogen, 2014).

In terms of responses, the review sufficiently evidenced that any intervention or response must understand and be contextualised in the affected communities' socio-cultural frameworks and how they understand and experience violence in their contexts (e.g. Abramowitz & Moran, 2012). So-called psychosocial services in humanitarian settings must consider the distinct aetiologies of different forms of violence and the factor of accumulated trauma that may require a combination of community-wide measures with individual-specific psychological/clinical support. To achieve this, however, as Miller and co-authors have suggested in a recently published paper, the meaning and usage of the term 'psychosocial' needs more conceptual clarity (Miller et al., 2021). As opposed to its broad and sometimes vague usage in humanitarian discourse, the authors suggest that psychosocial services may be classified as socio-environmental and clinical to evidence the different types of needs, aetiologies for the problem or causal mechanisms and specialisations involved. These distinct remedies should be ideally delivered in parallel informed by expert diagnoses and data collected through rigorous research.

Lastly, the review revealed that humanitarian responses, including SGBV approaches, have often been top-down recommendations and have not relied on research conducted on the ground (Horn, 2010; Asgary et al., 2013). Moreover, these have generally not engaged with religious beliefs and spiritual aspects of life that may be salient for communities. Such tendencies may have interfered with a proper understanding of local normative frameworks, especially were such frameworks are embedded in authoritative religious traditions, but also with leveraging on their resourcefulness (Istratii, 2020). A limited number of studies reviewed suggested that religious beliefs could serve for domestic violence and SGBV survivors as coping mechanisms and as a source of improved mental health (e.g. Al-Natour et al., 2019), which is more extensively documented in the domestic violence literature within religious communities (Shaikh, 2007; Johnson, 2015; Nason-Clark et al., 2018; Istratii, 2020).

In sum, the findings of this rapid scoping review can be summarised with a few key messages:

- Individuals affected by conflict continue to face trauma-related consequences for many years following conflict. These consequences are defined within wider gender and marriage normative frameworks, other socio-cultural standards and material realities, as well as individual histories of trauma.
- Responses to conflict-related violence in humanitarian settings must consider how political violence may intersect with pre-existing forms of violence and seek to support affected groups in ways that can prevent further abuse in domestic and communal life in refugee camps and in post-displacement settings.
- It is important to prioritise understandings of violence as upheld by communities and to embed these and attitudes around them in their socio-cultural and material realities.
- While domestic violence intersects with conflict-related SGBV and should not be approached in isolation from the latter in humanitarian settings, it is important to differentiate domestic violence/IPV from conflict-related SGBV in order to consider their distinct, albeit interlinked, aetiologies. Domestic violence/IPV is often maintained by a matrix of socio-cultural, intersubjective and individual factors and has complex consequences (e.g. psychological trauma from childhood violence, personality disorders or attachment insecurity) that might require different types of responses than does conflict-related or stranger SGBV.
- Psychosocial and other support services in humanitarian settings must consider the multiple ad distinct aetiologies of violence and the existence of accumulated trauma some related to childhood experiences of violence and not war violence that requires a combination of community-wide social-environmental measures with individual-specific psychological/clinical support (as per classification offered in Miller et al., 2021). These strategies may need to be delivered in parallel, ideally informed by expert diagnoses and data collected through rigorous research.
- Any intervention or response needs to understand and be contextualised in communities' religio-cultural normative systems and to consider how family and social structures and institutions broken or interrupted during conflict might be restored to prevent IPV or other forms of abuse in the family, as well as contribute to effective perpetrator treatment programmes in conflict and post-conflict times. Programmes in religious societies such as Tigray, where clergy are already involved in couples' marital life and mediate domestic violence and other problems, should consider how to integrate religious stakeholders better and leverage on their resourcefulness and close connections with communities.

A detailed discussion of the literature

War violence and IPV in military populations

Studies examining the relationship between war violence and IPV were mostly quantitative or diagnostic studies on the effects of war or deployment on male and/or female military personnel and veterans. More specifically, the studies that were reviewed explored: the effects of war violence or deployment on male and/or female military personnel and veterans and how these affect family integration, relationship dissolution or divorce (Schmaling et al., 2011), link of military deployment with violence towards spouses and children (McCarroll et al., 2010; Cesur & Sabia, 2016) and treatment programmes for military personnel and veterans affected by family violence (Love et al., 2015). The sample of studies reviewed included two systematic reviews examining IPV in military populations (Marshall et al., 2005; Kwan et al., 2020). All of the studies that were found relevant to the report involved populations in the US, with one systematic review including a study that had been conducted in Canada.

In 2005, Marshall and colleagues published a paper that assessed the state of evidence on the prevalence, consequences, correlates, and treatment of IPV perpetration among military veterans and active duty servicemen (Marshall et al., 2005). The systematic review captured works published between 1970 and 2005. The prevalence rates ranged from 13.5 to 58%, which fared higher than previously reported rates of male-to-female IPV in the US civilian population (12%). The authors found that IPV perpetration correlated with substance use, depression, and antisocial characteristics for both active servicemen and veterans. PTSD symptoms, in turn, accounted in large part for the relationship between IPV perpetration and exposure to conflict. The authors also reported that poor marital adjustment correlated with IPV, listing two studies, one of which had found that abusive servicemen reported lower marital adjustment and satisfaction, and one study that had found a negative association between marital adjustment and IPV frequency. The authors also reported results from an experimentally controlled study of IPV treatment effectiveness, which proposed that standard approaches could be ineffective with military populations.

A more recent systematic review of IPV in military populations was conducted by Kwan and colleagues (Kwan et al., 2020). They examined the prevalence rates of IPV reported for military populations and the relationship between IPV frequency and service status, era of deployment, socio-cultural characteristics, gender and other parameters. The studies analysed in the systematic review were all conducted in the US, with one from Canada. Thirty of a total of 42 papers reported prevalence of physical IPV, ranging between 5 and 57.6%. Fifteen studies were included in a meta-analysis, resulting in a pooled prevalence rate of 26% (95% CI: 23.0%–29.0%). This was considerably higher than reported prevalence rates for US civilians (4%-15%). Disaggregating 19 of the studies by gender, evidenced higher levels of past-year IPV for males than females, with pooled prevalence rates of 27% (95% CI: 23.0%–32.0%, $I2 = 99.6\%$, $p < 0.001$)

and 22% respectively (95% CI: 17.0%–27.0%, I2 = 96.9%, p < 0.001). However, six studies in the sample reported higher levels of physical IPV for females than males, although minimal differences were found for severe IPV perpetration. The review reported also high levels of emotional/psychological abuse, which the authors related to conflict-related high levels of stress and mental health that might make it harder for military populations to regulate anger and arousal in interpersonal relationships at home. In relation to characteristics, the studies found higher levels among veterans than active-duty personnel. According to the authors, this might be associated with transition-related stressors after returning home and spending more time engaging with interpersonal relationships. Higher levels were also found among lower military ranks, which the authors speculated could reflect their higher-risk demographics.

In 2010, McCarroll and colleagues published a paper that explored the relationship between a soldier's length of deployment and the probability of spousal violence during a 1-year period (McCarroll et al., 2010). This was a cross-sectional study that relied on data from a representative sample (n=26,835) in a previously administered survey involving deployed and nondeployed married active duty men and women in the US Army during the period 1990 to 1994. Spousal aggression was measured be means of a modified version of the Conflict Tactics Scale. The data were analysed using two different models, multinomial regression analysis and ordered probit analysis, controlling for different characteristics. The authors found that the probability of self-reporting severe aggressive behaviour was more significant for soldiers who had been deployed in the past year than those who had not. Moreover, the length of deployment seemed to have a small, but statistically significant effect on severe spousal abuse. The probability rates for severe spousal abuse without deployment were 3.7% to 4.1%, and increased to 5% with a deployment between 6-12 months. Due to the study design the authors could not establish causal mechanisms, since other parameters could be defining the relationship, but this was reportedly the first study to document the association.

A study published in 2011 by Schmaling and colleagues examined the longitudinal associations of psychosocial, demographic, and military service characteristics with IPV and relationship dissolution (Schmaling et al., 2011). The authors examined longitudinal data from 546 mostly Research Army Soldiers who had mobilised primarily in Operation Iraqi Freedom in 2003. The analysis found that over 13% perpetrated IPV in the year prior to mobilisation. At the stage of demobilisation, 5% reported relationship dissolution, which was reportedly associated with lower education levels, deployments and enlisted ranks. Notably, the data collected was self-reported and participants might have under-reported. Overall, the study suggested the need for pre-deployment and post-deployment specific programmes to support service personnel with stage-specific stressors in order to prevent relationship problems that could foster IPV.

