DOES FAITH MATTER?

Faith engagement, gender norms and violence against women and girls in conflict-affected communities

BASELINE RESEARCH IN ITURI PROVINCE, DEMOCRATIC REPUBLIC OF CONGO

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EXECUTIVE SUMMARY

This report explores the key findings of a baseline quantitative household survey undertaken across 15 communities in Ituri Province in the Democratic Republic of Congo (DRC) in July 2015. The survey was conducted as part of the integrated research component of Tearfund's project 'Engaging with Faith Groups to Prevent Violence Against Women and Girls in Conflict-affected Communities', which is funded by UK aid from the UK government as part of the What Works to Prevent Violence Against Women and Girls? Global Programme.

The project aims to address the underlying root causes of violence against women and girls (VAWG), and particularly sexual violence, by engaging and equipping faith leaders and local faith groups to transform the attitudes, behaviours and social norms within their communities that support gender inequality and enable VAWG.

In total, 769 people were interviewed – 400 women and 369 men.

The survey data shows that overall, the socio-economic indicators for these remote rural communities are low, even for the DRC context, with extremely low levels of education, particularly for women. More than 68% of women reported that they had not completed primary education, and 35.8% had received no education at all, compared to the national figure of 15%.[1] Households did not have electricity and owned very few assets; 67.4% had shared pit latrines (national figures for unimproved sanitation are 46%) and only two out of all 769 participants had a water supply on their property.

The data also highlights the significant reach and prevalence of faith within these communities, where 95% of respondents identified with a religion, of whom 83.4% described their faith as important or very important in their lives, particularly women. Attitudes around gender and social norms, including division of household and domestic tasks, revealed high levels of gender inequality, with the vast majority of respondents (89.9% of men and 81.7% of women) agreeing with the statement that 'men are superior to women'.

High levels of violence were reported within these conflict-affected communities, underlining the urgency of this intervention. Sexual violence was noticeably high in comparison with other contexts, with 38.4% of women reporting sexual intimate partner violence (IPV) in the past year. Experience of non-partner sexual violence (NPSV) within the past 12 months was reported by 20.8% of women who responded, compared to a national estimate of 16%,[2] and a global estimate of 7% for lifetime experience of NPSV.[3] The majority of perpetrators were known, rather than armed actors. Experience of physical IPV in the past 12 months roughly aligned with national averages, with 30.8% of women reporting it (compared to 27% across DRC).[4]

The survey data shows that women's experience of IPV correlated with a range of factors: active faith engagement, being married and holding the belief that a woman can refuse sex were protective factors; but geographical location, her partner's alcohol consumption, and witnessing domestic violence as a child increased a woman's risk of experiencing IPV. Men's perpetration of IPV was linked to increased alcohol consumption and to witnessing domestic violence as a child, while older men and those in employment were less likely to commit IPV.

Women's experience of NPSV was associated with geographical location, increased alcohol consumption, and the type of water source they used (as getting water from protected wells correlated with a much higher risk of experiencing NPSV). The minority of women with post-secondary education were more likely to disclose experience of NPSV, while married women were less likely. Male perpetration of NPSV was linked to increased alcohol consumption, geographical location, and the experience of sexual abuse as a child.

One of the most striking findings was that faith engagement* was consistently shown to correlate with more empowering attitudes for both men and women, and also showed a protective correlation in terms of women's experience of IPV.

* The 'faith engagement' variable combines those who actively take part in services (i.e. not just attend) along with the small number who are in decision-making or leadership positions within their faith group.

These findings underline the importance of interventions to reduce the incidence of violence against women and to empower women in rural DRC. They highlight the potential role for faith-based interventions, since a large number of research participants identified religion as being important in their lives. The findings show the influence of faith leaders, and how within these communities, understandings of scriptures can be used to justify violence, but also show faith engagement can be empowering for women and linked to reduced IPV.

This study provides formative research for an intervention with faith communities in the locality. These baseline findings confirm the reach and importance of faith communities and underline the importance of developing and testing interventions with them, as well as building better understanding of how faith communities can be effectively mobilised and equipped to help prevent VAWG.

BACKGROUND

The context

The Democratic Republic of Congo (DRC) is a country with vast resources, but has suffered from decades of conflict. Instability in the region has led to widespread poverty accompanied by violence, dividing communities and displacing families. The United Nations estimates that there are some 2.7 million displaced people and refugees in DRC and 323,000 DRC nationals living in refugee camps outside the country. It is among the poorest countries in the world and was ranked 176 out of 187 countries in the UN Human Development Index in 2015. Its per capita GDP is among the lowest in the world.[5] Government resources are spread thin, and corruption is rife. In many areas, NGOs or faith communities are the main service providers where the government is absent. The constant cycle of conflict and displacement has exacerbated instability in the country.

DRC was ranked 153 out of 159 countries in the 2015 Gender Inequality Index.[6] Violence against women and girls (VAWG) is a global human rights abuse, harming social and economic development. Sexual violence is a key and too often taboo aspect of VAWG, with severe life-limiting physical, emotional, social and economic impacts for survivors. It is particularly endemic in many conflict-affected environments, including DRC. A study on sexual violence in DRC reports that approximately 1.8 million Congolese women have been raped.[7] According to the Special Representative of the UN Secretary-General on Sexual Violence in Conflict, conflict-related sexual violence is one of the most critical challenges faced by the people and government of DRC.

Tearfund has been working with local partner organisations in eastern DRC since 1989 and is currently operational in the provinces of North Kivu, South Kivu, northern Katanga in Tanganyika Territory, Maniema, and Ituri (where this project is based – see Figure 1 on page 8), areas which have been particularly affected by conflict. Tearfund aims to reach the most vulnerable by focusing on those affected by conflict, displaced and returnee communities, and those living in poverty in isolated and rural areas. This specifically includes people living with a disability and survivors of sexual violence.

Project context

Tearfund's project 'Engaging with Faith Groups to Prevent Violence Against Women and Girls in Conflict-affected Communities' is funded by UK aid from the UK government, under the *What Works to Prevent Violence Against Women and Girls* Global Programme.

This three-year project seeks to engage and equip faith leaders to be catalysts within their communities to address the causes and consequences of VAWG. Tearfund works with local partner HEAL Africa[8] in 15 remote and conflict-affected communities in Ituri Province in DRC (see Figure 1). Quantitative and qualitative research, including this baseline household survey, and an ongoing panel study, is integrated into the project to inform the intervention and to develop an evidence base for evaluating the approach.

Tearfund's project aims to address the underlying root causes of VAWG by working to shift attitudes, behaviours and social norms that support gender inequality and enable VAWG. These norms also contribute to stigma, which limits survivors' access to services and support. Local faith leaders (both men and women) and other local volunteers are being trained to speak out against VAWG and begin to address its root causes within their local communities, from a faith perspective. The project engages men and boys and women and girls in the wider community in transforming harmful concepts of masculinity through a series of ongoing community conversations, facilitated by 'champions' – volunteers trained by the project.

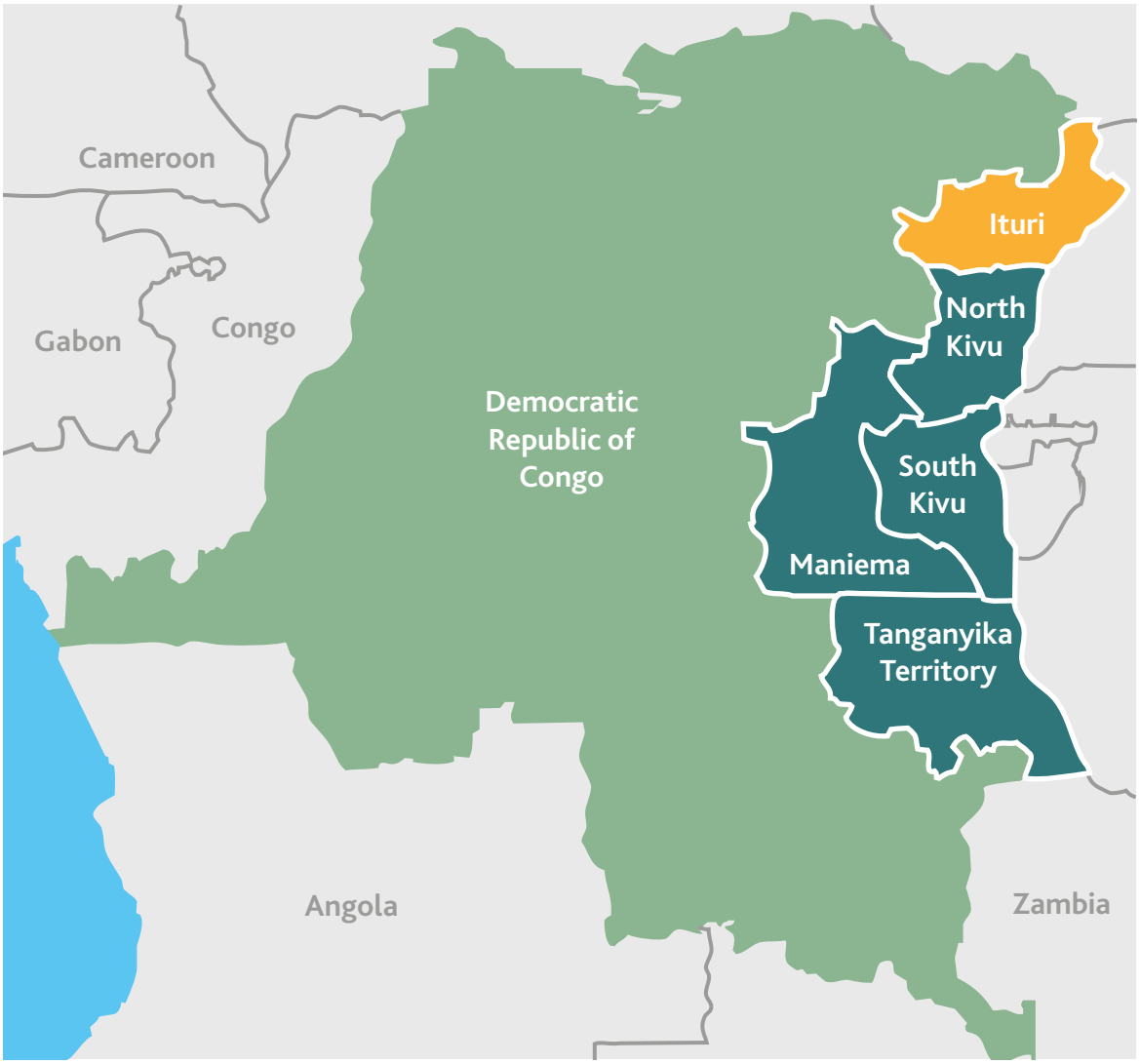
The integrated mixed-method research component of the project is led by Stellenbosch University. Quantitative and qualitative research activities are integrated into the project design throughout for formative research purposes, and to evaluate the impact of the project. The quantitative research is designed by Gamos, and the primary data gathering comprises two household surveys, to be conducted at the start and end of the three-year

programme. The aim of the survey exercise is not primarily to provide representative data on the prevalence of violence, but to explore changes in the desired outcomes (see Annex 1) over the duration of the programme, and to inform programme activities.

The overall project impact will be assessed through an endline evaluation, which includes the second household survey, due to take place across the same locations in early 2018, and qualitative research to enable a more nuanced investigation of the quantitative findings, and to explore the reasons and attribution behind any changes.

This report explores the key findings of the baseline household survey, undertaken across the target communities in July 2015.

Figure 1 Map of Democratic Republic of Congo

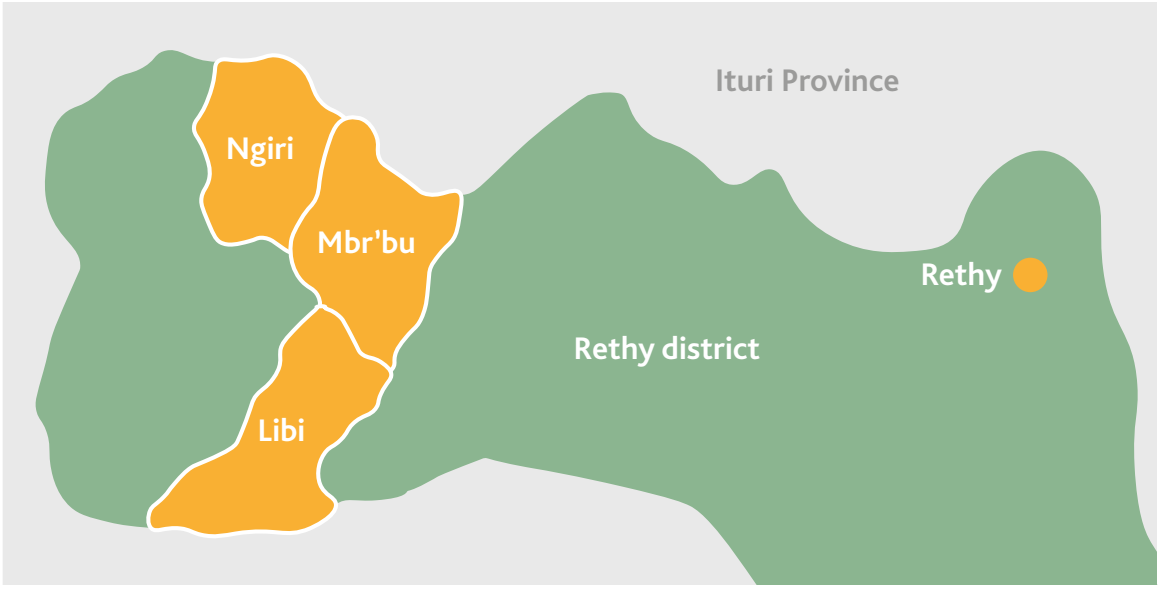


METHODS

Study setting

The study was conducted in three health areas (*aire de santé*) near Rethy in Ituri Province, north-eastern DRC, close to the border with Uganda (see Figure 2). Data was collected from household interviews in the 15 villages where the programme was to be conducted (five per health area), which made up about half of the villages in the area. The target villages were deliberately selected because they have larger populations, and a church or mosque. At the time of the study there were 2,601 households and 13,251 residents in the selected villages.

Figure 2 Map of project area (target health areas in Rethy district, Ituri Province)



Sample

The aim of the sampling was to approach 800 households for interviews with 400 men and 400 women. The sample was divided equally between the three health areas and the five villages in each area. Households were selected proportionate to the number of households in the village. The total number of households was divided by the number of interviews to be conducted to get the sampling interval, and a transect walk was conducted with a random start (pen spun in the middle of the community) and every nth household was approached for an interview. Within each household, the household head or spouse was invited for interview and if they were not available, other household members were selected to supplement the older and younger age groups of the sample. Interviews were conducted with one male or one female member per household. The sample was stratified according to gender (50:50 male: female) and age group. An age stratification guide was based on rural age distributions from the 2013 Demographic and Health Survey (DHS). The eligibility criteria required study participants to be aged 18 and over but the final age range was 15–75 years, with 18 interviews conducted with participants under the age of 18, of whom six were married.

A total of **769 interviews were held, with 400 women and 369 men**. Interviews were conducted face to face with a sex-matched interviewer, and part of the questionnaire (sensitive questions on experience/perpetration of violence) was self-completed by participants. The questionnaire was prepared in French and administered in local languages (mainly Kilendu). Enumerators went through the questionnaire together during training to agree how questions should be asked in local languages, and they also practised in local languages.

The survey was administered using tablets loaded with the FormAgent Android app, which enables enumerators to enter data directly into digital format in the field. Once the questionnaire was completed in the field, the enumerator tapped the 'submit' button and the data was either uploaded to the server or saved on the device if no internet connection was available at the time. The supervisor of each team was equipped with a mobile wireless router (MiFi). When enumerators met with their supervisor in the field, and the MiFi was switched on, stored files were uploaded to the server.

Questionnaire

The questionnaire was based on previous experience and existing literature, and included some standard questions and measures used in research on VAWG and agreed with the What Works consortium. All participants were asked about their village, household, social and demographic characteristics, and religiosity. They were questioned about beliefs and attitudes relating to gender equality and women's empowerment, especially as they pertain to intra-household dynamics, ideas of masculinity, and the treatment of survivors of rape. They were asked about their actual behaviour within intimate partner relationships around roles, decision-making, communication and violence.

In order to identify respondents who had experienced or perpetrated violence, the questionnaire incorporated a set of standard questions on experience of intimate partner violence (IPV) from a male partner, which includes acts of both physical and sexual violence. To conform to ethical guidance, the questions on personal experience of violence (women) and perpetration or experience of violence (men) were all self-completed by the participant, without the interviewer being able to see their responses. These questions were asked of all respondents who were married/living with a partner, or had had a relationship in the last 12 months.

The questionnaire also included questions on emotional violence (threats, humiliation), drawn from the DHS domestic violence module.[9] Questions for women about physical and sexual violence were based on the World Health Organisation (WHO) multi-country study questions; the UN multi-country study on men and violence in Asia and the Pacific formed the basis of questions for men.

Women were asked 'How many times has your husband/partner done the following things to you in the past 12 months?' To determine emotional IPV, the list included: 'Belittled or humiliated you in front of other people?'; and 'Threatened to hurt you or someone you care about?' To learn about physical IPV, the list included: 'Pushed you, shaken you, or thrown something at you?'; 'Slapped you or twisted your arm?'; 'Hit you with his fist or with something else that could hurt you?'; 'Kicked you, dragged you, beat you, strangled you or burned you?'; and 'Threatened you or attacked you with a gun, knife or other weapon?' To determine sexual IPV, women were asked: 'How often has he physically forced you to have sexual intercourse when you did not want to?'; 'In the last 12 months, how many times have you had sex with him because you were frightened he would become violent?'; and 'Did he force you to do sexual things which you didn't want to do?'

A woman was considered to have experienced physical or sexual IPV if she had experienced any act on one or more occasions. The combined variable captured women who had experienced any act of physical IPV or any act of sexual IPV or both in the past 12 months. Men were asked the same questions on IPV as women, but the wording was altered to measure perpetration.

The questionnaire also included questions on acts of sexual violence from, or perpetrated against, a person who was not a partner. The questions for women on non-partner sexual violence (NPSV) in the past year asked whether 'someone other than your partner/husband forced you to have sex or do something sexual that you didn't want to do (e.g. touching him, touching your sexual parts, your genitals etc)'. Women were also asked whether they had ever experienced NPSV: 'Since the age of 15, has anyone other than your partner/husband (past or present) ever forced you to have sex or to perform a sexual act when you did not want to?'. Men were asked about lifetime perpetration of sexual violence: 'In the past, have you ever forced someone to have sex

or do something sexual with you (e.g. touching, touching private parts, oral sex etc)?' Men were also asked about their childhood experience of sexual violence.

Data analysis and statistics

The completed surveys were downloaded by Gamos and compiled into a dataset. Data was analysed using Stata 13.0. Categorical variables were summarised as percentages, with Pearson's chi-squared tests used to test for statistical significance. Logistic regression models were built to show factors associated with a range of outcomes. In each case the candidate variables were included and backwards elimination performed to retain final variables at $p < \text{or} = 0.05$. Each model included a term for age group and health area. We have only presented the age groups when the term showed statistical significance at one or more levels. We do not present the health area in order to preserve anonymity.

One of the key variables in the analysis is faith engagement. All participants were asked about their religion, their attendance at their religious institution, the importance of faith and their degree of involvement. The response categories for involvement were: I am not engaged at all; I simply attend services; I take part in the services; I take part in decision-making; I am involved in leadership. We categorised faith engagement into a three-level variable, grouping 'I am not engaged at all' and no religion as level 1; 'I simply attend services' was level 2; and level 3 included all responses related to taking part and engagement in decisions/leadership. We tested the variables of religion, attendance and engagement to see which was more predictive of attitudes towards violence and gender and found this to be the faith engagement variable. We have therefore used this as the primary faith-related variable in the analyses.

Ethics and safety

Permission for this research was granted by the Provincial Health Division of Ituri (Ministry of Public Health, Orientale Province), as well as agreed in advance with community leaders in each of the targeted villages. Informed consent (verbal) was required for each person interviewed, and participants had to be over 18 years of age. All interviews followed WHO advice on ethical and safety considerations.[10] Only one interview was conducted per household, and household members who were spoken to for access to a home but not interviewed were not told of the violence questions in the survey. All participants were asked to give consent freely to participate in the interviews and told of the nature of the study. All were told they could skip questions and permission was expressly sought before asking questions on sex and violence. Sensitive questions on experience or perpetration of violence were all self-completed by the participants, so the enumerator did not know the responses to these questions.

The ethical principles and guidelines underpinning this project research, and which formed a key part of the training for the enumerators for this survey, are designed to protect the safety of survivors, as well as staff and the researchers. Following training on ethical principles (respect, confidentiality, consent, safety, Do No Harm, referrals) and two days' training on gender and gender-based violence (delivered by HEAL Africa staff), the enumerators each received a leaflet containing the key points to keep for reference. The leaflet also had the phone numbers of HEAL Africa staff to contact in case any questions or issues arose during the survey. These contact numbers could also be shared with individuals participating in the survey for further referrals as necessary, as it was recognised that local services are limited, particularly in terms of psychological support for survivors. HEAL Africa has professional, trained counsellors, as well as medical services. Details of local clinics were also shared so that the enumerators had information available.

FINDINGS:

1 DEMOGRAPHIC DESCRIPTION

1.1 Overview of sample

The data set comprises 769 respondents, of which 52% (n=400) were women and 48% (n=369) were men. The numbers of interviews were evenly spread across all three geographical areas (Libi, Mbr'bu and Ngiri health areas in Ituri Province), with a similar gender balance achieved in each.

The mean age for men was 31.8 years (range: 16–75), and for women it was 28.7 years (range: 15–67). The sample shows a reasonable correlation to the rural age distributions from the 2013 DHS survey, as shown in Table 1, except that older people (50+) are less well represented, and the sample includes instead a higher proportion of young adults (15–24). Female respondents tended to be younger.

Table 1 Age distribution

Age	Men	Women	Total	DHS[11]
15–24	35.8%	42.5%	39.3%	32%
25–34	29.3%	30.3%	29.8%	25%
35–49	25.8%	22.3%	23.9%	23%
50+	9.2%	5.0%	7.0%	21%

The majority of male respondents identified themselves as the head of the household (63.7%, n=233) and the majority of female respondents as the spouse of the head of the household (46.2%, n=184). Female household heads accounted for 9.2% of the total sample (n=71). Average household size was not large, with the mean size for male respondents calculated as 3.62, and 3.44 for women (range: 1–15).

Table 2 Social status

Social status	Men	Women
Head of household (HoH)	63.7%	17.8%
Spouse of HoH	1.4%	46.2%
Son/daughter of HoH	16.4%	14.6%
Other	18.5%	21.4%

Most respondents, both male and female, were married or cohabiting at the time of the survey (see Table 3.1), although there was a large percentage of women (36.3%, n=145) who had formerly been married but were not when the survey took place. A higher proportion of men than women had never married. Relationship status in the last 12 months differed between men and women, with a higher proportion of women having no relationship during that time. In total, 75.7% of men and 65.8% of women had a current regular sexual partner, were married, or cohabiting (Table 3.2). The number of men who were married was significantly higher for those over 24 than those aged 15–24 years, whereas for women there was a pattern of declining rates of marriage over 35 years.

Table 3.1 Marital status

Marital status	Men	Women
Married or cohabiting	51%	44.8%
Formerly married but currently unmarried	20.6%	36.3%
Never married	28.4%	18.9%

Table 3.2 Relationship status (current /last 12 months)

Relationship status	Men	Women	p value
Married or cohabiting	51.0%	44.8%	0.029
Currently has regular sexual partner	24.7%	21.0%	
Partner in last 12 months, but no current sexual partner	3.8%	5.3%	
No relationship in last 12 months	20.6%	29.0%	

Education levels were generally very low, with the majority of respondents (61% of total sample) having either no education or failing to complete primary education. The proportion of women with no education was significantly higher than that for men, highlighting gender inequalities within the area in terms of girls' access to education. Overall, the low education levels also reflect the remote and under-resourced communities that the project targets.

Correlating with age, the least well-educated group was the oldest participants (50+ years). The youngest age group (15–24s) contained the lowest proportion of people who had never been to school, but also a higher proportion of people who had not completed primary school and secondary school than was found in the 25–49 age groups (p=0.001 for this pattern).

Table 4 Education

Highest education level attained	Men	Women	p value
None	17.9%	35.8%	<0.0001
Incomplete primary	35.0%	32.8%	
Complete primary	16.3%	10.8%	
Incomplete secondary	18.2%	11.0%	
Complete secondary	9.2%	8.0%	
Post-secondary education	3.5%	1.8%	

In terms of employment (not including housework), 45.4% of men and 37.5% of women reported that they had worked in the last 12 months. The majority of working men and women contributed more than half, or nearly all, of household income, suggesting that they were the primary breadwinner for the household. These figures, however, do not necessarily take into account labour for subsistence farming.

Table 5 Contribution to household income

Contribution to household income	Men	Women	p value
None	6.7%	4%	
Less than half	6.7%	12.2%	
Half	23.6%	27%	0.017
More than half	25.5%	12.2%	
Nearly all	37.6%	44.6%	

A range of indicators reflected poverty levels in the target communities. The majority of households reported that they had two meals per day (Table 6.1), with a minority eating only once a day (or fewer times); however, the quantity and quality of food were not measured. The majority of households used a pit latrine (and 67.4% of pit latrines were shared), with 10.8% of men and 17.3% of women reporting open defecation. Only two participants had water on their property, with the most common water source being a protected well or spring, while a third of respondents (33.3% of the total sample) were using an unprotected source (Table 6.2).

Table 6.1 Household food consumption

Number of meals per day	men	women	p value
One or fewer	13.6%	13.8%	
Two	65.0%	61.5%	0.52
Three or more	21.4%	24.8%	

Table 6.2 Household water and sanitation

Water supply	Men	Women	p value
Public tap	10.8%	9.8%	
Protected well or spring	56.4%	50.5%	0.057
Unprotected well or spring	31.2%	35.3%	
Other	1.6%	4.4%	

Toilet	Men	Women	p value
Pit latrine	79.7%	76.8%	
None – bush, field	10.8%	17.3%	0.012
Other	9.5%	6%	

Households reported owning very few assets, except for a radio (62.6% of men and 51.8% of women) or a mobile phone (32.3% of men, 23.4% of women). Other asset ownership was negligible, and in total only 3% (n=25) of respondents had any electricity at home, and this was sourced through batteries or a generator; there was no mains electricity or solar power reported within the entire sample.

In terms of means of transport owned by households, bicycles were the most common, owned by 54.1% of male and 32.9% of female respondents. As with household assets, a few households owned multiple forms of transport, and women were more likely than men to have none (65.8% of women, compared to 43.4% of men, said that their household owned no form of transport).

Table 6.3 Household-owned forms of transport

Household-owned forms of transport	Men	Women
No form	43.4%	65.8%
Bicycle	54.1%	32.9%
Scooter or motorbike	12.6%	7.1%
Car or van	0.27%	0.5%

1.2 Faith

Over 95% of the surveyed population identified as belonging to a religion (n=734). The majority were Christian (73.2% of men, 79.8% of women) or Muslim (15.5% of men, 12.8% of women), and the remainder included Jehovah's Witness, Kimbanguist and traditional religions. Only 35 people responded 'none'. Of the Christian denominations, more than half (59.8%) were Catholic, and 28.9% evangelical.