Some years later, Love and co-authors published a study that assessed the effectiveness of the Strength at Home (SAH) programme, a 12-session cognitive-behavioural intervention intended for abusive military personnel and veterans in order to establish the effectiveness of military-specific IPV programmes and the extent to which a programme such as SAH was effective and appropriate for veterans from diverse backgrounds (Love et al., 2015). The study used multiple methods,

including a survey and examined perspectives by providers, focus group discussions with servicemen from the recent wars in Iraq and Afghanistan who participated on the SAH pilot programme and interviews with their female partners. It found that militant members experienced stressors related to deployment and combat and were more likely to manifest mental health disorders (for example, PTSD and substance abuse) than it has been reported for the general population. Pertinent to this review, the authors found that exposure to war could lower the threshold for negative arousal in servicemen and veterans and reduced their ability in self-regulating anger when faced with stressors in interpersonal situations, which could increase the risk of them resorting to use of aggression (p. 2347). The findings overall suggested the need for veteran-specific treatment programmes that consider war-related trauma. The SAH programme that was piloted (n=6) was found to be generally effective in reducing psychological aggression and increasing anger control in the participants.

A study published in 2016 by Cesur and Sabia involved active-duty military personnel in the Global War on Terrorism (GWOT) and aimed to identify the effect of combat service on relationship health, IPV, and child abuse (Cesur & Sabia, 2016). The sample consisted of 476 active-duty male soldiers who reported overseas deployment and provided full information on domestic violence. The authors found a strong relationship between exposure to combat and increased risk of domestic violence and reported descriptive evidence that suggested associations between combat-related stressors and substance abuse with IPV. The study pointed to the need for further research to disentangle the effects because of the length and number of deployments and those resulting from combat exposure alone.

War violence and IPV in the general population

A second sub-group of studies comprised of quantitative studies that explored prevalence rates, associations and causal mechanisms between exposure to conflict violence and IPV in the general population (including ex-combatants from the civilian population). These studies were either country-specific (Rwanda - La Mattina, 2012; Uganda - Saile et al., 2013 and Annan & Brier, 2010; Palestinian territory - Clark et al. 2010 and Al-Krenawi et al., 2007; Liberia - Kelly et al. 2018; Northern Ireland - Doyle & McWilliams, 2018; 2020; South Africa - Gupta et al., 2012; Timor-Leste - Rees et al, 2018; Peru - Gutierrez & Gallegos, 2016 and Østby et al., 2019; Lebanon - Usta et al., 2008) or multi-country (sub-Saharan Africa - Østby, 2016). The sample of studies reviewed included also qualitative studies of women's lived experiences of domestic violence and other forms of violence experienced in conflict or post-conflict time (Afghanistan - Mannell et al., 2020). Other studies explored family and community responses to domestic violence in post-conflict contexts (DRC - Kohli et al., 2015) and women's and/or community leaders' perceptions about IPV (Sri Lanka - Guruge et al., 2017; Sierra Leone and Liberia - Horn et al., 2014).

Many of these studies accounted for the influence of other important variables, such as victim/perpetrator characteristics, childhood abuse, alcohol and drug abuse and mental ill-health, such as PTSD and depressive symptomatology, providing important insights on the relationship between war violence, mental health and IPV. Studies reviewed examined: partner alcohol misuse and associations with IPV affecting women in post-conflict time (Uganda – Mootz et al., 2018), the relationship with IPV through the influence of traumatic events (Liberia - Vinck & Pham, 2012), and the association between conflict violence, IPV and PTSD (Côte d'Ivoire - Gupta et al., 2014). One study more specifically examined the effects of war or political violence on mental health and associations with gender-based violence (Bougainville, Papua New Guinea - Jewkes et al., 2017), another examined the relationship between mental health and IPV in post-conflict (Rwanda - Verduin et al., 2013) and another the relationship between trauma exposure and IPV in probation sample of men (Travers et al., 2020).

A study published in 2007 by Al-Krenawi and co-authors explored associations between exposure to political violence with violence at home and in school in a sample of 2,328 adolescents in the West Bank. Adolescents were defined as individuals between 12 and 18 and had to attend school at the time of the study (Al-Krenawi et al., 2007). The study was based on a national longitudinal survey conducted in the West Bank in 2005. The authors found associations between the different variables, with some geographic differences. Adolescents reporting lower economic status had more psychological symptoms and more domestic violence. Respondents with high exposure to violence reported significantly more somatisation, anxiety, phobic anxiety and psychoticism. Overall, the study evidenced that exposure to political violence is strongly associated with psychological stress and mental health issues, violence at home and violence in school.

A study published in 2010 by Clark and co-authors assessed whether political violence was associated with male-to-female IPV in the occupied Palestinian territory (Clark et al., 2010). The

study involved married women (n=3510, 92% participation rate), who were asked to complete a short version of the revised Conflict Tactics Scales. The regression analysis found that political violence was significantly related to higher odds of IPV. As reported, ORs were 1.89 (95% CI 1.29–2.76) for physical and 2.23 (1.49–3.35) for sexual intimate partner violence in respondents whose husbands were directly exposed to political violence compared with those whose husbands were not directly exposed. Women whose husbands had direct exposure to violence were also 47% more likely to report psychological violence. Women whose husbands were indirectly exposed to political violence were 61% and 97% more likely to experience physical and sexual IPV respectively. Lastly, respondents in households affected economically were 40%, 51% and 55% more likely to experience psychological, physical and sexual IPV. The authors proposed a combination of feminist, occupation and psychological theories to explain the results, such as that violence can render men powerless, who might then aim to re-assert their power by being abusive with partners, that violence can foster humiliation, stress and depression in men that can manifest as aggression and that economic policies related to occupation can result in household financial stress and family dysfunction.

In 2010, Annan and Brier published a study which assessed the relationship between domestic violence, gender-based discrimination, and the structural violence of poverty in armed conflict in Northern Uganda (Annan & Brier, 2010). The methodology consisted of a survey with 619 females and qualitative interviews with 36 females aged between 16 and 30, selected from the survey sample and purposely recruited to include women who had returned from abduction by the Lord's Resistance Army. The qualitative interviews revealed extensive experiences of sexual violence during abduction, but also violence experienced upon returning to communities. Many women faced reintegration challenges due to dire economic conditions, having to care for children born as a result of their abduction. Women also faced challenges if they remarried, such as facing insults from other wives in polygynous marriages and because their children were seen as 'bush' children and were not always accepted. The authors stressed that victim support services in post-conflict time need to consider the multi-faceted effects of conflict-related violence and their interface with structural and normative factors that make women vulnerable to abuse. Interventions to address trauma related to sexual violence should combine with comprehensive strategies to address underlying structures, norms and attitudes that contribute to or may exacerbate this vulnerability.

In a study published in 2012, La Mattina presented evidence on the relationship between war violence and IPV from Rwanda (La Mattina, 2012). The aim of the study was to examine the long-term effects of the Rwandan genocide in 1994 on women's lives, including trauma and new opportunities as a result of changes in society using data collected in 2005. The author employed data from the Rwanda Demographic and Health Survey and Census results and conducted a cross-sectional analysis to examine the relationship between genocide intensity and domestic violence. She found no direct correlation between genocide intensity and IPV experienced by women in general, but she established that genocide intensity was positively associated with domestic violence only for those women who had married after the genocide. She proposed that the change was mediated by changes in the sex ratio, with the decline in the number of men to

women contributing to a decrease in women's decision-making power in relation to spouse selection and marriage and subsequently increased IPV. In other words, while La Mattina found, in line with previous studies, that exposure to high intensity violence increased the probability of domestic violence, she did not find direct causal mechanisms with men's exposure to genocide, but rather changes in marriage market conditions.

A cross-sectional study from Liberia by Vinck and Pham sought to determine the relationships between war, intimate partner physical violence (IPPV), and mental health (Vinck & Pham, 2013). The study involved 4,501 participants, with one adult randomly selected from 4,501 households. After controlling for other important variables, the regression analysis found significant associations between severe IPPV and experiencing war-related traumatic events, although with differences for men and women. Men were more likely to have experienced severe beating by a spouse or partner if they had direct exposure to war-related events. Women were more likely to have experienced severe beating if they had direct exposure to war-related events, exposure to crime, having participated in the conflict and having higher income. Additionally, exposure to war-related events (direct and being a witness) and participation in conflict were associated with higher levels of PTSD symptomatology. Women were found to have higher prevalence rates of PTSD and depression, which previous literature cited by the authors associated with differences in conflict-related experience of violence, different coping mechanisms, and differences in women's sense of control in their lives (Cloitre et al., 2002; Tolin & Foa, 2002 cited on p. 47). In general, experiencing PTSD symptoms or depression seemed to be a risk factor for men and women experiencing IPPV.

Another cross-sectional study published in 2012 by Gupta and co-authors investigated the influence of conflict-related human rights violations and IPV perpetration in South Africa (Gupta et al., 2012). The study involved 772 South Africa men, or whom 389 had been liberation supporters and 383 had been government supporters. After adjusting for various related variables, the study found higher odds of physical IPV perpetration for men who had experienced major human rights violations (AOR: 2.40, 95% CI 1.20 to 4.81), custody-related human rights violations (AOR 6.61, 95% CI 2.00 to 21.83) and victimisation of close friends/family relatives (AOR 3.38, 95% CI 1.26 to 9.07).

In 2013, Saile and co-authors explored the prevalence and predictors of current partner violence experienced by women in the context of the past war in Northern Uganda (Saile et al., 2013). The study analysed a subsample of 235 guardian couples from seven rural communities obtained from a previously completed epidemiological survey in Northern Uganda, which had involved 2nd-grade children, female guardians and male guardians. The authors found significant associations between women having previous war-related exposure and their victimisation by intimate partners and between men's self-reported alcohol abuse and women's experience of IPV. The regression analysis showed that women's exposure to war-related events strongly predicted IPV (β=0.24, $p<0.01$). Other predictive variables were women's re-experiencing symptom severity level and men's level of alcohol-related issues. The authors also found that different risk factors had different

predictive power for different types of IPV. Previous experience to war-related events predicted all types of IPV, except sexual violence, which was predicted rather by long-term abduction. Long-term abduction emerged also as a risk factor for isolation.

In 2013, Noe and Rieckmann published a study that analysed the impact of civil conflict on domestic violence in Colombia (Noe & Rieckmann, 2013). The study combined data on domestic violence from the Demographic and Health survey conducted in 2004-2005 and data on conflict intensity from the Colombian "Presidential Program for Human Rights and International Humanitarian Law." The authors conducted econometric analysis using Probit regression to determine the probability for each individual woman in the sample to have become a victim of domestic violence in the previous year. The analysis involved 41,344 women between the ages of 13 and 49 years living in 37,211 households. The results reinforced previous evidence that conflict intensity increases the risk of women experiencing domestic violence, with the highest estimates showing over 12 percentage points of higher incidence of domestic violence in an intensely conflict-affected than peace environment. The regression analysis led the authors to suspect as causal mechanisms a higher normalisation of violence, higher manifestation of violence as a consequence of conflict-related stress and victim's higher hesitation to leave a domestic abusive environment in fear of losing the protection it offers.

In 2016, Gutierrez and Gallegos examined how women's exposure to civil conflict violent events during childhood and early teenage years affected their likelihood of experiencing IPV in adult life in Peru (Gutierrez & Gallegos, 2016). The authors used a cross-sectional analysis combining data from the Peruvian Demographic and Health Survey (DHS) for years 2004-2012 and a registry of conflict-related events for 1980-2000. Findings suggested that exposure to conflict increased the likelihood of both perpetrating and experiencing IPV in later adult life. The authors also found a link between the level of exposure to conflict and the risk of adult-life IPV, with women experiencing more conflict-related events being more likely to justify the use of violence against women and to remain in an abusive relationship. This was proposed to reinforce evidence about a direct link between conflict and the normalisation of violence.

A study published in 2016 by Østby is one of the few that tested the relationship involving multiple countries (Østby, 2016). Østby analysed the impact of conflict intensity on intimate partner sexual violence (IPSV) in 17 sub-Saharan African countries, involving a sample of 95,913 women aged 15-49. Data was collected using demographic and health surveys from the 17 countries, while data on conflict-related events was extracted from the UCDP-GED dataset. The analysis established an independent and significant effect of conflict and a woman's risk of IPSV in her home region. The relationship was still significant after controlling for other important variables, such as childhood exposure to parent violence and partners' alcohol abuse. The study adds to evidence that shows a mutually reinforcing relationship between conflict-related events and IPSV, with conflict increasing the risk of IPSV and experience of abuse during childhood contributing to women's vulnerability to abuse in adult life.

In a study published in 2018 Mootz and colleagues conducted research with women in Northeastern Uganda to determine their level of exposure to alcohol misuse, low socioeconomic status, gender (in)equitable decision-making, IPV, and armed conflict and to test how these different indicators related to each other (Mootz et al., 2018). While alcohol consumption is reported among militant elements and much IPV has been associated with alcohol misuse, the mechanisms relating exposure to conflict, IPV and alcohol misuse need to be established (e.g. could be by affecting mental health), which the authors aimed to shed more light on. The study involved 605 women aged 13 to 49 randomly selected through multistage sampling across three districts. The authors employed a moderated structural equation model to evaluate the strength of the relationships and to determine the goodness-of-fit of the proposed model with the population data. The study found that 88.8% of the respondents experienced conflict-related violence and that 30.7% of the respondents' partners consumed alcohol daily. The lifetime and past 12-month prevalence of experiencing IPV was 65.3% and 50.9% for psychological abuse and 59.9% and 43.8% for physical. The authors found that the partner alcohol misuse pathway was significant for women who made healthcare decisions alone and not for women who decided jointly with their partners. However, IPV was significantly associated with socioeconomic status for those respondents who made healthcare decisions jointly. The implication of the study is that interventions to address IPV and alcohol misuse in humanitarian settings should consider exposure to armed conflict and gender dynamics within couples.

Another study published in 2018 by Kelly and co-authors assessed the link between levels of armed conflict and post-conflict IPV experienced by women in Liberia (Kelly et al., 2018). The study combined data from the Liberia Demographic and Health Survey 2007 with measures of conflict from the Armed Location Conflict and Event Data Project (ACLEDP). For data collection, women aged 15-49 were administered a Domestic Violence Module, of which ever-partnered women were asked IPV-related questions. The final sample with full data included 3,596 women. Multilevel regression models were then used to combine different confounding variables to assess the relationship between conflict and IPV. After adjusting the odds for different variables, it was found that a woman living in a district with conflict-related fatalities was 50% more likely to experience IPV as opposed to a woman in a district that did not report conflict-related fatalities (adjusted OR: 1.55, 95% CI 1.26 to 1.92). The number of conflict years also seemed to influence the odds, with women living in districts that experienced 4 - 5 cumulative years of conflict having a higher likelihood of experiencing IPV (aOR 1.88, 95% CI 1.29 to 2.75). The study reinforced evidence about a strong association between political violence and IPV, even after controlling for various confounding variables and individual characteristics, such as women's previous IPV experience and partner's alcohol consumption. The authors proposed that the results could be explained by numerous direct and indirect pathways, such as the possibility that in conflict-affected districts more men might normalise violence in the family and the deterioration of family and social structures respectively.

A third study published in 2018 by Rees and co-authors examined the risk of perpetrating IPV among individuals with exposure to conflict-related torture and whether this risk was mediated by

the mental health effects of torture-related trauma (Rees et al., 2018). The study involved a cohort of 870 women (recruited from antenatal clinics) and their male partners in Dili district, Timor-Leste. The authors used a bivariate and path analysis to test associations between men's characteristics and IPV as reported by women. The analysis linked men's younger age, exposure to conflict-related torture and lower socioeconomic status to mental health disturbance, which was in turn linked to a higher risk of perpetrating IPV. The same characteristics - younger age, lower socioeconomic status, exposure to conflict-related torture and mental health disturbance were directly related to IPV. This is reportedly one of the first studies to link IPV to torture in a specific post-conflict context.

Two articles published by Doyle and McWilliams summarised women's experiences of IPV in Northern Ireland, with special interest in how these were shaped by previous political conflict and societal parameters, including religious conservative attitudes (Doyle & McWilliams, 2018; 2020). The authors also explored how service providers, from general practitioners to police officers, responded to IPV victims and whether victims had found these responses helpful. This was a longitudinal study that included interviews with 100 women interviewed at two different points in time, in 1992 (when paramilitary hostilities were still on-going) and in 2016 (after peace had been restored). The study resulted in numerous insights relevant to this review, suggesting important links between IPV experience and war and religious parameters. The authors found that in 1992 IPV victims could be threatened by perpetrators on the basis of their (real or claimed) connections to paramilitary groups, which was not the case in 2016. In 1992, IPV victims from Catholic and nationalist/republican backgrounds, in contradistinction from the Protestant and unionist majority, were hesitant to seek police support from the state. This had changed in 2016, with considerably more victims seeking police services, thus reducing the power of paramilitary groups to control IPV perpetrators (e.g. by threatening them). The use of firearms was found to be important in the 1992 cohort, with numerous victims being threatened with guns, which was not the case following demobilisation.