Table 7 Faith affiliation

Faith	Men	Women
Christian	73.2%	79.8%
Muslim	15.5%	12.8%
Traditional religion	1.4%	0.8%
Other (incl. Kimbanguist)	4.9%	2.8%
None	5.2%	4.0%

Most respondents who identified as belonging to a religion considered that their faith was important or very important to them (83.4%, n=612, out of 734[12]). This was particularly true for women, as 87% of Christian women and 86% of Muslim women rated faith as important or very important. For men, there was some variance, as 83% of Christian men said religion was important or very important to them, compared to 67% of Muslim men (p=0.007). Only 3.1% (n=23) considered that faith was not important or not at all important, but a significant minority (16.1% of men and 10.5% of women) didn't give an opinion.

Younger respondents (under 35 years old) were more likely to say they didn't know, or had no opinion, and were less likely to say that faith was very important to them.

Table 8 Importance of faith

Importance of faith	Men	Women	p value
Don't know/no opinion	16.1%	10.5%	
Not at all important	0.6%	1.1%	
Not important	2.9%	1.8%	0.167
Important	59.9%	64.4%	
Very important	20.6%	22.3%	

Despite the clear prevalence of religious affiliation within these communities, and the value most individuals placed on faith, there were variations in terms of practical engagement and attendance. The majority of those who identified with a religion attended a religious institution (such as a church or mosque), as shown in Table 9.1. In total, 38.0% of men and 40.7% of women reported regularly attending services, prayers or other activities, and a further 41.7% of men and 44.4% of women were attending occasionally. However, 17.4% (n=128) reported

that they do not attend at all, and men were more likely not to attend than women (20.3%:14.9%). A higher percentage of Muslims than Christians regularly attend (44.5% versus 38.6%), but there was no disparity among those who occasionally or never attend.

Table 9.1 Attendance at religious institution (e.g. church/mosque)

Attendance	Men	Women	p value
I do not attend	20.3%	14.9%	0.006
I occasionally attend services/prayers	32.0%	31.9%	
I occasionally attend other activities	9.7%	12.5%	
I regularly attend services/prayers	19.1%	27.9%	
I regularly attend both services/prayers and other activities	18.9%	12.8%	

In terms of actual participation, a significant number (38.9% of men and 32.5% of women) reported that they were not engaged at all with their religious institution. The pattern of engagement between men and women differed, as shown in Table 9.2, with men more likely than women to be in decision-making and leadership positions, as well as more likely not to be engaged at all. There was no difference in the pattern between Christians and Muslims. The younger age groups (15–24s and 25–34s) were less likely to be engaged with a religious institution, and less likely to have leadership roles than those older (p=0.05 for men and p=0.001 for women).

Only a very small number of the sample (6 women and 19 men) were involved in leadership or any decision-making roles within the church or mosque, limiting the conclusions that can be drawn for this group, who were predominately male and middle aged.

Table 9.2 Engagement with religious institution

Engagement	Men	Women	p value
I am not engaged at all	38.9%	32.5%	<0.0001
I simply attend services	19.4%	25.1%	
I take part in the services	29.4%	37.2%	
I take part in decision-making	6.0%	3.7%	
I am involved in leadership	6.3%	1.6%	

Overall, levels of attendance and engagement[13] generally correlated across genders, for both Christians and Muslims (p=<0.0001). More than 90% of those who did not attend unsurprisingly also did not feel engaged at all. However, more than half of those who stated they were not engaged at all still registered occasional or even regular attendance at services, suggesting that a considerable proportion of the congregation in faith institutions is only passively engaged.

Respondents were also asked about membership of other community groups, including various women's groups, men's groups, and youth groups. Most women (57.8%) and 42.2% of men did not belong to any other group, highlighting the comparative reach of faith institutions in these communities.

Of those who did belong to other groups, there was a similar gender disparity in terms of active roles, with 45.3% of men, compared to only 18.8% of women (p=<0.0001), reporting that they were involved in decision-making within the group, and almost identical proportions who regularly spoke at meetings (46.0%:18.8%), For both men and women, involvement in decision-making and speaking at meetings increased with age up to age 49 but then was very low at age 50+ (lowest for women). There was also a strong correlation between faith engagement

(Table 9.2) and engagement in decision-making in groups, indicating that the same people have influence across different sectors of the community.

Table 10 Community group engagement

Involvement in decision-making	Men	Women	p value
Never	15.89%	32.09%	<0.0001
Seldom	19.16%	23.53%	
Sometimes	19.63%	25.67%	
Often	45.33%	18.72%	

2 GENDER

2.1 Gender equality

Roughly half of respondents (45.8% of men and 54.0% of women) agreed with the concept that God created men and women equal. However, the vast majority (89.9% of men and 81.7% of women) then agreed with the statement that 'men are superior to women', which likely reflects strong gender inequalities that exist in practice within these communities. It is noted that people holding both these contradictory views (41% of men (n=151/364) and 43% (n=172/397) of women) represent the majority of those who believe God created men and women equal. This group was also more likely to be actively engaged or in leadership roles within their faith groups, and thus perhaps more familiar with faith texts about creation. There were no significant differences between Christians and Muslims.

Table 11 Attitudes to gender equality

Attitude	Men			Women			p value
	Strongly agree / agree	Don't know	Strongly disagree / disagree	Strongly agree / agree	Don't know	Strongly disagree / disagree	
God created man and woman equal	45.8%	2.7%	51.5%	54%	4%	42%	0.053
Men are superior to women	89.9%	0.8%	9.2%	81.7%	2.3%	16%	0.02

2.2 Gender roles

2.2.1 Attitudes

Respondents were asked a number of questions around the division of work and roles in the household, which reflect attitudes to gender and gender roles. The findings show strong agreement across both genders, with traditional roles for women as caregivers and men as providers, as shown in Table 12. However, 57.5% of men and 46.0% of women did agree that men should share the housework with women, including doing dishes, cleaning and cooking. Around two-thirds of both men and women agreed that once a man has paid bride price (a customary practice in this area), his wife becomes his property.

Table 12 Household roles (attitudes)

Gender attitudes	Men			Women			p value
	Strongly agree / agree	Don't know	Strongly disagree / disagree	Strongly agree / agree	Don't know	Strongly disagree / disagree	
Changing nappies, giving a bath, and feeding children is the mother's responsibility	88.4%	0.54%	11.1%	90.2%	0.3%	9.5%	0.35
A woman's primary role is to take care of, and cook for her family	87.5%	0.3%	12.2%	87.3%	0.5%	12.3%	0.59
Men should share the work around the house with women such as doing dishes, cleaning and cooking	57.5%	1.4%	41.1%	46%	1.5%	52.5%	0.78
A man should provide for his family	77.8%	0.5%	21.7%	72.3%	2.0%	25.7%	0.2

2.2.2 Practice

However, only 31% of men who agreed that men should share the housework actually said that they did share the work. In practice, the gendered division of housework appears stark and consistent, with women responsible for most household work and tasks, as shown in Table 13. Outside the home, labour in terms of growing crops was more evenly divided, with the majority (73.9% of men and 68.4% of women) saying that this was shared equally between them and their partner.

Interestingly, 90.9% of men and 77.4% of women indicated that they were satisfied with the current division of labour in the household. Overall, there were no significant differences in attitudes to gender and gender roles by age or by marital status. A higher proportion of women (31.9%) who were actively engaged or in leadership roles within their faith group expressed dissatisfaction with the current division of household labour, compared to 19.3% of women who just attended services, and only 9.8% of women who were not at all engaged with a faith group.

Table 13 Household roles (practice)

Household roles	Men Strongly agree / agree	Women Strongly agree / agree	p value
Division of washing of clothes with partner:			
I do everything	5.3%	41.5%	<0.0001
usually me	2.9%	54.6%	
shared equally	5.3%	2.3%	
usually partner	62.5%	1.1%	
partner does everything	24%	0.5%	
Division of cleaning with partner:			
I do everything	5.3%	40.5%	<0.0001
usually me	2.9%	54.9%	
shared equally	4.7%	2.3%	
usually partner	64.2%	1.7%	
partner does everything	22.9%	0.6%	
Division of cooking with partner:			
I do everything	5.2%	41.5%	<0.0001
usually me	3.5%	55.1%	
shared equally	5.8%	1.7%	
usually partner	62.2%	1.1%	
partner does everything	23.3%	0.6%	
Division of work with crops with partner:			
I do everything	2.1%	6.2%	0.36
usually me	11.7%	12.4%	
shared equally	73.9%	68.4%	
usually partner	9.6%	10.7%	
partner does everything	2.7%	2.3%	

2.3 Decision-making

2.3.1 Attitudes

Attitudes to decision-making within the household, including issues of consent about sex, also reflect gender inequalities within the communities (see Table 14). The majority of both men and women in the survey believed that men should have the final say in household decisions, and that women should obey, even when they disagreed.

Table 14.1 Attitudes to power in relationships

Attitudes	Men			Women			p value
	Strongly agree / agree	Don't know	Strongly disagree / disagree	Strongly agree / agree	Don't know	Strongly disagree / disagree	
A good woman obeys her husband even if she doesn't agree	80.5%	3%	16.5%	73%	4%	23%	0.144
A man should have the final word about decisions in his home	90%	0.5%	9.5%	83.5%	2%	14.5%	0.002
When married, a woman has no right or control over her body according to scriptures (Bible/ Qur'an)	81.8%	3%	15.8%	74.9%	4.5%	20.6%	0.205
A man is entitled to sex from his partner/wife/girlfriend, even if she doesn't feel like it	76.1%	1.9%	22%	67.2%	5.5%	27.3%	0.024

It is interesting to note that when a woman's lack of right to refuse sex with her partner was phrased as a scriptural (religious) principle, responses were stronger: 81.8% of men and 74.9% of women agreed that 'a married woman has no right or control of her body according to the Bible or Qur'an', but a reduced number (76.1% of men and 67.2% of women) agreed with the statement that 'a man is entitled to sex … even when his partner doesn't feel like it'. This could reflect more conservative views condoned by faith teaching, or may be due to a reluctance to contradict anything worded as scripture.

Again, there was some correlation with active faith engagement for women and more empowered attitudes; 28.4% of those actively engaged or in positions of leadership within their faith group disagreed with the statement that married women have no right or control over their body according to scripture, compared to only 14.4% of those not engaged (p=0.015). There was no direct correlation with age, but it has previously been noted that those who were not engaged with faith groups were more likely to be younger and have less or no education, while the small group of women who were most active in faith groups were likely to be better educated, and older.

Responses across these questions on gender attitudes indicate a distinct and consistent minority of women who are both empowered and engaged[14] within their faith group.

Table 14.2 Correlation between faith engagement and belief a married woman does not have rights over her body, according to scripture

Overall engagement in religion	Men			P value	Women			P value
	Strongly agree / agree	Don't know	Strongly disagree / disagree		Strongly agree / agree	Don't know	Strongly disagree / disagree	
No religion/not engaged	77.4%	5.2%	17.4%	0.027	79.1%	6.5%	14.4%	0.015
Attends services	91.2%	1.5%	7.4%		83.3%	1.0%	15.6%	
Takes part in services or leads	82.2%	1.4%	16.4%		66.7%	4.9%	28.4%	

2.3.2 Practice

Both men and women mostly reported joint decision-making with their partner (see Table 15.1). Around 25% of women stated that they made decisions themselves, and a proportion said that their partner made them, whereas for men, the proportion according decision-making control to their spouse was negligible.

Table 15.1 Distribution of normative practice in gendered roles in household decision-making

Who in your relationship decides (or should decide)	Men				Women				p value
	Me	Spouse	Jointly	Someone else	Me	Spouse	Jointly	Someone else	
How the money you earn will be used? (asked to those who worked)	34.8%	2.1%	63.1%		25.6%	21.7%	52.8%		<0.0001
Decisions about your health care ?	29.5%	0.8%	69.6%		26.7%	17.7%	55.3%	0.4	<0.0001
Decisions about health care for your children? (among those with children)	25.8%	0.9%	73.4%		25.3%	15.8%	58.9%		<0.0001
Decisions about visits to family or parents?	27.5%	0.4%	72.1%		24.9%	17.8%	57.3%		<0.0001
Decisions on your choice of contraception? (among users)	34.7%	0.8%	64.5%		42.1%	10.6%	47.4%		<0.0001

Decision-making within the household can reflect gender equality and empowerment at the household level. Correlating decision-making with faith engagement showed that men who were not engaged with a faith group were more likely to be controlling, and those who were more engaged were more likely to make joint decisions (Table 15.2). Women actively engaged in faith groups were more likely to make their own financial decisions.

Table 15.2 Correlation of household decision-making with faith engagement

Overall engagement in religion	Men			p value	Women			p value
	Me	Spouse	Jointly		Me	Spouse	Jointly	
p value for the association between decision-making about money and religious engagement in men /women								
No religion/not engaged	51.1%	2.2%	46.7%		33.7%	15.1%	51.2%	
Attends services	24.4%	4.4%	71.1%	0.001	15.3%	20.3%	64.4%	0.034
Takes part in services or leads	24.8%	1%	74.2%		24.1%	27.8%	48.2%	
p value for the association between decision-making about family visits and religious engagement in men /women								
No religion/not engaged	37.8%	0	62.2%		33.3%	14.9%	51.7%	
Attends services	28.9%	0	71.1%	0.064	17%	23.7%	59.3%	0.22
Takes part in services or leads	19.6%	1%	79.4%		24.1%	19.4%	56.5%	

2.4 Masculinities

It has already been noted that a majority of both men and women agreed that a man should be the provider and primary decision-maker in the household. Respondents were also asked a series of questions around attitudes to masculinity, particularly exploring harmful notions of masculinity linked to violence. Despite the evidence of male dominance in terms of gender attitudes and sexual consent exposed by previous questions, the questions on masculinity revealed a very consistent and gender-equitable attitude scale (Cronbach's alpha 0.77). The

clear majority of both men and women rejected the statements linking violence with masculinity, and this was consistent across different questions.