In 2019, Østby and colleagues published a study from Peru that specifically examined the statement that war-time violence increases one's risk to IPV (Østby et al., 2019). The data set consisted of 217,934 woman-year observations on IPV extracted from the Peruvian Demographic and Health Surveys and data on war-time violence from the Comisión para la Verdad y Reconciliación (Truth and Reconciliation Commission). The authors found that conflict-related violence (including sexual violence) affected women's risk levels of experiencing IPV, but this was not the main determinant. Other important parameters reported were having a father who was abusive and partner alcohol abuse. Level of exposure to conflict also emerged to have a significant influence for all forms of IPV, but especially for sexual violence. A woman who was more affected by conflict-related violence by a department-year, had a 0.44 percentage point higher risk of experiencing sexual violence for the first time.

War violence, mental health and IPV

Exposure to conflict was associated with mental illness, but also PTSD was found to be more frequent among individuals who were likely to use violence (Mootz et al., 2018: 2). The aforementioned studies by Doyle and McWilliams (2018; 2020) had found substantial links between women experiencing IPV and having mental health issues, including suicidal thoughts and depression.

In 2013, Verduin and co-authors explored the association between IPV and common mental health disorders (CMD), and more specifically, suicidal ideation, among inhabitants of post-genocide Rwanda (Verduin et al., 2013). For this cross-sectional study involving 241 married women and men, the authors used the Self-Reporting Questionnaire (SRQ-20) to establish CMD symptomatology and the Conflict Tactics Scale, Short Version (CTS2S) to establish IPV experience. They, then, ran multivariate logistic regressions, correcting for gender and age parameters. This study was distinctive in the fact that the authors considered the possibility of IPV being mutual in some couples and adopted the concept of 'mutual partner violence' as an analytical framework. The study found that respondents that reported IPV had higher odds of CMD (corrected OR = 1.7, 95% CI = 0.92-3.15) and suicidal ideation (corrected OR= 1.6, 95% CI= 0.70-3.53). Interestingly, this association was not found for victims of IPV only, but it was found for those who reported being both a victim and a perpetrator in their relationship (corrected OR = 1.75, 95% CI = 0.82-3.72, or a perpetrator only (corrected OR = 3.13, 95% CI = 0.49-20.0). None of these associations were significant, but they suggested that perpetrators of IPV might experience more mental health problems than victims in post-genocide Rwanda. The study was not able to establish the causal direction between IPV and mental health, with the authors hypothesising that the cumulative effects of conflict-related events and IPV probably result in mental health issues, and that conversely mental health problems, such as PTSD, may foster more abusive behaviour.

In 2014, Gupta and co-authors published a study that assessed associations between IPV, violence during armed conflict and PTSD in Côte d'Ivoire (Gupta et al., 2014). The study involved 950 women in rural areas. Associations were assessed through logistic generalised estimating equations. As other studies found, the prevalence of IPV was high, with about one third of women having experienced past year IPV and about one fourth having experienced IPV prior to the past year. The authors found that women reporting past-year IPV experience had 3.1 times higher odds of past-week PTSD (95% CI: 1.8–5.3). The association between conflict violence and PTSD was not significant. IPV was more strongly associated with past-week PTSD than conflict-related violence. The authors stressed the importance of accounting for the timing of victimisation and the need to integrate responses to IPV in post-conflict interventions and psychosocial support.

In 2017, Jewkes and colleagues published a study from Bougainville, Papua New Guinea that described the conflict-related experiences of former combatants and people in the general population, the long-term impact of these experiences and associations with mental health problems about 14 years after the end of civil war (Jewkes et al., 2017). Data collection was achieved through a household survey involving 864 men and 879 women. To examine associations between the different variables the authors used multiple regression analysis. The

findings overall showed high prevalence of mental health ill-health, including high depressive symptomatology among both women and men, substance and alcohol abuse among men and PTSD symptoms in both women and men. In the regression analysis, severe partner violence and non-partner rape and war trauma were associated with PTSD symptoms among women. Among men, PTSD symptoms were associated with war trauma. Severe partner violence and non-partner rape were also associated with depressive symptoms and alcohol abuse among women. Among men, depressive symptoms and drug abuse were associated with conflict impact. Moreover, enduring conflict impact was associated with perpetrating past-year rape and physical and/or sexual IPV. The overall study pointed to multiple effect pathways, with exposure to war increasing the risk of PTSD symptoms, and the latter, in turn, depressive symptomatology that was associated with alcohol and drug abuse or suicidal thoughts. Moreover, the authors found that the enduring impact of conflict increased the risk of perpetrating rape and physical and/or IPV.

A study conducted in Northern Ireland and published in 2020 by Travers and colleagues examined relationships between multiple traumas (childhood trauma, conflict-relate trauma, or both), mental health problems, and five indicators of domestic violence perpetration severity, including sexual violence (Travers et al., 2020). The authors relied on case file data for 405 perpetrators, which they analysed using binary logistic regressions. In order to assess the effects of accumulated trauma, the authors controlled for numerous individual characteristics, including mental health history and substance abuse. The logistic analyses established that each additional trauma was associated with 24% higher odds of causing injurious IPV and 28% higher odds for perpetuating sexual violence. The authors could not establish a direct link between conflict-related trauma and violence perpetration severity, which could be explained by the construction of their model and how the authors assessed conflict-related trauma. For instance, respondents were not asked about proximity to or severity of conflict-related violence. The results could also mean that there is a mediating factor between conflict-related trauma (e.g. substance abuse, family disintegration) and injurious violence at home.

Women's perceptions and experiences

In 2008, Usta and colleagues investigated the effects of the July 2006 conflict that erupted between Hezbollah and the State of Israel to understand personal experiences of violence and coping mechanisms (Usta et al., 2008). The study involved 310 women recruited from Ministry of Social Affairs Centers (MOSA) located in six geographic areas that had varying degrees of exposure to the conflict. The questionnaire that was administered showed that 89% of the respondents had been displaced from their homes due to fear of conflict. Of all the respondents, 39% had at least one encounter with combatant violence, 27% had at least one incidence of violence at home during the conflict, and 13% had at least on incidence of violence by husbands or other relatives after the conflict. Mental ill-health was associated both with combatant violence and domestic violence during and after the conflict. Women also reported different coping responses, which associated with their likelihood of experiencing domestic violence during the conflict and reporting mental ill-

health. Women who did not know how to cope or tried to forget their experiences were more likely to report domestic violence during conflict and mental ill-health after.

A 2014 study published by Horn and co-authors explored women's perceptions of the causes of IPV in Sierra Leone and Liberia, and the ways in which women related these causes to their experiences of war (Rebecca Horn et al., 2014). The study comprised of 14 focus group discussions and 20 individual interviews in two locations in Sierra Leone and two locations in Liberia. The interview analysis suggested that respondents considered that previous violence had left an impact on men, both those had witnessed violence and those who committed it. Women felt that men who had committed violence, including assaulting women sexually, were more likely to become violent and be disrespectful to women. Respondents spoke about men abusing drugs during the war, which some continued after the war, which was linked to some violent behaviour. It was thought that those who had not perpetrated war violence, but had witnessed it or experienced the loss of relatives were more likely to become violent because of lower tolerance for additional stresses. Traditionally in both societies, men were expected to be breadwinners, but the war had resulted in many women's economic independence. Some respondents thought that this had reduced domestic violence because it took some stress off men's shoulders. Overall, the authors reported that while no individual woman directly considered the war a cause for her spouse's violence, it was unanimously agreed that the war had impacted on IPV.

A more recent study published in 2020 by Mannell and co-authors examined and presented Afghan women's experiences of domestic violence to explore relationships with conflict (Mannell et al., 2020). Semi-structured interviews were held with 20 women living in safe houses. The authors identified three themes in the interviews that suggest possible connections between conflict and domestic violence, namely: violence from loss of male support, violence due to men's substance use under the booming drug trade during the conflict, and violence as a result of women's vulnerability due to poverty resulting from conflict. As a result of conflict, women lost male relatives and consequently the protection of male guardians that made them more vulnerable to forced marriages, IPV, neglect, psychological or other forms of abuse. The study demonstrated the interdependent nature of the public and private sphere, with women's lived experiences of domestic violence being directly informed by society-wide conflict, poverty and other changes caused by war.

Responses and interventions

A 2015 study published by Kohli and co-authors examined risk factors, individual and family consequences and community-driven responses to IPV in eastern Democratic Republic of Congo following conflict that had lasted over 18 years (Kohli et al., 2015). This was a qualitative study that involved 13 female survivors and 5 male perpetrators of IPV in 3 villages in South Kivu Province. As in other studies, some female participants reported men's problems with alcohol abuse, which they reported was encouraged through peer pressure in the post-conflict environment. Women also spoke about men judging women as disobedient and men needing to reaffirm control in the

household. The participants of the study spoke extensively about the breakdown of traditional, community institutions and support systems, economic deprivation and financial stresses resulting from the war and a lack of local leadership that made difficult the alleviation of the problems they discussed.

A study from Sri Lanka published in 2017 by Guruge and co-authors explored women's experiences of and responses to IPV, how health and social service providers perceived the problem and what IPV-related services and support systems were available after the end of the 30-year civil war (Guruge et al., 2017). The study involved qualitative interviews with 15 women who had experienced IPV aged 18-55 and 15 service providers in the Eastern Province of Sri Lanka. In addition to finding that physical, sexual and psychological IPV were all pervasive forms of violence that women experienced, the authors reported that this was a 'hidden' problem. IPV affected women of all backgrounds, but it was believed that Tamil and Muslim women were disproportionately affected due to war dynamics and trauma and restrictions experienced by women under Muslim laws (e.g. around marriage). Some providers thought that perpetrators may have become used to violence because of the war, with violence becoming normalised. Some women thought that men's inability to provide as breadwinners caused conflict, which could lead to violence. In general, women hesitated to leave abusive relationships due to the risk of community violence, for fear of becoming outcasts by the wider society if they separated/divorced and a perceived lack of support systems.

Sexual and gender-based violence studies in refugee camps, displaced contexts or migrant communities

Studies on sexual and gender-based violence (SGBV) in refugee camps, displaced contexts or migrant communities included both qualitative and quantitative studies. Qualitative studies described GBV types, contexts and perpetrators among female refugee populations (Wirtz et al., 2013, 2014); explored factors impacting on domestic violence in refugee settings (Zannettino, 2012); described the lived experiences of marital and stranger violence among displaced Syrian women in Lebanon (Usta et al., 2019); documented SGBV experiences by refugee women from Syria and Afghanistan (Al-Natour et al., 2019; Freedman, 2016); and explained the effects of war and displacement on spousal relations in the aftermath of genocide among Darfur refugees in Cairo, emphasising the need for mental healthcare (Meffert & Marmar, 2009). One study attempted to related conditions in a refugee camp in Kenya and humanitarian responses related to how domestic violence was experienced in the camps.

Quantitative studies examined the prevalence and measurement of SGBV in refugee camps and humanitarian settings (Stark et al., 2010; Feseha et al., 2012; KL et al., 2013), women's knowledge and disclosure patterns and the validity and reliability of secondary reporting of GBV in conflict and disaster-affected settings (Stark et al., 2020); and associations between pre-migration political violence exposure and past-year IPV perpetration among immigrant men in Boston (Gupta et al., 2009). Additionally, numerous ystematic reviews evaluated strategies and approaches that could prevent and manage GBV and its health consequences in refugee or displaced populations (Asgary et al., 2013); the effectiveness of interventions, programmes and strategies recommended by humanitarian organizations for GBV prevention in refugee settings (Tappis et al., 2016); the magnitude of GBV in emergency settings (Stark & Ager, 2011); and the predictors of household violence in humanitarian emergencies (Rubenstein et al., 2020).

Prevalence, types and predictors

In terms of frequency, a systematic review of studies on prevalence rates of GBV in complex emergencies found that IPV rates ranged between 3% and 52%, which were higher than most of the rates of wartime rape and sexual violence perpetrated by strangers (Stark and Ager, 2011). The authors also reported that numerous studies agreed that GBV increased in war-time for incidents outside of the home. A study that examined associations between pre-migration political violence exposure and past-year IPV perpetration among immigrant men in Boston reported that 20.1% of the sample had exposure to political violence and IPV perpetration and established that men with exposure were more likely to perpetrate IPV than those who have no exposure to such violence (Gupta et al., 2009).

A study published by Stark and co-authors measured incidence rates for gender based violence in camps hosting internally displaced persons (IDPs) in Northern Uganda using a "neighbourhood

methodology," in which adult female heads of household reported on their own, their sisters' and their neighbours' experiences (Stark et al., 2010). Findings were based on interviews with 204 respondents, who reported about themselves, 268 sisters and 1,206 neighbours. The reports produced estimates of overall incidence of IPV in the past year of 51.7% (95% CI 44.8 to 58.7; respondents), 44.0% (95% CI 41.2 to 46.9; respondents' sisters) and 36.5% (95% CI 30.7 to 42.3; respondents' neighbours). The authors also estimated the incidence of forced sex by husbands, which was 41.0% (95% CI 34.2% to 47.8%), 22.1% (95% CI 17.0 to 27.2) and 25.1% (95% CI 22.5 to 27.6) respectively. Lastly, rape by a perpetrator other than an intimate partner was estimated at 5.0% (95% CI 2.0% to 8.0%), 4.2% (95% CI 1.8 to 6.6) and 4.3% (95% CI 3.1 to 5.5) respectively. The authors stressed, thus, the existence of a combination of forms of violence among IDPs, with IPV being considerably more prevalent than stranger sexual violence.

A study published in 2012 by Feseha and colleagues, in turn, assessed the magnitude of intimate partner physical violence and associated factors among women in Shimelba refugee camp, Northern Ethiopia (Feseha et al., 2012). The research team combined a survey in seven zones of the refugee camp with descriptive, bivariate and multivariate logistic regression analyses where applicable. They found that the prevalence of physical violence in the last 12 months and lifetime was 25.5% and 31% respectively. In terms of risks factors, the authors reported that the likelihood of experiencing intimate partner physical violence was higher in Muslim and Catholic followers than Orthodox adherents (OR =2.8 [95%C.I: 1.6,5.0]) and (OR = 2.4 [95%C.I: 1.2, 4.5]) respectively, higher among women with a farmer occupation (OR = 5.6 [95%C.I:2.3, 13.2]) and higher among couples who had arranged their relationship between them than those who had families' support (OR = 2.0 [95%C.I: 1.3, 3.3]).

A qualitative study by Wirtz and co-authors on the development of a screening tool to identify female survivors of GBV in Addis Ababa and three refugee camps in Jijiga, Somali Region, hosting migrants from the Democratic Republic of Congo (DRC), Burundi, Rwanda, Sudan, Somalia and Eritrea, as well as the host country (Ethiopia), reported occurrence of psychological violence, rape, gang rape, sexual coercion, abduction, physical violence and domestic violence (Wirtz et al., 2013). Perpetrators included both unknown individuals (armed actors, strangers in the host country and the country of origin, in transit) and known individuals (husbands, family member and relatives, neighbours, other camp residents, and even religious and authority figures and humanitarian staff).

A 2013 study by Falb and co-authors documented the prevalence and characteristics of conflict victimisation and its associations with past-year IPV among refugee women affected by the protracted conflict in Burma (Myanmar) located at the Thai-Burma border (KL et al., 2013). The research team conducted a cross-sectional survey with 861 women, finding that 9.6% of partnered women reported conflict victimisation and 7.9% of women reported experiencing past-year IPV. Further analysis showed that women who experienced conflict victimisation were 5.9 times more likely to report past-year IPV than women who had not experienced conflict victimisation (95% confidence interval, 5.0-6.9).

Another qualitative study by Wirtz and co-authors published in 2014 identified the range of GBV experiences, perpetrators and contexts in conflict and displacement in Colombia (Wirtz et al., 2014). The authors held in-depth interviews with 35 GBV survivors and focus group discussions (FGDs) with 31 service providers. In addition to GBV, including rape and violence against family members, perpetuated by armed forces, and opportunistic violence perpetuated by strangers, violence experienced included physical and sexual IPV. Other forms of reported GBV included partners' control of a woman's reproductive decisions, including forced sex, forced abortions, partner control over contraceptive use and use of physical violence during pregnancy.