There were no differences in terms of age or education level, but in terms of marital status, those who had sexual partners but who were not formally married or cohabiting were more likely to agree that men had to be tough (21% compared to 11% for those in a formal relationship). There was some correlation with faith engagement, as again, women who were actively engaged within faith groups were more likely to hold more gender-equitable views. Men who agreed that men had to be tough, or disagreed that a good husband would not use violence on his partner under any circumstances, also tended to be less engaged with faith. However, on some other key variables, including beating his wife, being head of the household or defending family honour, no correlation with faith engagement was noted for either men or women.

Table 16 Concepts of masculinity

Concepts of masculinity	Men			Women			p value
	Strongly agree / agree	Don't know	Strongly disagree / disagree	Strongly agree / agree	Don't know	Strongly disagree / disagree	
It is important for a man to demonstrate that he is the head of the house, even using violence	21.5%	2.7%	75.8%	13%	4.8%	82.3%	0.019
To be a man, you need to be tough (strict, stern, hard, harsh, firm, adamant, inflexible, uncompromising, unsentimental, unsympathetic)	14.1%	3%	82.9%	5.5%	5%	89.5%	0.001
It is manly to defend the honour of your family even by violent means – is proof of virility	16.1%	2.2%	81.7%	8.8%	5%	86.2%	0.003
It is manly for a man to beat his wife	14.7%	3.5%	81.8%	7.5%	5.3%	87.2%	0.011
A good and God-fearing husband will not use violence on his wife/partner under any circumstances	91.6%	1.9%	6.5%	93.7%	2.3%	4%	0.44

2.5 Attitudes to gender, sex and violence

Attitudes to IPV also highlighted gender inequalities in these communities. Just over half of all male respondents (51.0%) agreed that there are times when a woman deserves to be beaten, while 42.6% of women agreed, and roughly the same proportion disagreed (44.3%), with an unusually high minority (13.3%) responding 'don't know' to this question. Considering sexual IPV and the question of consent within relationships, 76.1% of men and 67.2% of women agreed that a man is entitled to sex from his wife/partner, even if she doesn't feel like it. It is noted that for both these questions (Table 17), the expressed attitudes were generally moderate rather than extreme, as there were few responses in the 'strongly agree/strongly disagree' categories.

Table 17 Attitudes to physical and sexual IPV

Attitudes	Men					Women					P value
	Strongly agree	Agree	Don't know	Disagree	Strongly disagree	Strongly agree	Agree	Don't know	Disagree	Strongly disagree	
There are times when a woman deserves to be beaten.	3.3%	47.7%	7.3%	36.3%	5.4%	3.3%	39.3%	13.3%	38.5%	5.8%	0.041
A man is entitled to sex from his partner/wife/ girlfriend, even if she doesn't feel like it	4.9%	71.2%	1.9%	19.6%	2.5%	4.3%	62.9%	5.5%	23.6%	3.8%	0.024

2.5.1 Physical intimate partner violence

When exploring in more detail a range of potential justifications for physical VAWG, it is clear that, in fact, the majority condone violence in some cases. Only 26.6% of men and only 27.3% of women consistently responded that physical violence was never justified in any circumstances (out of the examples given, see Table 18). Education and marital status made no significant difference to these attitudes, but age was a major correlated factor, as for both men and women, older age groups were increasingly less likely to agree that violence was justified. Faith engagement was also significant, with the more actively engaged men and women more than twice as likely to think violence was never justified, compared to those who were not engaged at all.

Table 18 Justification for physical IPV

Justification	Men	Women	p value
Physical violence is justified in any circumstance	71.0%	66.0%	0.136
Physical violence might be justified in a circumstance	0.5%	1.5%	
Physical violence is never justified in any (of these) circumstances	26.6%	27.3%	0.829

For men, a total of 71% (n=262) believed that a man was justified in beating his wife/partner for one or more reasons, and 66% (n=264) of women. There was no significant difference between male and female responses. The most commonly acceptable justification was infidelity (with 48.9% of men and 51% of women agreeing that violence was justified if a man finds out that his wife/partner has been unfaithful). Disobedience was the second most accepted reason, with other justifications (i.e. neglecting children, arguing, burning food, refusing sex, unsatisfactory housework) being less commonly accepted.

It is noted that there are some obvious inconsistencies in responses, with 173 of those who disagreed with the initial statement that 'there are times a woman deserves to be beaten' then agreeing with one or more of the justifications for physical violence, and 50 who agreed that 'there are times a woman deserves to be beaten' then not agreeing with any of the specific justifications given.

2.5.2 Sexual intimate partner violence

When asked whether a married woman could refuse sex with her partner, only 17.9% of men and 22.8% of women believed a woman was justified in refusing in all of the circumstances suggested. Analysis of the associated factors for the women in this group showed that as education levels increased, so did the likelihood of agreeing that refusal is justified. Age was not significant, but this group was less likely to have a current partner.

Women actively engaged in faith groups were four times more likely to agree with a woman's right to choose. For men, neither age nor education were significant factors, but again strong faith engagement correlated with being four times more likely to agree that a woman was able to refuse sex.

Table 19 gives the breakdown of responses for the different justifications; the consistency of responses between men and women could indicate strong social norms around this issue. Sexually transmitted disease and sickness were accepted as justifiable reasons for the majority of men and women, but personal choice or abusive behaviour were not. Again, very few people held extreme positions ('strongly agree/disagree'). A small minority (5.2% of men, 5.3% of women) believed that a woman was never justified in refusing sex in any circumstances, but this group was too small to meaningfully analyse.

Table 19 Reasons a married woman could refuse sex

Reasons for refusing sex	Male			Women		
	Can refuse	Don't know	Cannot	Can refuse	Don't know	Cannot
She knows that he has a sexually transmitted disease	82.9%	4.9%	12.2%	79.7%	7.3%	13.0%
She doesn't want to	34.3%	1.9%	63.8%	39.9%	4.5%	55.6%
He is drunk	34.3%	3%	62.7%	39.0%	5.0%	55.9%
She is sick (fatigue, fever, general illness – not menstruation)	60.1%	4.1	35.9%	59.1%	5.5%	35.4 %
He mistreats her (e.g. abusive to her, has multiple partners, beats the children, forces her to have sex etc)	43.2%	4.1%	52.7%	45.4%	6.5%	48.1%

2.5.3 Tolerating violence

Attitudes around tolerating violence showed some contradictions (Table 20); while more than half of men and women agreed that IPV was a private matter that shouldn't be discussed outside the couple, the majority (>90%) agreed that those outside the family should intervene if a man mistreats his wife. While the majority of men (62.4%) agreed that a woman should tolerate violence to keep her family together, there were almost equal proportions of women agreeing and disagreeing with the statement.

Table 20 Response to violence

Response	Men			Women			p value
	Strongly agree / agree	Don't know	Strongly disagree / disagree	Strongly agree / agree	Don't know	Strongly disagree / disagree	
If a man mistreats his wife, others outside of the family should intervene	90.7%	1.4%	7.9%	91.4%	1.8%	6.8%	0.789
A woman should tolerate violence to keep her family together	62.4%	3.3%	34.3%	47.4%	7.5%	45.1%	<0.0001
A man using violence against his wife is a private matter that shouldn't be discussed outside the couple	54.2%	3%	42.8%	52.5%	4.3%	43.3%	0.656

In terms of community responses to violence, there seems to be a gap between perceptions and actions. While 77% of both men and women agreed that local leaders have a role in taking action against a man who violently or sexually attacks a woman, fewer (67.1% of men and 69.7% of women) agreed that in practice, local leaders

actually did take action on this. However, the survey instrument did not explore any further specifics on the nature or effectiveness of these actions.

Most respondents also felt that religious institutions have a role to play in responding to sexual and gender-based violence (SGBV), with more than 85% of both men and women agreeing that religious institutions should be a safe space for those affected by SGBV, and should play an active role in addressing harmful attitudes and practices (see Table 21).

Table 21 Religious institutions' role

Religious institutions' role	Men					Women					P value
	Strongly agree	Agree	Don't know	Disagree	Strongly disagree	Strongly agree	Agree	Don't know	Disagree	Strongly disagree	
Religious institutions should play an active role in promoting gender equality (values and equal rights)	12.2%	74.8%	6.5%	5.4%	1.1%	15.5%	68.4%	9.8%	5.3%	1%	0.272
Religious institutions should be a safe space for those affected by SGBV	11.7%	74.8%	7.6%	5.4%	0.5%	15.0%	70.4%	9.3%	4.8%	0.5%	0.565
Religious institutions should urge men and boys to stop their harmful attitudes and practices	14.6%	72.1%	6.5%	5.4%	1.4%	18.6%	67.6%	8.3%	4.0%	1.5%	0.405

2.5.4 Stigma for survivors

Attitudes around rape reflected the prevalence of some common rape myths, and the stigma that survivors face in these communities. More than half of respondents (59.5% of men and 52.5% of women) believed that it is not really rape if a woman does not physically fight back. Victim-blaming was also common, particularly among male respondents, with 53.9% of men, compared to 38.5% of women (p=<0.0001), questioning the victim's character in any rape incident (see Table 22). With men, there was some correlation with faith engagement, with those more engaged less likely to agree with this stigmatising attitude, but with women there was no significant correlation.

Table 22 Rape myths

Rape myths	Men			Women			p value
	Strongly agree / agree	Don't know	Strongly disagree / disagree	Strongly agree / agree	Don't know	Strongly disagree / disagree	
When a woman is raped, she usually did something careless to put herself in that situation	37%	4.6%	58.4%	24.9%	8.8%	66.3%	0.001
In some rape incidents, the victims actually want it to happen	38.2%	4.3%	57.5%	28%	9.3%	62.8%	0.002
If a woman doesn't physically fight back, you can't really say it was rape	59.5%	4.1%	36.4%	52.5%	6.8%	40.8%	0.14
In any rape incident one would have to question if the victim had a bad character	53.9%	4.9%	41.2%	38.5%	9.3%	52.3%	<0.0001
God condemns rape	93.2%	3.3%	3.5%	93.3%	2.5%	4.3%	0.74

There was almost unanimous agreement that God condemns rape, and that rapists should be punished, and overall, the majority of respondents disagreed with attitudes stigmatising rape survivors (Table 22 and Table 23). However, there is a considerable minority of both men and women who clearly do hold highly stigmatising beliefs, particularly around relationships for survivors, where 37.1% of men and 27.0% of women believed that a man is justified in rejecting his wife if she has been raped. There was some general correlation in views across the different examples of stigma against survivors.

Analysing factors associated with the belief that a man is justified in rejecting his wife if she has been raped showed few correlates except for age and location: women in the oldest age group were less likely to agree with this statement, and it was significantly less likely in one of the two communities where lower rates of NPSV in the past year were reported. For women, it was not associated with having personally experienced NPSV. For men, it was also less common among older men (especially those over 50) and among men from the communities with less reported violence. A man who had been sexually violent towards his own wife/partner in the last year was four times more likely to think that a husband should reject his wife if she has been raped.

Table 23 Survivor stigma

Survivor stigma	Men			Women			p value
	Strongly agree / agree	Don't know	Strongly disagree / disagree	Strongly agree / agree	Don't know	Strongly disagree / disagree	
A man is justified in rejecting his wife if she has been raped	37.1%	10.3%	52.6%	27%	14.8%	58.3%	0.028
A raped woman's family members should have nothing to do with her	19.9%	9.3%	70.8%	15.5%	12%	72.5%	0.24
A young man should not marry a young woman who has been raped	36%	8.9%	55%	28.4%	12.3%	59.3%	0.128
A man who rapes a woman should be punished	95.4%	1.6%	3%	94%	3.5%	2.5%	0.141
If a woman says she has been raped, she is probably not telling the truth	34.2%	7.3%	58.4%	31.8%	11%	57.1%	0.45

2.5.5 Social referents

In an effort to understand who are the most influential social referents in shaping social norms in the target communities, respondents were asked about their motivation to comply with different people's opinions. The question was posed as a statement in the form 'I want to do what [referent] thinks I should do regarding [behaviour]', so the answers were on an agree / disagree Likert scale.

A range of different social referents was considered (partner, friends, parents, family, community leaders, faith leaders) for three key behaviours (striking a partner, forced sex with a partner, supporting a survivor of sexual violence). There was little noticeable distinction between what people assumed each of the different social referents would think of each behaviour (generally negative about the first two, and positive about the third), and for most social referents the data shows that overall, respondents felt limited motivation to comply or not comply. However, the striking exception to this was for faith leaders, who were the only social referent that both men and women felt a distinct and positive motivation to comply with, across all three behaviours (see Table 24). It is also interesting to note that in terms of supporting survivors, men and particularly women were most concerned to comply with their partner's opinion.

Table 24 Motivation to comply with social referents (various behaviours) – mean values*

Social referent	Striking a partner		Forced sex		Supporting a survivor	
	Men	Women	Men	Women	Men	Women
Partner	-0.01	-0.13	-0.02	-0.13	0.59	0.87
Friends	0.10	0.08	0.08	0.03	0.43	0.54
Parents	0.05	0.06	-0.06	-0.03	0.36	0.45
Other members of my family	0.02	-0.02	-0.12	-0.04	0.31	0.44
Community leaders	0.14	0.10	0.05	0.06	0.42	0.47
Faith leaders	0.28	0.36	0.25	0.29	0.53	0.62

* Mean score: scoring: -2 = strongly disagree; -1 = disagree; 0 = no opinion; 1 = agree; 2 = strongly agree

3 EXPERIENCE OF VIOLENCE

3.1 Household violent attack

In total, 26% of respondents reported that a member of their household had been the victim of a violent attack, and most of these reported that the attack had taken place within the last year (Table 25). Overall, the reported perpetrators of these attacks were split almost evenly between either family members, members of the community, or armed groups. For attacks that took place within the last 12 months, there was a higher likelihood that the perpetrators were local (39.0% neighbours, 31.3% family members, 15.6% soldiers/militia), while for attacks more than five years ago the perpetrators were most likely to be soldiers/militia (41.5%). Since respondents were only asked about the most recent attack, this may reflect a higher frequency of local attacks. There was no significant difference in reporting between men and women.