IPV among refugees, internally displaced populations and migrant families was described as a result of emotional distress, changes in gender roles, shifts in family power structures and male unemployment in post-conflict time (Meffert & Marmar, 2009; Zannettino, 2012). Other studies spoke of women feeling abandoned and isolated in the aftermath of war-related violence, which was also associated with under-age marriages in refugee camps (Newbury & Baldwin, 2000). IPV victims were reported to be reluctant to leave their abusive husbands, to report the abuse and to use humanitarian services. Reasons included perceived and experienced stigma, reliance on social/economic/security support from husbands, lack of awareness of services, and fear of the risk children being kidnaped while mothers sought services (Al-Natour et al., 2019; Wirtz et al., 2013; Horn, 2010).

In a 2016 paper Freedman documented the various forms of SGBV experienced by women refugees to Europe, pointing to new forms of GBV experiences during flight and at destination points (Freedman, 2016). The study took place in Greece, Serbia and France and involved interviews with 40 women and 20 men. The findings indicated that the conditions for reception of refugees both created new forms of GBV and exacerbated existing violence, such as domestic violence / IPV. The paper spoke about increasing numbers of women attempting journeys alone or with children, often due to fleeing war violence at home, which increased their vulnerability to new forms of violence during their journey and when they arrived at destination points. Reception facilities were reported as lacking adequate accommodation, while women could face harassment by male police officers. Moreover, due to rigid refugee policies and closed borders, smugglers multiplied and this increased risks for new forms of violence.

A systematic review published in 2020 sought to identify predictors of interpersonal violence in the household in humanitarian settings (Rubenstein et al., 2020). The authors analysed the results from 33 studies that met the inclusion criteria. The review highlighted several predictors common to both violence affecting women and violence affecting children, namely: conflict exposure, alcohol and drug use, income, economic status, mental health/coping strategies, and limited social support. However, the authors noted the need for more longitudinal research and experimental designs to establish better causal mechanisms and temporality, calling for integrated approaches that are regularly evaluated.

Women's perceptions and experiences

Zannettino (2012) explored the factors that impacted on domestic violence in Liberian refugee communities settled in South Australia. The author employed a qualitative approach, holding 17 FGDs with female participants. The study reported that women's perspectives pointed to domestic violence in the refugee community being shaped and reinforced by cultural, socioeconomic, familial and individual factors. It noted the influence of 'culture' in the exacerbation of the problem, including: disruptions to traditional gender roles; beliefs that minimised rape in marriage, with rape being understood in terms of its perpetration by a stranger; acceptability of using violence within the family for child discipline and chastisement; and men feeling threatened by a lack of control over the family finances or providing as breadwinners, leading to the use of violence to reassert power and control. Women also expressed beliefs that seeking help for domestic violence might bring shame to the family or harm their partners. Most of the participants had either witnessed or experienced war-related violence and thought that experiences of war and conflict had had a major impact on domestic violence, causing a breakdown of family structures, affecting children, and many other stressors affecting the behaviour of men.

Another study explored Syrian refugee women's experiences of violence in Lebanon (Usta et al., 2019). The study was part of a rapid needs assessment carried out with the United Nations Population Fund (UNFPA) and comprised of FGDs with 29 Syrian women in NGO community centres in Lebanon. Overall, women reported IPV, which they associated with men experiencing stressors in the host environment, harassment, and community violence. They spoke about difficult living conditions due to crowding and a lack of privacy, unemployment and poverty. They also found the children hard to manage, who were constrained from playing outside or faced harassment in the host society, which made the children stressed and irritable. Numerous coping strategies were reported by the women, such as not speaking back and keeping a low profile, letting go of IPV-related stress by beating their children, or finding solidary in other members of the community. The women also referred to problems regarding the aid they received from humanitarian services, expressing beliefs that these provided help haphazardly or with discrimination that reinforced or created new power hierarchies in the community, or divided people by religious affiliation.

In 2019, Al-Natour and co-authors described the lived experience of Syrian refugee women with marital violence during the Syrian civil war, under the premise that marital violence increases during war (Al-Natour et al., 2019). The authors conducted 16 semi-structured interviews with displaced Syrian women in displacement centres in Jordan. Participants were aged between 22 and 68 years old, were financially dependent on their spouses and identified with the Islamic faith. The authors found that women felt loss and insecurity and experienced many stressors and hardships as a result of the flight from Syria and the resettlement in refugee camps. The women referred also to their husbands' changed behaviour following the war, with many becoming easily irritable, nervous or verbally abusive. They also found that women often responded to abuse by being silent and enduring, hoping that this might end it. They endured in the hope that their husbands might change, because of their children or because they needed the social support of

their husbands and family relatives in the refugee community. As coping strategies, women often found recourse to their faith, tried to appease their husbands or focused on protecting their children from marital conflict.

Responses and interventions

Horn (2010) explored how refugees in Kakuma refugee camp in north-west Kenya experienced IPV in an effort to relate the conditions in the camps with the problem of domestic violence. The study relied on qualitative data collected through focus group discussions with 157 refugees from various nationalities, including Sudanese, Somali, Ethiopian, and Congolese. The study found that numerous 'nested' factors contributed to an exacerbation of domestic violence in the refugee camps, recommending that humanitarian responses be designed to reduce the likelihood of domestic violence. The paper noted that responses in refugee camps that caused dependency of populations on local agencies or sought women's empowerment without engaging men and their conditions were associated with domestic violence. The paper acknowledged the importance for responses that understood how individual, family, community, socio-economic and systemic factors contributed to domestic violence in refugee camps, identifying the need for multi-dimensional approaches that recognise the difficult of bringing change, such as in cases of men with antisocial behaviour or other psychological issues that require more complex remedies. Overall, the author stressed that pursuing only women's empowerment while neglecting relationships dynamics and how displacement affects men has mixed results and can, in fact, undermine positive change.

Asgary and colleagues published a systematic review of studies on the prevention and treatment/management of GBV among refugees and internally displaced populations (Asgary et al., 2013). This noted that most of strategies and programmes being used for prevention and management of GBV in humanitarian services are "expert recommendations" by the UNHCR, Inter-Agency Standing Committee (IASC), the WHO, Women's Commission for Refugee Women and Children and the International Rescue Committee (IRC) rather than the result of primary research with actual displaced populations. In general, high-level recommendations focused on outlining strategies for preventing and / or treating the health consequences of GBV and emphasised the need for women and communities to take an active role in risk identification, prevention and interventions. Some of the reasons for this reliance on technoscientific directions rather than context-specific evidence included: a) GBV being underreported; b) poor quality of data on GBV due to the volatile nature of the refugee setting affecting by refugee mobility and threatened by ongoing violence; and c) service providers working in these contexts lacking the technical expertise necessary to conduct rigorous research as feasible in academic/research-intensive institutions.

War violence and family violence studies

Studies on war violence and family violence comprised mostly of quantitative studies with a focus on family relations in post-conflict communities, including the association between parents' experience of war trauma and children's health and safety and between IPV and patterns of harsh parenting. More specifically, studies investigated prevalence rates and predictors of family violence in post-conflict contexts (Rieder & Elbert, 2013), war experiences of children and extension of their experience to family violence (Catani, Jacob, et al., 2008; Catani, Schauer, et al., 2008; Saile et al., 2016), predictors of psychopathology among post-war children (Saile et al., 2014, 2016), variables associated with the experience and perpetration of child maltreatment in post-conflict families (Sriskandarajah et al., 2015), and family violence as an extension of PTSD symptoms and different types of violent behaviour in veterans (Sullivan & Elbogen, 2014). One study explored the interplay between and children's cumulative experience of war, family violence, child labour and poverty (Catani et al., 2009) and another examined patterns of harsh parenting associated with IPV (Rees et al., 2015). Another studied mother/child dyadic regulation and associations with children's wellbeing (Dalgaard et al., 2020).

A study from Southern Rwanda examined prevalence rates of child abuse in the post-genocide context and whether family violence associated with depression and anxiety in descendants (Rieder & Elbert, 2013). The research sample include 188 randomly selected child-parent pairs from the Southern Province of Rwanda and the administration of diagnostic questionnaires for PTSD, child maltreatment and depression symptomatology in descendants. Participants were eligible if they were genocide survivors or former prisoners accused of committing genocidal violence. Descendants were defined as child and adolescent genocide survivors and born after 1994 between 13 and 15 years old. The study found that mean scores for child maltreatment were 32.6 (SD8.6, range 25-74) for the parent generation and 33.3 (SD7.7, range 25-103) for the descendants, with descendants born before 1994 reporting higher levels that those born after. Regression analysis further established that child maltreatment correlated strongly with exposure to war and trauma (ρ=0.35, p<0.001), economic status/poverty (ρ=0.30, p<0.01), parents' exposure to childhood maltreatment (ρ=0.21, p<0.001), and parents' PTSD symptoms (ρ=0.21, p<0.01). Additionally, descendants of poor physical health, who had exposure to war and genocide, and whose parents' manifested PTSD symptoms were likely to show increased levels of depressive and anxious symptoms.