Table 25 Household violent attack

	Total	Men	Women	p value
Member of the household has been the victim of a violent attack	26.0%	24.5%	27.5%	0.337
Time of the most recent attack:				
within the last 12 months	48.0%	44.4%	50.9%	0.434
within the last 5 years	32.5%	32.2%	32.7%	
more than 5 years ago	19.5%	23.3%	16.4%	
Person who committed the most recent attack:				
neighbour (someone local)	30.0%	33.3%	27.3%	0.325
soldiers / militia	31.0%	34.4%	28.2%	
family member	28.0%	22.2%	32.7%	
don't know or other	11.0%	10.0%	11.8%	

3.2 Intimate partner violence: consent/sexual partners

In terms of intimate partner relationships, respondents who were married or had a current partner were asked if they felt comfortable talking to their partner about their sexual relationship: 71.2% of men and 61% of women agreed that they always felt comfortable. However, when asked if they were able to say no to sex (or for men, if their female partner was able to say no), then just under half (47.4%) of men said that their partner could not refuse, and 44.7% of women said they were not able to refuse sex with their partner, while a further 7.4% of women said they didn't know.

When asked about the number of sexual partners in the last 12 months (see Table 26), men most commonly reported four or more partners (41.6%), and women most commonly reported one partner (37.0%). A significant proportion (27.5%) of women also reported having four or more partners in the last 12 months. There was some inconsistency noted in the responses to this question, both in terms of the numbers responding (n=319 women and 298 men, with 152 missing responses) and also in that 139 people, who had previously responded that they did not have a partner, reported sexual partners in the last year in response to this question.

Table 26 Sexual partners in last 12 months

Number of sexual partners in last 12 months	Men	Women	p value
None	16.1%	17.6%	0.002
1	19.1%	37.0%	
2–3	23.2%	17.9%	
4+	41.6%	27.5%	

There were very high numbers of both men and women who reported engaging in transactional sex in the last 12 months: 65.8% of men reported they had paid for sex and 49.4% of women had been paid (cash, goods, favours) for sex. Transactional sex was particularly common for women and men who were not married. Of the women who reported transactional sex, 76% had a sexual partner at the time of the study or in the last 12 months and 49% had no partner, while 15% were married. Again, there was some drop-out on this question, with 153 missing responses (82 women, 71 men).

Respondents had been asked to give specific consent to answering this section of questions on sexual behaviour and violence. A total of 138 respondents did not give consent at this point; they tended to be people who were single and over the age of 50.

3.3 Experience of violence

All the questions on experience and perpetration of violence were self-administered by the participant to comply with ethical guidelines. Questions on IPV were only put to those who had reported being in a relationship in the last 12 months.

3.3.1 Intimate partner violence

Female respondents were asked about their experience of IPV in the past 12 months. IPV was defined as:

- **psychological** violence (belittled or humiliated you; or threatened to hurt you or someone you cared about);
- **physical** violence (pushed/shaken you or thrown something at you; slapped you or twisted your arm; hit you with a fist or something that could hurt you; kicked, dragged, beaten, strangled or burned you; threatened or attacked you with a gun, knife or other weapon); and
- **sexual** violence (forced you to have sex when you did not want to; or you had sex because you were afraid he would become violent).

Male respondents were asked about their perpetration of each form of violence on an intimate partner.

Only those who had consented, and had earlier reported being in a relationship within the previous 12 months were asked these questions, which accounts for a further reduction in the number of responses. Percentages given reflect the percentage of actual respondents, rather than the whole survey sample.

The results, which reveal high rates of IPV within these communities, are shown in Table 27.1.

Table 27.1 IPV in last 12 months (male perpetration, female experience)

	Male perpetration		Female experience	
	Number	Percent	Number	Percent
Psychological IPV in last 12 months	125	50.8%	119	50.2%
Physical IPV in last 12 months	86	35.1%	73	30.8%
Sexual IPV in last 12 months	77	31.3%	91	38.4%
Any IPV in last 12 months	167	68.2%	163	68.8%
Physical IPV – frequency:				
never	159	64.9%	164	69.2%
once	14	5.7%	17	7.2%
more than once	72	29.4%	56	24.6%
Sexual IPV – frequency:				
never	169	68.7%	146	61.6%
once	7	2.9%	10	4.2%
more than once	70	28.4%	81	34.2%
Psychological IPV – frequency:				
never	121	49.2%	118	49.8%
once	14	5.7%	24	10.1%
more than once	111	45.1%	95	40.1%

Reported rates of experience of violence by women and perpetration by men were generally consistent across the different types of IPV, with 68.8% (n=167) of women who responded reporting that they had experienced some form of IPV in the previous year, and 68.2% (n=163) of men reporting perpetrating IPV in the same time period. While psychological violence was the most commonly reported (half of both men and women reporting), it is noted that sexual IPV was particularly high, and reported by significantly more women (38.4%) than men reported perpetrating it (31.3%), while for physical violence this was reversed, with 35.1% of men reporting having committed physical violence and 30.8% of women reporting having experienced it. This discrepancy may be due to perceptions of what is considered as violence, or normal, within relationships. In terms of the frequency of attacks, it was clear that the violence is generally recurring, as most of those who experienced or committed violence in each case reported that it had occurred multiple times within the past 12 months.

There was also considerable overlap between different types of violence (Table 27.2), with only 31.2% of women not experiencing any form of IPV, and 17.1% of men committing all three types of violence.

Table 27.2 Overlap between types of IPV (male perpetration and female experience)

Overlaps: types of IPV	Male perpetration		Female experience	
	Number	Percent	Number	Percent
No IPV	78	31.8%	74	31.2%
Only physical	15	6.1%	7	3.0%
Only sexual	16	6.5%	23	9.7%
Only psychological	57	23.3%	52	21.9%
Physical and psychological	18	7.3%	13	5.5%
Sexual and psychological	8	3.3%	15	6.3%
Physical and sexual	11	4.5%	14	5.9%
All three types	42	17.1%	39	16.5%

Women who had experienced physical or sexual violence were asked if they had ever fought back physically, or tried to defend themselves, and more than half (56.2%, n=59/105) reported that they hadn't.

Women were also asked if they had ever hit, slapped, kicked or done anything to physically hurt their partner, at times when he was not physically hurting them. Most women (63.8%, n=67/105) responded that they had never done so, but a minority had once (13.3%) or several times (18.1%), while a very small minority reported that they were violent most of the time (3.8%, n=4/105).

3.3.2 Non-partner sexual violence

Women were also asked about their experience of NPSV (i.e. with a broader definition than rape) within the past 12 months, and the rates reported were very high, with 20.8% of respondents (n=67/322) reporting that they had experienced NPSV on one or more occasions within the last year (Table 28). The majority of perpetrators were a known person (in 68.7% of cases, n=46), or a family member (17.9%, n=12) while in 6% of cases (n=4) the perpetrator was a member of the militia or other unknown person (7.5%, n=5).

Table 28 Female experience of NPSV in past 12 months

Female experience of NPSV in past 12 months	Number	Percent
Never	255	79.2%
Once	37	11.5%
Sometimes	20	6.2%
Many times	10	3.1%

Women were also asked about their experience of NPSV from the age of 15 (i.e. adult lifetime experience), and 29.2% (n= 94) of respondents reported experiencing sexual violence on one or more occasions. Again, the majority of perpetrators were known (62.8%, n=59/94), or family members (13.8%), rather than militia (8.5%) or other unknown persons (14.9%).

Men were asked about lifetime perpetration of NPSV (again, defined more broadly than rape), and 19.5% (n=58) admitted having committed sexual violence on one or more occasions (Table 29.1). It is noted that perpetration begins early, as the majority of perpetrators (67.3%, n=39) reported that they were under 20 years old when they first forced someone to have sex (Table 29.2).

Table 29.1 Male perpetration of NPSV (ever)

Male perpetration of NPSV (ever)	Number	Percent
Never	240	80.5%
Once	30	10.1%
Sometimes	17	5.7%
Many times	11	3.7%

Table 29.2 Age of first NPSV perpetration

How old were you when you first forced someone to have sex with you?	Number	Percent
Less than 12 years old	2	3.5%
12 to 15 years	8	13.8%
15 to 19 years	29	50.0%
20 to 29 years	16	27.6%
30 to 40 years	2	3.5%

Men were also asked about the consequences they experienced after perpetrating NPSV. There was some attrition in the number of responses, but only 37.3% (n=19/51) reported any form of consequence. In terms of personal responses, although more than half of perpetrators (54.9%) reported feeling guilty or sad afterwards, while 21.6% (n=11/51) felt no emotions, and a small minority reported feeling happy (Table 29.3).

Table 29.3 Emotional response to perpetration

How did you feel after you committed such an act?	Number	Percent
Felt guilty	17	33.3%
Felt sad	11	21.6%
Felt bad for the victim	3	5.9%
Felt angry about myself	2	3.9%
Felt happy	4	7.8%
Felt no emotions	11	21.6%
Prefer not to say / no response	3	5.9%

3.3.3 Male experience of childhood sexual violence

Men were also asked about their own experience of sexual violence (forced sex, or sexual acts) before the age of 18. More than 30% of men (n=90/298) reported that they had experienced some form of sexual violence as a child (Table 30). Again, in most cases the perpetrator was known or a family member.

Table 30 Male experience of sexual violence (childhood)

Before the age of 18 how many times did someone force you to have sex or to perform a sexual act when you did not want to?	Number	Percent
Never	208	69.8%
Once	32	10.7%
Sometimes	37	12.4%
Many times	21	7.1%
Perpetrator:		
known person	56	62.2%
family member	16	17.8%
militia member	5	5.6%
other unknown person	13	14.4%

3.4 Witnessing violence

As well as direct personal experience of violence, respondents were also asked if they had witnessed any kind of physical violence: 49.3% of men and 44.6% of women responded that they had, mostly within the last 12 months, and that the most common perpetrators were neighbours or family members (see Table 31).

When asked whether they had witnessed domestic abuse as children, 27.1% of men and 22.8% of women reported that their mother had been abused by a husband or partner when the respondents were children; and nearly all of them reported that they had actually seen or heard the abuse taking place.

Table 31 Witnessed violence

	Men	Women
Witnessed physical violence	49.3%	44.6%
When was the last time:		
within the last 12 months	65.9%	64.4%
within the last 5 years	21.2%	29.4%
more than 5 years ago	12.9%	6.2%
Committed by:		
neighbours	53.3%	47.5%
soldiers/militia	16.1%	16.4%
family member	25%	26.0%
other	5.6%	11.1%

4 RESPONSE TO VIOLENCE

4.1 Response to IPV in neighbourhood

Both male and female respondents were asked if they would intervene in a case of IPV, and there were some significant gender differences between responses (p=<0.0001), with women far more likely to say they already do, or would intervene, and men more likely to say they would not (Table 32).

Table 32 Willingness to respond to IPV

Would you intervene if you knew your friend or neighbour used violence against his wife?	Men		Women		p value
	Number	Percent	Number	Percent	
Yes I do	17	10.12%	41	26.28%	<0.0001
Yes I would	45	26.79%	47	30.13%	
No	100	59.52%	63	40.38%	
I don't know	6	3.57%	5	3.21%	

4.2 Help-seeking

Women who reported experience of severe physical IPV (all categories, except for: pushed/shaken you or thrown something at you; slapped you or twisted your arm), or sexual IPV (any) in the last 12 months were then asked if they had sought medical help as a result. Most had not. Only 23.2% of respondents to this question (n=24/105) had gone to a doctor or health centre and only 16.8% (n=18/107) reported that they had actually received some kind of health care. The same women were also asked if they had ever tried to get help to prevent or stop this person from hurting them, and fewer than half (45.7%) responded that they had (n=48/105).

Those who did seek help (both male and female survivors) were asked who they had turned to; the results (Table 33) show that friends, neighbours and parents were the main confidants chosen, rather than doctors, faith leaders or other community leaders.

Table 33 Who survivors turn to for help

Who survivors turn to for help	Male survivors (n=90 responding)	Female survivors (n=111 responding)
Friends	40	23
Parents	6	10
Brother/sister	5	3
Uncle/aunt	2	3
Husband/partner	1	3
Husband's/partner's family	8	10
Neighbours	17	13
Teacher	1	0
Employer	1	0
Police	6	3
Doctor/medical personnel	11	6
Faith/religious leader	4	2
Lawyer	0	0
NGO/women's organisation	0	0
Local leader	3	9
Other	1	0
Nobody	29	n/a

The majority of female and male survivors who did not seek help said this was because they felt it would be of no use. Other reasons given were around fear of the consequences, and disgrace for the family (see Table 34).

Table 34 Reasons why survivors did not turn to anybody for help

Reasons	Male survivors (n=29)	Female survivors (n=57)
Don't know who to go to	6	8
No use	15	26
Part of life	7	8
Not manly to ask for help	3	n/a
Afraid of divorce/desertion	n/a	12
Afraid of further beatings	4	8
Afraid of getting person into trouble	4	14
Embarrassed	5	2
Don't want to disgrace family	2	14
Other	1	0

Women were also asked if they had left their husband or partner because of violence, and 35.6% (n=36/101) reported that they had, while 28.7% (n=29/101) reported that their partner had left them because of violence.

4.3 Experience of stigma as a result of violence

Women who reported severe physical or sexual IPV in the last 12 months[15] were also asked about their experience of stigma or support. The majority of survivors said they were not supported by their family, community or faith group (see Table 35). Only 5.4% (n=6) survivors agreed that their church or faith group was supportive.

Table 35 Stigma and support for survivors

Stigma questions (asked of women with severe physical or sexual IPV)	Strongly agree	Agree	Don't know	Disagree	Strongly disagree
My husband/partner doesn't love me any more	2.7%	24.3%	18.9%	46.9%	7.2%
My parents were supportive towards me	2.7%	28.8%	5.4%	57.7%	5.4%
People in the community were supportive towards me	0	17.2%	6.3%	69.4%	7.%
People in the church /faith group were supportive towards me	0	5.4%	4.5%	80.2%	9.9%
I feel guilty	0	34.2%	18.0%	42.3%	5.4%

4.4 Faith institutions – activities to prevent and respond to SGBV

Although, at the time of the study, survivors did not in practice feel supported by their faith groups, wider community perceptions were clearly that a faith group should be a safe space for those affected by SGBV (see Table 21), and around half of men and women said that their religious institution provided counselling or support, or advocated for those affected (Table 36). There was no significant difference between Christian and Muslim respondents.

The survey also highlighted several possible channels for improved teaching and support on these issues through faith groups, as 46.3% of men and 42.8% of women said that they had heard some form of teaching or talk at their place of worship on how men and women should relate to each other, within the past month. However, the content, tone or impact of the teaching was not measured. More than 65% of men and women reported that their church or mosque provided some sort of counselling service for the congregation, and some had attended marriage preparation classes or couples' seminars. Those who had attended were more likely to be male and to be older (both men and women), but these questions were only asked of respondents who were married at the time of the survey, and the p value is likely driven by age.

Table 36 Counselling and support in faith groups

Agreeing with the following statements:	Men		Women		p value
	Percent	Number	Percent	Number	
Did you attend marriage preparation classes at your place of worship (church/mosque) before getting married?	29%	53/183	18.3%	31/169	0.02
Have you attended a couples seminar?	25.1%	47/187	13.5%	24/178	0.005
Have you attended any counselling or teaching on SGBV?	20.7%	75/363	12.9%	50/388	0.004
Does your religious institution (church/mosque) provide any kind of counselling?	64.5%	207/321	66.7%	230/345	0.554
Does your religious institution provide counselling or support for those affected by SGBV?	54.8%	170/310	51.1%	170/333	0.336
Does your religious institution advocate for those who have been affected by SGBV?	55%	170/309	53.8%	179/333	0.748

5 OTHER FACTORS

5.1 Media

Only 26.0% of men and 16.3% of women reported that they owned a mobile phone, and the majority of both men (61.8%) and particularly women (76.6%) had not used any mobile phone at all within the last month. Only a very small minority ever watched TV or read print media, likely reflecting the poverty levels and low literacy rates in these communities. Radio was by far the most common form of access to media, with 54.2% of men and 41.5% of women reporting listening to the radio every day (Table 37). It could also represent a key medium for messaging, as 63.4% of men and 58.8% of women said that they had heard a radio advert or programme questioning men's use of VAWG within the last 12 months.

Table 37 Media exposure

How often do you:	Men				Women				p value
	Not at all	Less than once a week	At least once a week	Every day	Not at all	Less than once a week	At least once a week	Every day	
Listen to the radio	28.5%	11.1%	6.2%	54.2%	43%	10.5%	5%	41.5%	<0.001
Watch TV	89.7%	5.4%	2.7%	2.2%	92.4%	3.8%	2.3%	1.5%	0.608
Read a newspaper or magazine	86.1%	7.9%	4.4%	1.6%	91.2%	3.8%	3.8%	1.3%	0.088

5.2 Alcohol consumption

Both men and women were asked about their own and their partners' alcohol consumption. Alcohol consumption was more frequent in men. The self-reporting figures for men and women were fairly consistent with perceptions of spouse/partner consumption (although the male/female samples responding were obviously not in the same household). The majority of men and women said they did not drink at all, but there was a minority reporting that they drank every day, or saw their partner drunk every day – around 10% of men and 4% of women (Table 38).

Table 38 Alcohol use

Alcohol use	Men	Women	p value
How often do you drink alcohol?			
Never	45.4%	52.9%	<0.001
Occasionally, less than once a month	19.8%	26.6%	
1–3 times a month	6.4%	5.2%	
Once or twice a week	17.6%	11.5%	
Every day or nearly every day	10.9%	3.9%	
How often does your spouse/partner drink alcohol?			
Never	58.6%	45.5%	<0.001
Occasionally, less than once a month	24.3%	23.1%	
1–3 times a month	9.6%	5.4%	
Once or twice a week	3.1%	13.4%	
Every day or nearly every day	0	12.6%	
In the past 12 months, how often have you seen your spouse / partner drunk?			
Never	70.5%	60.7%	0.025
Less than once a month	8%	8.2%	
Once a month	6.6%	9.6%	
Weekly	10.8%	11.1%	
Most days	4.2%	10.4%	

5.3 Relationship satisfaction

At the end of the survey, respondents were asked about their sense of satisfaction with their relationships, their sense of security and their sense of belonging in the community. The majority of both men and women consistently rated themselves satisfied or very satisfied with all factors (see Table 39). There was a significant minority (20% of both men and women) who reported they did not feel satisfied with how safe they felt, but no correlation was noted between those who felt safe, and satisfied with their relationships, and those who had experienced IPV.

Table 39 Relationship satisfaction

Relationship satisfaction	Men	Women	p value
How would you describe your relationship with your partner on the whole?			
Very bad	1.1%	3.3%	0.022
Bad	2.8%	5.8%	
Neither good nor bad	14.8%	20.6%	
Good	68%	59.6%	
Very good	13.4%	10.8%	
How would you describe your communication with your spouse/partner?			
Very bad	1%	2.5%	0.024
Bad	2.4%	5.8%	
Neither good nor bad	14.4%	20.6%	
Good	69.4%	61%	
Very good	12.7%	10.1%	
How satisfied are you with your personal relationships?			
Very dissatisfied	0	0.75%	0.147
Dissatisfied	12.5%	14.5%	
No opinion	0	0.5%	
Satisfied	83.7%	82%	
Very satisfied	3.8%	2.3%	
How satisfied are you with how safe you feel?			
Very dissatisfied	0.5%	0.75%	0.977
Dissatisfied	20.9%	20%	
No opinion	0.3%	0.25%	
Satisfied	77.2%	78.3%	
Very satisfied	1.1%	0.75%	
How satisfied are you with feeling part of your community?			
Very dissatisfied	0.3%	0.5%	0.652
Dissatisfied	10%	12.8%	
No opinion	0.5%	0.3%	
Satisfied	81.3%	80%	
Very satisfied	7.9%	6.5%	

6 LOGISTIC REGRESSION MODELS

In order to demonstrate the independent effect of different factors on the experience or perpetration of IPV or NPSV, we used the statistical technique of logistic regression modelling. This essentially enables a clearer picture to be given of associated (or risk) factors for the different forms of violence. In this report, we present analyses which were undertaken with four key outcomes:

- for women – any experience of NPSV in the last 12 months
- for women – any experience of physical or sexual IPV within the last 12 months
- for men – perpetration of NPSV ever
- for men – perpetration of any physical or sexual IPV within the last 12 months

These outcomes were then modelled with a range of possible predictor variables, including:

- socio-demographic variables like age, education, relationship status, employment, meals per day (as a proxy poverty indicator), location (i.e. the three health areas)
- faith engagement
- alcohol consumption
- certain gender attitudes

The results of the regression modelling are presented below.

6.1 Factors associated with women's experience of violence

6.1.1 Non-partner sexual violence in the last 12 months

We looked at associations between socio-demographic characteristics (age, education, relationship status, work in past 12 months, geographical location and poverty) and women's experience of NPSV in the last 12 months (see Table 40.1). There were significant differences between communities, as living in one of the three health areas was associated with a higher risk of having experienced NPSV in the past year (findings not included in the table). After adjusting for other variables, there were no significant risks associated with age group, but women who had post-secondary education (a very small minority of the sample) were much more likely to disclose experience of NPSV than those who had not. Women who were married were significantly less likely than other women to disclose experience of NPSV. Poverty was a consideration, since having food twice a day or more was associated with a lower risk of NPSV than those who ate only once (i.e. lower economic status correlated with increased risk), but having work (employment) was not associated.

Table 40.1 Logistic regression model of social, demographic and faith engagement factors associated with women experiencing NPSV in past 12 months*

Factors	Odds ratio	95% confidence intervals		p value
Engagement in religion:				
no religion/does not attend	1.00	–	–	–
attends services only	0.95	0.42	2.11	0.891
participates actively or leads	0.76	0.36	1.59	0.462
Post-school education	13.11	1.87	92.17	0.010
Married	0.24	0.12	0.46	<0.0001
Number of daily meals:				
one	1.00	–	–	–
two	0.37	0.15	0.92	0.033
three	0.88	0.32	2.39	0.800

* Adjusted for location and age group

Access to water and sanitation was also considered. There was no association with type of toilet, but there was a strong correlation between NPSV and the type of water source women used (Table 40.2). Compared to having a public stand pipe for water, getting water from a well (whether protected or unprotected) was associated with a very much higher risk of having experienced NPSV. The highest risk was in getting water from protected wells, as these sources are often located away from villages in more remote locations.

Women who drank alcohol regularly were more likely to have experienced NPSV within the last 12 months, even after adjusting for other risk factors.

Table 40.2 Logistic regression model of associations between water source and alcohol use, and women's experience of NPSV in past 12 months*

	Odds ratio	95% confidence intervals		p value
Water source:				
protected well/spring	1.00	–	–	–
unprotected well/spring	0.46	0.23	0.92	0.028
other	0.21	0.03	1.77	0.152
tap	0.06	0.02	0.25	<0.0001
Drinks alcohol:				
never	1.00	–	–	–
occasionally	1.57	0.70	3.48	0.272
more often	2.16	1.01	4.60	0.047

* Adjusted for location, age group and marital status

6.1.2 Physical or sexual IPV in the last 12 months

We looked at associations between socio-demographic characteristics (as above) and women's experience of (any) physical or sexual IPV in the last 12 months.

After adjusting for these variables, there was no significant variation by age group, education, work or number of meals consumed per day (as a poverty indicator). However, contribution to household income was a protective factor where the woman contributed more than her partner. Women who were married (as opposed to a less formal relationship status) were significantly less likely than other women to disclose experience of IPV. However, the number of partners in the past year, and engaging in transactional sex were not significant associations. There were significant differences between communities, as living in one of the three health areas was associated with

a higher risk of experiencing IPV in the past year –- this was the same area where women also had a higher risk of experiencing NPSV. Increased alcohol consumption was strongly associated with higher IPV risk.

Experience of IPV did not correlate with any specific religion or denomination, but it was associated with faith engagement. Women who either attended services or were actively engaged (participated/ led) were less likely to experience IPV. The relationship between faith engagement and IPV was not accounted for by the woman's alcohol consumption, as the association remained even after adjusting for other variables.

Experience of IPV was not associated with a woman's general attitudes to gender, nor with her attitudes to whether IPV was ever justified. However, it was associated with the belief that a woman could refuse sex when she didn't want it; women who believed that a woman could refuse sex were also less likely to report experience of IPV during the past year.

Women who reported that their mother had been abused by a partner were more likely to report personal experience of IPV. Women who drank alcohol more than very occasionally were at greater risk of experiencing IPV, but the risk is actually due to the fact that these women have partners who are more likely to drink, and it is the partner's drinking which poses the greater risk factor to them. In other words, a woman's risk due to her own alcohol consumption is not significant, after adjusting for her partner's drinking.

The final full model of factors associated with women's experience of IPV (Table 41) shows therefore that a woman is at greater risk of experiencing IPV if she has a mother who was abused, or if her partner drinks alcohol regularly, or if she lives in one of the three health areas. Women who are married, or who believe that a woman can refuse sex, or who are more faith engaged are at a lower risk of experiencing IPV.

Table 41 Logistic regression model of factors associated with women experiencing physical or sexual IPV in past 12 months*

Factors	Odds ratio	95% confidence intervals		p value
Household income contribution:				
unemployed/no income	1.00	–	–	–
less than half of income	0.42	0.10	1.78	0.237
about half	1.34	0.45	4.03	0.596
more than half of income	1.66	0.41	6.69	0.479
all/nearly all	0.38	0.15	0.96	0.04
Partner's alcohol drinking:				
never	1.00	–	–	–
occasionally	0.88	0.37	2.09	0.765
more often	3.56	1.63	7.79	0.001
Engagement in religion:				
no religion/does not attend	1.00	–	–	–
attends services only	0.36	0.14	0.91	0.032
participates actively or leads	0.32	0.15	0.73	0.006
Witnessed abuse of mother as a child	2.77	1.26	6.11	0.012
Married	0.25	0.12	0.51	<0.0001
Believes a woman can refuse sex when she doesn't want it	0.36	0.15	0.84	0.018

* Adjusted for location and age group

6.2 Factors associated with perpetration of violence by men

6.2.1 Non-partner sexual violence (ever)

We looked at associations between socio-demographic characteristics (age, education, relationship status, work in past 12 months, geographical location and poverty) and men's lifetime perpetration of NPSV. Factors associated are shown in Table 42.

Relationship status and location proved to be factors, since having a girlfriend was associated with a much greater likelihood of having committed NPSV than being married, as was living in one of the three health areas (this was the same health area where women reported more violence). Otherwise, men's education, employment and how many meals eaten per day (as a proxy poverty indicator) were not associated with whether they had ever perpetrated NPSV. Religious affiliation and faith engagement were also not associated.

Men's perpetration of NPSV has been shown in other research[16] to be associated with men engaging in transactional sex, having multiple sexual partners, and having conservative gender attitudes, but these factors were not significant in the data from the full models for this survey. Instead, aligning with wider literature,[17] the key factors here strongly associated with perpetrating NPSV were having been sexually abused as a child, and alcohol consumption. Men who had been sexually abused as a child were nine times more likely to have perpetrated NPSV.