A study that assessed domestic violence against children in Afghanistan and Sri Lanka found that the war violence experienced and witnessed by children continued as domestic violence in the post-war period by fathers, mothers and older siblings (Catani, Schauer, et al., 2008). A study involving school children from Afghanistan reported that 41.6%, 59.9% and 37.8% of children were being beaten by the father, the mother and older sibling respectively, uncovering also extensive child labour involving half of the boys and a third of the girls (Catani et al., 2009). A study from post-conflict Sri Lanka involving Tamil children, mothers and fathers found that children were more likely to report victimisation if they had been exposed to mass trauma and if children manifested

psychopathological characteristics (Sriskandarajah et al., 2015). Moreover, maternal violence toward children associated with mass trauma, family violence and IPV, whereas paternal violence towards children associated with all types of trauma

A study from with veterans who had been deployed to Iraq and Afghanistan found a significant relationship between PTSD symptoms (flashbacks, numbing, anger, being physically reactive to a reminder, and being on guard/hyper-vigilant) and perpetration of violence against children (Sullivan & Elbogen, 2014).

A study noted a link between IPV and experiences of explosive anger amongst mothers in post-conflict Timor-Leste, associated with harsh parenting (Rees et al., 2015). The study relied on qualitative interviews with 77 mothers followed by a focus group with service providers. According to the analysis of the data collected, women referred to the pressures they faced in marriage, such as unrealistic expectations that men had from women and men's drunkenness associated with men's expressions of jealousy or demeaning attitudes towards wives. Women associated these and other pressures, such as the expectation to constantly care for many children, with heightened levels of anger amongst women, which they associated with being harsh with children.

In a study from post-conflict Northern Uganda, Saile and co-authors investigated distal and proximal risk factors of child victimisation, including family violence against children, childhood victimisation among guardians, war-related trauma, PTSD in guardians, depression in guardians and alcohol abuse (Saile et al., 2014). The study comprised of an administration of standardised questionnaires with 368 children, 365 female guardians and 30 male guardians. According to the analysis of the data, the strongest predictors of aggressive parenting were guardians' own childhood maltreatment, female guardians female guardians victimisation in intimate relationships and male guardian's PTSD. Children were more likely to report victimisation if there was violence among adults in the household, whereas male guardian's PTSD symptom severity predicted higher levels of maltreatment. The authors speculated that given a strong association between war violence and women's IPV, and children's own victimisation with violence between adults, addressing women's IPV might have a remedial effect on child maltreatment in post-conflict contexts.

In a later study, Saile and co-authors sought to examine the effect of ecological risk factors and intergenerational risk factors in guardians on children behaviour problems, depression, and posttraumatic stress symptoms in post-conflict Northern Uganda (Saile et al., 2016). This was a cross-sectional epidemiological study involving 513 second-grade students and their female guardians, which used a two-generational design to control for ecological and intergenerational guardian variables that could covary. The study found that exposure to traumatic events in the community, more violence experienced and witnessed within the family, and lower child-reported care from female guardians independently predicted psychopathological symptoms in children.

A recent study explored mother/child dyadic regulation and mothers' and children's psychosocial adjustment levels in traumatised refugee families affected by family violence (Dalgaard et al.,

2020). Among other questions, the authors sought to understand better the relationship between affected mother's caregiving with respect to attachment styles and children's wellbeing, as well as relate maternal symptoms of anxiety, depression of PTSD to children's dyadic adjustment and wellbeing. Families were recruited from a family violence rehabilitation centre for refugees in Denmark. The procedure involved the administration of the Marschak Interaction Method (MIM), which is a play-based observational method consisting of nine tasks that allows therapists to observe parent-child interactions. According to the qualitative analysis of mother-child interactions during the test, the majority of dyads showed problems of dyadic functioning, and in some cases it showed clearly dysfunctional mother behaviour. The majority of mothers in the study manifested clinical symptoms of PTSD, depression and anxiety. However, surprisingly, the study found that children's subjective wellbeing was less directly linked to maternal symptoms of PTSD, anxiety and depression and children's psychosocial adjustment

Some linkages with culture-specific religious and other beliefs

The review showed that religious and spiritual parameters have received minimal attention in the existing scholarship and should be better integrated when appraising alleviation strategies in conflict and post-conflict contexts and among displaced populations. The resourcefulness of clergy and religious beliefs has not been generally considered or assessed, although reports exist that religious experience and spiritual activity can serve as coping mechanisms. Other literatures, such as those focusing on domestic violence in religious communities or faith-informed approaches to IPV and SGBV in psychotherapy and marital counselling or the sector of international development have more substantively integrated religious beliefs, evidencing the relevance of such approaches to religious populations and communities and their potential resourcefulness in addressing gender-related issues as well.

Among the studies that were reviewed, one from Syria found that IPV female victims used coping strategies that included keeping silent, reading the Quran, fasting, and offering prayers of forgiveness to avoid conflict (Al-Natour et al., 2019). That faith serves as a coping mechanism has been reported also widely in the literature that examines domestic violence in religious communities. In such contexts, female victims may resort to religious beliefs to condemn the abuse and through their ordeals may acquire a more justice-oriented understanding of their faith, helping them to address the harmful situation (Shaikh, 2007; Johnson, 2015; Nason-Clark et al., 2018).

Within the sector of international development, the influence of a religious stakeholders and the need to integrate them in community-based approaches has been widely recognised in recent decades, although the sector still lacks a substantive engagement with religio-cultural worldviews and belief systems in understanding and addressing domestic violence. More critical research conducted previously in Tigray that analysed conjugal abuse in the countryside and the city of Aksum through the religio-cultural framework found that faith helped women to face and overcome difficult situations and painful marital experiences (e.g. separation, divorce or spousal unfaithfulness) and did not generally serve as a source for justifying intimate partner abuse, which the faith clearly taught against (Istratii, 2020). Moreover, the clergy were found to be directly involved in the mediation of conjugal problems and despite some lacking complete awareness of the extent of the problem of conjugal abuse in their societies or not being prepared to support victims and perpetrators with the utmost sensitivity to risks involved, the majority tried to prioritise the safety of the usually female victim and comprised an important resource when other institutions failed to have an impact (ibid).

The study by Saile and colleagues in Northern Uganda that was discussed as part of the current literature review, in turn, made reference to culture-specific beliefs about spiritual activity, suggesting more pernicious implications (Saile et al., 2013). The authors related the problem of women's isolation to beliefs in the local society that re-traumatisation symptoms they experienced

(e.g. flashbacks) were due to evil spirits called ‘cen.’ The authors mentioned that people in the local communities believed that those who had committed atrocities during conflict were possessed; subsequently, those who manifested symptoms associated with spirit possession could be perceived as ‘murderers’ and be abused, isolated or mistreated by people in their surroundings. According to the authors, women identified with ‘cen’ possession could also be abused by partners who might fear them and employ aggression to control them.

The aforementioned study by Doyle and McWilliams reported, in turn, important influences of the participants’ religious identity (Doyle & McWilliams, 2018; 2020). In 1992, as opposed to 2016, IPV victims were more concerned about the reactions of the clergy and their responses to the abuse they faced was more directly shaped under the influence of religious standards and expectations upheld by the wider society. Despite such attitudes weakening over time, the authors found that IPV victims in 2016 still experienced consequences that were underpinned by rigid religious standards, such as stigma or fear of being judged for being a single parent, divorcing their (abusive) spouses, or having children from different fathers. According to the authors, 45% of interviewed women in the 2016 cohort expressed such concerns and attitudes, which seemed to interfere with them reporting the abuse or seeking to exit their harmful situations. Lastly, in relation to services provision, many of the interviewees felt that GPs were not responding appropriately to their problems and that social workers were mostly concerned with child welfare as opposed to women’s conditions. There was, however, a 37% increase in respondents’ positive appraisals of police support. Still, respondents felt that police were not equally responsive to psychological abuse and did not always enforce protection orders appropriately.

Key messages and implications

Albeit a partial and rapid engagement with the available literature on war violence, domestic violence and migration, the study provides important directions to inform the project's ongoing work on domestic violence in Tigray and to guide also humanitarian responses in the region as the conflict is still ongoing. The reviewed studies evidence that the consequences of war-related violence should not be understood in isolation from previous trauma, such as that associated with childhood abuse or parental IPV. On the other hand, the consequences of war-related violence will continue for many years following the end of the conflict, through intergenerational, structural, normative and psychological mechanisms. Responses to conflict-related violence in humanitarian settings must therefore consider the socio-cultural framework in which political violence erupts, the individual trauma history of the victim/survivor and the nature of war violence itself in order to understand the complex consequences and to provide support that can both address the immediate needs of war-related violence and proactively prevent further abuse in domestic and communal spheres in post-displacement or post-conflict time.

Moreover, any intervention or response should understand and be contextualised in the affected communities' socio-cultural frameworks and how they define and experience violence in their contexts, as opposed to applying theorised definitions of GBV that may obscure other contextually salient forms of violence. While domestic violence intersects with conflict-related SGBV and should not be approached in isolation from the latter in humanitarian settings, as feminist perspectives on war violence would argue, there is value in differentiating domestic violence / IPV from conflict-related SGBV to consider their distinct aetiologies. There is no doubt that gendered asymmetries are in most cases conducive to domestic violence, but they do not provide a full aetiology for it, which may have additional or more salient psychological and material underpinnings; therefore. applying the GBV aetiology to IPV without context-specific analysis could misguide in identifying appropriate approaches to address the problem (Istratii 2020). Moreover, treating these issues as one and the same can miss the important relationship between SGBV and IPV, which are interlinked and may reinforce one another in complex ways, as seen in the extensive studies of conflict violence and IPV reviewed in this working paper.

The provision of so-called psychosocial services in humanitarian settings must consider these distinct aetiologies and the factor of accumulated trauma that may require a combination of community-wide measures with individual-specific psychological/clinical support. To achieve this, however, as Miller and co-authors have suggested, the meaning and usage of the term 'psychosocial' needs more conceptual clarity (Miller et al., 2021). As opposed to the broad and sometimes vague usage of the umbrella term 'psychosocial services' in humanitarian discourse, interventions may be classified as socio-environmental and clinical to evidence the different types of needs, aetiologies for the problem or causal mechanisms and specialisations involved. The authors define the two types of approaches as follows:

> *Clinical interventions prioritise the role of intrapersonal variables, biological and/or psychological, as mediators of change in the treatment of distress. Social-environmental interventions emphasise the role of social determinants of distress and target factors in the social and material environments in order to lower distress and increase resilience in the face of adversity. Both approaches play a critical role in humanitarian settings.* (Miller et al., 2021)

The authors evidence that these do not need to contradict each other and can proceed complementarily. On the basis of the earlier discussion regarding the restrictions of top-down, agency-guided recommendations for humanitarian responses, such strategies should be ideally delivered informed by expert diagnoses and data collected through rigorous research.

Lastly, the review sufficiently evidences that any intervention or response must understand and be contextualised in the affected communities' culture-specific religious or other normative systems, which may amplify or alleviate consequences of war-related violence in complex ways. In general, humanitarian responses, including SGBV approaches, do not appear to have engaged substantively with the religious worldviews and spiritual experience that are important to many communities and individuals, and this may have interfered with a proper understanding of local normative frameworks and their complex influences on human attitudes and behaviour, but also the resourcefulness of these. As was mentioned, religious beliefs could serve for affected individuals, including SGBV survivors, as sources of coping and, potentially also improved mental health. On the other hand, culture-specific beliefs about spiritual activity may inform community behaviour in such ways that prove negative for ex combatants or victims of war-related violence. Lastly, humanitarian responses must consider how family and social structures broken during conflict might be restored to prevent domestic and communal forms of violence during or after the conflict, including IPV, and to support victims/survivors by better-integrating religio-cultural parameters important to them.

Applying the evidence to the Tigray crisis

The humanitarian agencies coordinating or supporting the GBV response in Tigray have focused on providing immediate support to victims of SGBV arriving to refugee camps and other displaced contexts, such as through the provision of dignity kits, and psychosocial support and case management for GBV survivors and women and girls at risk (UNHCR Ethiopia, personal communication, January 21, 2021). Humanitarian responses by UNHCR in Ethiopia have been reportedly guided by the Ethiopia National Refugee Strategy for Prevention and Response to SGBV 2017-2019, whose SGBV response incorporates individual case management, provision of material support, referral to physical protection, medical and psychological services, and where available legal services (Ethiopia National Refugee Strategy, n.d., p. 3). These agencies have worked with numerous international implementing partners on the ground, as well as existing regional and local women's organisations and resources to support SGBV victims and survivors.

While these responses are vital, humanitarian agencies are faced with restrictions and challenges, including the limited ability to provide comprehensive medical and psychosocial support to victims and survivors due to reasons that include an insecure environment and inaccessibility to those who need aid the most and a lack of specialised professionals (van Dongen, 2021). The Ethiopian National Refugee Strategy also reports that often capacity to train social workers in supporting/counselling victims is missing (Ibid). The current review evidences the urgency to leverage on both social-environmental and specialised clinical methodologies in order to address cumulative and complex trauma in war-affected populations. It seems important for humanitarian responses to deploy personnel who can rapidly respond to the immediate needs of victims/survivors of war-related violence, and who can train local or regional social workers to reach more populations, as well as professional psychologists and counsellors with highly specialised training to address more complex cases of individual trauma.

All humanitarian agencies seem particularly aware of the need to strengthen SGBV referral pathways, acknowledging that this may require a better integration with national services and collaboration with providers already supporting victims of IPV and SGBV within the country and the region of Tigray (UNHCR Ethiopia, personal communication, 21 January 2021). A recent presentation by the GBV AoR at UNFPA reported the existence of 10 NGOs and women-led organisations based in Mekelle and operating across Tigray, suggesting that such collaborations are already being pursued (van Dongen, 2021). Additionally, it should be noted that all regions of Ethiopia have zonal, woreda and kebele women's bureaus and associations, which may be still providing services to the best of their capacity despite the threat of war violence and themselves being affected by the conflict.

Humanitarian responses are also concerned about the provision of legal services, with the Ethiopian National Refugee Strategy mentioning the objective to build the capacity of traditional justice and safety system inside the camps on formal legislative procedures, case records and case management, gender sensitivity and the needs of SGBV survivors. It may be noted that in

Tigray region all village units (*tabiya* level) have their own social courts that adjudicate on family issues. The workers, if present in refugee camps and other displaced contexts, could become part of the task force setting up 'mobile courts' or training other community members in this work. Such measures would have to consider, however, socio-cultural and gender-related reasons that may restrict the effectiveness of court workers (who tend to be male and may not eschew gender-related biases) and should equip the latter with the awareness and tools to support SGBV survivors sensitively and appropriately.

What seems to be missing from current responses is any mention of working with religious stakeholders and spiritual parameters both in awareness-creation and in the provision of so-called psychosocial support. The Ethiopian National Refugee Strategy does identify the objective to collaborate with religious leaders on children's issues, but it does not speak of the same integration in SGBV responses. The literature review evidenced that in religious communities, faith can function as a coping mechanism and that this might, in fact, serve as a resource for war-related violence survivors, including SGBV survivors. This insight has immediate relevance to Tigray's deeply religious population. It is common practice for individuals to have a spiritual father, who advises and supports during important life events and problems, including illness and potentially traumatic events. The centrality of the clergy in Tigray, but specially in the countryside, compels the full integration of the clergy in SGBV response strategies, including in IPV responses in refugee camps.

While the clergy can become resourceful in addressing gender-related issues and domestic violence as evidenced in previous research (Istratii 2020; 2021), on which the current work of project dldl/ድልድል builds, it is important to recognise that most members of the clergy will need bespoke training to respond with sensitivity to this new complex situation. Such training should understand and consider the clergy's culture-specific socialisation and their influence in society, their theological training and gaps in knowledge, and their level of exposure to domestic violence safeguarding risks and trauma understanding. An approach that integrates and engages wisely with the clergy would not only leverage on the work that the clergy are already doing on the ground (which still goes unrecognized), but could help to address current gaps in the lack of human resources in the humanitarian response. The timely training of clergy could help towards providing immediate and sensitive support to victims/survivors, with the potential of preventing further re-traumatisation.

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