Table 42 Logistic regression model of factors associated with men ever perpetrating NPSV against a woman*

Factors	Odds ratio	95% confidence intervals		p value
Engagement in religion:				
no religion/does not attend	1.00	–	–	–
attends services only	1.83	0.73	4.59	0.199
participates actively/leads	0.80	0.33	1.94	0.623
Religion:				
Christian	1.00	–	–	–
Muslim	1.27	0.48	3.39	0.632
other	1.76	0.62	4.99	0.288
Sexually abused as a child	9.67	4.46	20.97	<0.0001
Drinks alcohol:				
never	1.00	–	–	–
occasionally	0.71	0.22	2.26	0.559
more often	2.70	1.19	6.12	0.017

* Adjusted for location and age group

6.2.2 Men's perpetration of physical or sexual IPV in the last 12 months

The research considered the association between socio-demographic characteristics (age, education, relationship status, work in past 12 months, community and wealth) and men's perpetration of any physical or sexual IPV in the last 12 months. Age was a factor, as perpetration became less likely with advancing age and was significantly lower among older men (over 50) than young men. It was also lower among men who worked than those who were unemployed. Perpetration tended to be higher in the health area where women also reported more violence.

Being very actively involved in a faith institution (both Christian and Muslim) was associated with a much lower likelihood (reduced by half) of having been violent towards a partner in the last year (however, the mechanism is through reduced alcohol consumption among the more faith engaged – men who are most faith engaged are twice as likely to be non-drinkers than those not engaged). Drinking alcohol regularly was associated with a

greater likelihood of having committed IPV, while gender attitudes, number of partners, transactional sex, and the (female) partner's drinking were not associated. Men whose mother was abused were twice as likely to have perpetrated IPV.

The final full model of factors associated with men's perpetration of IPV (Table 43) therefore shows that a man is more likely to have committed IPV if he drinks alcohol regularly or has a mother who was abused by her partner; and is less likely if he is in work or older.

After adjusting for alcohol consumption, geographical location and faith engagement were not significantly associated.

Table 43 Logistic regression model of factors associated with men perpetrating physical or sexual IPV in past 12 months*

Factors	Odds ratio	95% confidence intervals		p value
Household income contribution:				
unemployed/no income	1.00	–	–	–
less than half of income	0.12	0.02	0.66	0.015
about half	0.69	0.26	1.81	0.449
more than half of income	0.89	0.39	2.04	0.79
all/nearly all	0.53	0.22	1.24	0.144
Drinks alcohol:				
never	1.00	–	–	–
occasionally	0.95	0.42	2.16	0.896
more often	3.18	1.58	6.42	0.001
Engagement in religion:				
no religion/does not attend	1.00	–	–	–
attends services only	1.39	0.62	3.14	0.423
participates actively or leads	0.64	0.31	1.35	0.239
Witnessed abuse of mother as a child	2.47	1.25	4.85	0.009
Age group:				
15–24 years	1.00	–	–	–
25–34 years	0.69	0.34	1.41	0.312
35–49 years	0.43	0.20	0.93	0.032
50 + years	0.14	0.03	0.62	0.009

* Adjusted for location

6.3 Factors associated with the belief that a woman has the right to refuse sex

Since the belief that a woman can refuse sex strongly correlated with reduced experience of IPV for women, factors associated with it were also modelled (Table 44).

This showed that for women, faith engagement is a key factor associated with holding this more empowered view, as women who were actively engaged in their church or mosque were four times more likely to believe a woman can refuse sex than those not attending. Women living in one health area (with the least reported violence) were much more likely to believe this. Poverty was a factor, as those who had two or three meals a day were more likely to hold this view than those who had only one meal. Education was also a factor, as those who had completed primary school, high school or had post-secondary education were more likely to believe that women can refuse sex, compared to women who had not been to school.

Table 44 Logistic regression model of factors associated with women agreeing that a woman can refuse sex if she does not want it*

Factors	Odds ratio	95% confidence intervals		p value
Engagement in religion:				
no religion/does not attend	1.00	–	–	–
attends services only	1.86	0.77	4.49	0.167
participates actively or leads	4.46	2.24	8.87	<0.0001
Number of daily meals:				
one	1.00	–	–	–
two	0.47	0.22	1.03	0.059
three	0.35	0.14	0.88	0.026
Education:				
none	1.00	–	–	–
incomplete primary	0.74	0.37	1.48	0.394
completed primary	2.44	1.04	5.73	0.04
incomplete secondary	1.37	0.56	3.37	0.494
completed secondary	2.64	1.06	6.60	0.037
higher than secondary	5.61	1.06	29.76	0.043

* Adjusted for location and age group

Factors associated with agreeing that a woman can refuse sex if she does not want it were also modelled for men, although no clear correlation with perpetration of NPSV or IPV was found. Factors associated with supporting a woman's right to refuse sex (see Table 45) were male faith engagement (men actively engaged were more than four times as likely to agree), working (those with employment in the last 12 months were twice as likely to agree) and relationship status (un-partnered men were more likely to agree than married men).

Table 45 Logistic regression model of factors associated with men agreeing that women can refuse sex if they do not want it*

Factors	Odds ratio	95% confidence intervals		p value
Engagement in religion:				
no religion/does not attend	1.00	–	–	–
attends services only	2.59	1.05	6.43	0.04
participates actively/leads	4.61	2.21	9.62	<0.0001
Relationship status:				
married	1.00	–	–	–
has a sexual partner	0.45	0.17	1.16	0.1
partnered in last 12 months, none now	2.05	0.54	7.77	0.289
unpartnered	2.64	1.25	5.60	0.011
Worked in last 12 months	2.22	1.22	4.04	0.009

* Adjusted for location and age group

DISCUSSION OF FINDINGS

Overview

Overall, the socio-economic status of these remote rural communities is low even for the DRC context, with extremely low levels of education, particularly for women. Households did not have electricity, owned very few assets, and only a minority had access to improved sanitation facilities or safe water at home. Nearly all participants belonged to a religion, and most rated faith as important in their lives, particularly women. Prevalent beliefs in male superiority, women's lack of decision-making or right to sexual consent, and the gendered assignment of household tasks reflected strong gender inequalities within these communities.

North-eastern DRC is a conflict-affected context, and levels of violence reported within these communities are high, particularly sexual violence. High rates of both IPV and NPSV were reported in the last 12 months, and significant stigma is attached to survivors. There is also a high incidence of physical IPV. Overall, levels of violence reported by women were not dissimilar to reported perpetration by men, and perpetrators were more likely to be intimate partners or otherwise known (family or community members), rather than armed groups.

The survey data shows that women's experience of IPV correlated with a range of factors; active faith engagement, being married, and holding the belief that a woman can refuse sex were protective factors; but geographical location, her partner's alcohol consumption, and witnessing domestic violence as a child increased the risk of experiencing IPV. Men's perpetration of IPV was linked to their increased alcohol consumption and to witnessing domestic violence as a child, while older men and those in employment were less likely to perpetrate IPV.

Women's experience of NPSV was associated with geographical location, increased alcohol consumption, and the type of water source they used (as getting water from protected wells correlated with a much higher risk of experiencing NPSV). The minority of women with post-secondary education were more likely to disclose experience of NPSV, while married women were less likely than others to report it. Male perpetration of NPSV was linked to increased alcohol consumption, geographical location, and experiencing sexual abuse as a child.

One of the most striking findings was that faith engagement[18] was consistently shown to correlate with more empowering attitudes for both men and women, and also showed a protective correlation in terms of women's experience of IPV.

Faith communities

The project design was based around engaging and equipping faith groups to prevent and respond to VAWG. There is currently a lack of research and (particularly quantitative) evidence base available on faith-based approaches in this field,[19] despite an increasing recognition by the UK government and others of the need to engage with faith groups in tackling harmful social and gender norms to prevent SGBV.[20] This survey data confirms the relevance of a faith-based approach within this context, highlighting the significant reach and prevalence of faith within these target communities, where 95% of respondents identified with a religion and 83.4% of those described their faith as important or very important in their lives, particularly women. The majority were Christian (76.6%) or Muslim (14.0%), roughly reflecting national demographics in DRC. Most women (57.8%) and 42.2% of men did not belong to any other community group, further emphasising the comparative reach of faith institutions in these remote communities. The influence of faith leaders was underlined, as they were the only social referent whose opinion people felt significantly motivated to comply with (in comparison to partner, friends, parents, family, community leaders).

Violence

Overall, the data shows high levels of violence within these communities, which emphasises the urgency of this intervention. Sexual violence was noticeably high in comparison to other contexts,[21] with 38.4% of women reporting sexual IPV in the past year. Experience of NPSV within the past 12 months was reported by 20.8% of women, compared to a national estimate of 16%[22] and a recent global estimate of 7% for lifetime experience of NPSV.[23] Experience of physical IPV in the past 12 months roughly aligned with the national average, with 30.8% of women reporting it (compared to 27% across DRC[24]). This violence was reflected in gender attitudes, as more than half of male respondents (51.0%) and 42.6% of women agreed that there are times when a woman deserves to be beaten.

In contrast to common narratives of sexual violence in conflict, which focus on perpetration by armed actors and rape as a weapon of war, in 86.6% of NPSV cases in the past year the perpetrator was a family member or otherwise known, with only 8.5% of cases attributed to militia. Overall, by far the most prevalent form of violence reported was IPV, with 68.8% of women experiencing some form of IPV within the past 12 months, consistent with 68.2% of men reporting having perpetrated IPV within the same time period. Domestic violence was also generally recurring rather than an isolated incidence, with most respondents reporting multiple occasions. These findings emphasise the need to continue to address IPV as a priority, and the relevance of community-based approaches in preventing SGBV, even within conflict-affected contexts.

Faith engagement and women's empowerment

One of the most striking factors this data shows is that for women, there is a clear and consistent association between active engagement within a faith group and both reduced experience of IPV and more 'empowered' attitudes around gender and rights for women. Since there is currently very little quantitative data available on faith and SGBV,[25] these findings provide an interesting new contribution to the field, and an invitation for further research on these links. Although representing a minority within the wider community sample, women who were actively engaged or in leadership roles within their faith group (both Christians and Muslims) reported more say in decision-making in relationships, and were more likely to believe that physical violence is unjustified in any circumstances, and that a woman can refuse sex, compared to women who simply attended services or were not engaged at all. In contrast to findings from some other contexts,[26] this belief in a woman's right to sexual consent also strongly correlated with reduced experience of IPV.

Faith engagement was highlighted as one of the few variables that remained a significant correlation with reduced experience of physical/sexual IPV for women, even when adjusted for other factors. For men, faith engagement was also significant in terms of equitable gender attitudes. Men who were actively engaged or in leadership in faith groups were more likely to believe that God created men and women equal, much more likely to support a woman's right to refuse sex, and more likely to share household decision-making with their partner. Being actively involved in a faith institution (both Christian and Muslim) was also associated with a much lower likelihood (reduced by half) of violence towards a partner in the last year. This correlation was mediated through reduced alcohol consumption among the more faith engaged.

A common perception may be that faith groups, assumed to preach conservative and submissive values, would encourage gender inequitable attitudes and behaviour, and indeed the theory of change was partially based on the need to address such teaching. However, the data shows a surprising correlation between women's empowerment and active female participation and engagement in faith groups. It could be that the minority of women who hold more empowered attitudes and beliefs within a patriarchal context are more likely to engage more actively in community life, and can express that through participation within a faith group. Or it may be that the opportunities for active participation and some form of leadership and decision-making role that this key community forum provides creates or strengthens a sense of empowerment. Or perhaps it is due to an understanding of individual value and dignity conferred through personal faith beliefs. It may be a combination of all of these. Very little research or comparative findings are currently available within the wider literature, so further qualitative research could help to explore in more depth how active engagement within a faith group links

to more empowered attitudes and increased decision-making for women, why it has a protective mechanism in terms of experience of IPV, and how this can then be strengthened and supported, within the target communities.

Stigma for survivors

This survey revealed a stark gap between general perceptions that faith groups are supportive of survivors of sexual violence and the realities of survivors' own experience, with only 5.4% of survivors reporting that their faith group behaved in this way. This highlights that although faith groups may well have the potential and mandate to play a key role, much work remains to effectively realise this in practice. It also highlights the strength of stigma against survivors that currently prevails within these communities and is a barrier to disclosure and accessing essential care and support. More than half (53.9%) of men and 38.5% of women said they would question a rape victim's character, and 37.1% of men (27.0% of women) felt that a man is justified in rejecting his wife if she has been raped. The majority of survivors said they had not sought help, and the main reasons given were that it was 'no use' (both male and female survivors) or (for women) because they did not want to disgrace the family, did not want to get the person in trouble, or they were afraid of divorce or desertion. This reflects current understanding of the impact of stigma,[27] which is increasingly recognised as an enabling factor for violence, and as a barrier for survivors to access essential services, and so highlights the urgency of addressing this stigma at the local level.

It is striking that men and women actively engaged within faith groups tended to have more empowering attitudes, and were less likely to agree that a man could reject his wife if she has been raped. However, the general congregation (i.e. the majority who just attend services) were often more discriminatory than those not engaged with a faith group at all. There remains, therefore, a need to engage with faith leaders, both to address stigma within faith groups themselves, and to ensure that the positive attitudes consistently shown by those most engaged can be effectively translated across the wider community.

Faith and gender norms

In general, attitudes around gender and social norms, including division of household and domestic tasks, revealed high levels of gender inequality in these communities, with the vast majority of respondents (89.9% of men and 81.7% of women) agreeing with the statement that 'men are superior to women'. The data also confirms the influence of faith teaching and understanding on attitudes around gender. Across the sample, belief that a woman could not refuse sex with her partner was consistently stronger when it was phrased as a scriptural (i.e. religious) principle. For example, 81.8% of men and 74.9% of women agreed with the statement that 'a married woman has no right or control of her body according to the Bible/Qur'an', but a reduced number (76.1% of men and 67.2% of women) agreed with the comparable statement that 'a man is entitled to sex even when his partner doesn't feel like it'. This could reflect popular understanding of more conservative views being condoned by faith teaching, or may simply be due to a reluctance to publically contradict anything worded as scripture.

Either way, this supports the project's theory of change and underlines the importance of an approach to tackling gender norms that engages with these faith texts. It is clear that most of the community hold gender inequitable beliefs around sexual consent in relationships. However, men and women who were actively engaged with faith groups were, in fact, twice as likely to disagree with the former 'scriptural' statement, and maintain a woman's right to consent, compared to those not engaged. Since regression analysis shows that believing a woman has the right to refuse sex was linked to reduced experience and perpetration of IPV, a key question would then be how best to leverage these leaders' more empowering understanding of their faith texts across the wider community.

Risk factors: alcohol consumption, childhood experience

Other factors commonly associated with experience or perpetration of IPV and NPSV in available research[28] were also considered, and a range of gender and social norms, including harmful constructs of masculinity, were measured. As noted, the findings reflected significant levels of gender inequality within the communities, particularly around decision-making and division of household tasks. However, apart from the specific beliefs

around sexual consent and justification of physical violence already referenced, these norms were not clearly associated with either experience or perpetration of IPV within this sample. Risk behaviours such as transactional sex, and having multiple partners, were in this case not consistently associated, although relationship status was a factor, in that married women experienced less NPSV and IPV compared to others. Married men were also less likely to perpetrate NPSV than those with a less formal relationship status.

For both women and men, increased alcohol consumption was clearly associated with experience or perpetration of NPSV and IPV, correlating with similar findings in other studies.[29] For IPV, it was consistently male alcohol consumption that was the primary correlation – as women who drank regularly were more likely to have a partner who also drank. Men who were actively engaged in their faith group were twice less likely to drink, leading to a correlation with reduced perpetration of IPV. Since the project's theory of change did not initially focus on alcohol consumption as a risk factor, these findings suggest that this could now be considered and raised as an issue, particularly in training and engagement with men and boys.

Childhood experience was relevant for both men and women. Women who reported that their mother had been abused by a partner were more likely to experience IPV, and men whose mothers had been abused were more likely to perpetrate IPV. Consistent with other literature, male experience of sexual abuse in childhood was one of the strongest correlating factors for sexual violence,[30] with these men twice as likely to perpetrate IPV, and nine times more likely to commit NPSV. This highlights the need for prevention work with male youth, particularly given the young ages reported for first perpetration (the majority were under 20 years old), and the prevalence of experience (30% of men surveyed reported experiencing sexual abuse as a child). These findings also emphasise an urgent need for more space and appropriate tools to address male trauma and abuse. This is still taboo and rarely even considered within local communities, and is often lacking within a violence against women and girls programme framework.

Contextual factors: poverty, water source

In considering the findings and implications of this research, it is important to contextualise it. As anticipated, given the remote rural location within Ituri Province, the data reveals very low socio-economic status indicators. Levels of education were extremely low, especially for women, even within the DRC context, with more than 68% of women reporting that they had not completed primary education, and 35.8% reporting that they had received no education, compared to the national figure of 15%.[31] Households did not have electricity, owned very few assets, and 67.4% had shared pit latrines (national figures for unimproved sanitation are 46%).[32] Poverty and low levels of education are shown to be associated with SGBV in wider literature.[33] Here, a reduced number of meals per day, as a proxy indicator for poverty, correlated with increased experience of NPSV for women, but was not significant in terms of IPV experience. For women, contributing more than half of household income had a protective correlation with reduced experience of IPV (a third of these women were married), suggesting the importance of women's economic empowerment, although that is not currently a focus of this project design. Men who work were also less likely to perpetrate IPV than those who were unemployed, but for NPSV no significant correlation was shown with education, work or poverty.

Water source was a significant contextual factor, with women who fetched water from a protected well being more likely to experience NPSV, consistent even when other factors (including geographical location) were adjusted for. Out of all 769 participants, only two people had access to a water supply on their property and in subsequent focus group discussions, project actors explained that there was no piped water or gravity-fed system in the target area. All the protected sources were up in the hills, requiring women to walk a considerable distance from the villages to fetch safe water. While protecting water sources is clearly a positive development intervention, the data shows that, in this context, it has put women at risk, and so highlights the need for gender considerations to be taken more strongly into account in water and sanitation interventions, to mitigate risk. Geographical location was also a significant factor, with residence in one of the three health areas consistently correlating with higher experience and perpetration of both IPV and NPSV, without any clear attribution to other variables. Although not directly verifiable from the data, this could perhaps be linked to the fact that there is a main access road and market centre in this area which draws people from the surrounding areas, whereas the target villages in the other health areas are generally more remote, with fewer commercial stalls and traffic. The

variation shown according to these geographic factors underlines how communities or areas within a region or country can be affected differently by conflict and violence, and thus emphasises the need for context-specific research, understanding and approaches.

Limitations of the study

The research has limitations. Because of its small size, the sample cannot be considered representative of the population of the region or province, and selection was not fully randomised. Therefore, although the findings are interesting and may have wider relevance, they cannot be generalised beyond the area of the research. There is also a small possibility that the questionnaire was administered inconsistently, as it was translated into French and verbally translated by the enumerators conducting the interviews into the local language, Kilendu, which is not regularly used in a written format. Although the translations into Kilendu were workshopped intensively during the enumerators' training beforehand, and the translation of key words and questions agreed by the group, there may well have been inconsistencies in practice, and the possibility of misunderstandings.

As with any survey on these sensitive issues, and despite efforts to ensure confidentiality, there may well also be under-reporting, especially of perpetration of violence, although the high levels reported and the rough consistency between levels of male perpetration and female experience of violence indicates that this was, perhaps, less of a factor in this case.

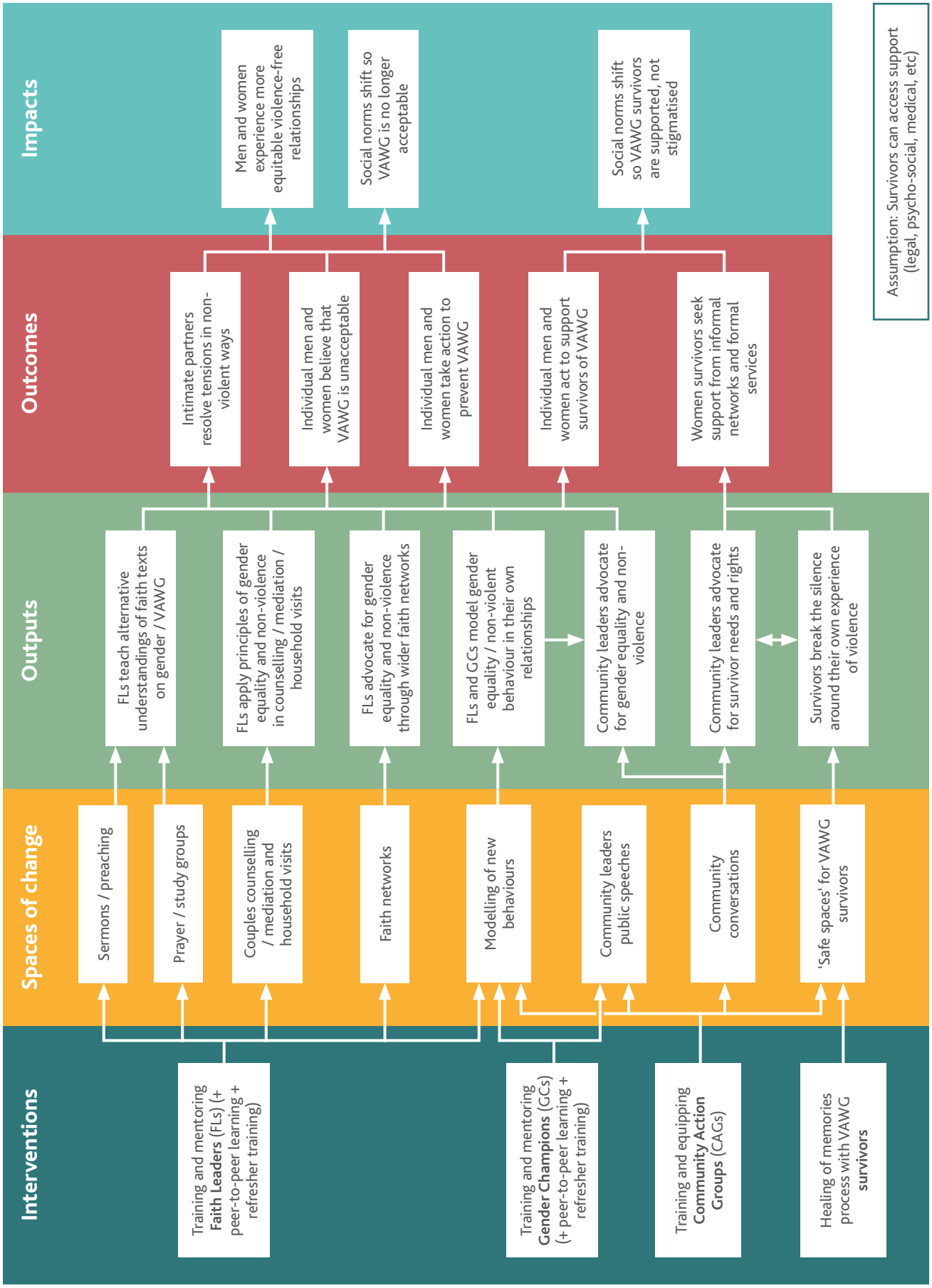
Conclusion

The theory of change for this project was based on global research linking the root causes of SGBV to harmful social and gender norms.[34] The intervention design built on Tearfund's qualitative data and understanding – gained over years of practical programming – of faith leaders' and faith groups' influence within communities, and the need to mobilise them to help transform harmful social norms and thus to prevent VAWG. Given the lack of academic literature, particularly quantitative data, on the role of faith in relation to SGBV,[35] the project seeks to help address this evidence gap and to evaluate Tearfund's faith-based approach.

These findings will provide input for project activities and help to contextualise planned workshops. While confirming the project's emphasis on a faith-based approach, they also highlight the need to strengthen the intervention focus on addressing IPV within conflicted-affected communities, and to mobilise more practical support for survivors.

The findings of this initial baseline research confirm the reach and importance of faith groups within these target communities in DRC, and thus validate the need to engage with this influential demographic in seeking to prevent VAWG. They also highlight specific striking associations between faith engagement, gender attitudes, and experience or perpetration of SGBV, which challenge current understanding of these issues through showing the empowering effect of faith engagement on women's lives. Further qualitative research could help to explore in more depth how active engagement within a faith group links to more empowered attitudes and increased decision-making for women, why it has a protective mechanism in terms of experience of IPV, and how this can best be strengthened and supported within the target communities.

ANNEX 1: PROJECT THEORY OF CHANGE



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3 World Health Organization 'Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence', 2013. Available at: http://apps.who.int/iris/bitstream/10665/85239/1/9789241564625_eng.pdf

4 DRC Demographic and Health Survey 2013–2014

5 Data from www.worldbank.org/en/country/drc/overview.

6 http://hdr.undp.org/sites/all/themes/hdr_theme/country-notes/COD.pdf

7 Peterman A, Palermo T, and Bredenkamp C, 'Estimates and determinants of sexual violence against women in the Democratic Republic of Congo', *American Journal of Public Health*, 101(6) (June 2011), 1060–1067.

8 For more information on HEAL Africa's work, please see www.healafrica.org

9 DHS 'Domestic violence module. Recommendations for implementation and questions', available at: http://dhsprogram.com/topics/gender-corner/; https://dhsprogram.com/pubs/pdf/DHSQMP/domestic_violence_module.pdf

10 http://www.who.int/gender/violence/womenfirtseng.pdf

11 Rural age distributions from 'DRC Demographic and Health Survey 2013–14'.

12 In the remainder of this section, figures are calculated as a percentage of the sample who indicated religious affiliation (i.e. 734, out of the 769 total respondents).

13 A 'faith engagement' variable was used throughout the analysis to look at how engagement with a faith group correlates with other attitudes and behaviours. It was calculated as 'actively engaged' (combining those who actually take part in services with those who have decision-making or leadership roles), those simply 'attending services', or 'unengaged' (combining those who are not engaged at all, or have no religion).

14 Either actively participating in services, or with a decision-making or leadership role.

15 An error in the logic of the questionnaire meant that these questions were not also asked of those who had experienced NPSV.

16 Jewkes R, Fulu E, Roselli T, Garcia-Moreno C on behalf of the UN Multi-country Cross-sectional Study on Men and Violence research team, 'Prevalence of and factors associated with non-partner rape perpetration: findings from the UN Multi-country Cross-sectional Study on Men and Violence in Asia and the Pacific', 2013. *The Lancet Global Health*, Volume 1, Issue 4, e208-e218.

17 Ibid.

18 The 'faith engagement' variable combines those who actively take part in services (i.e. not just attend) along with the small number who are in decision-making or leadership positions within their faith group.

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20 Global Summit to End Sexual Violence in Conflict, Chair's Summary, June 2014, extract: *'We noted that good laws and international agreements in themselves are not enough if attitudes don't change. In this respect, faith groups have a key role to play, including in their role providing care, treatment and support for survivors. Through their networks, they often have access and influence with local communities that no other actor has. As such, they are uniquely placed to change hearts and minds, and challenge cultural and social norms, including notions of masculine identity as it affects sexual violence. The Summit recognised the need to engage faith-based organisations as active partners in the fight against sexual violence.'*

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22 'DRC Demographic and Health Survey 2013–2014'.

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29 Ibid; Abbey A, 'Alcohol's role in sexual violence perpetration: theoretical explanations, existing evidence and future directions', *Drug and Alcohol Review*, 30 (2011), 481–489.

30 Fulu et al., 2013.

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DOES FAITH MATTER?

Faith engagement, gender norms and violence against women and girls in conflict-affected communities

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