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Situational Analysis of Intimate Partner Violence Interventions in South Asian and Middle Eastern Countries

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It is vital to identify forms of intimate partner violence (IPV) experienced by women and men in intimate relations, their underlying causes, and the impact on their own lives and the society. Research on victimization of women is ample; however, men's victimization in intimate relations is a neglected area of research in many world regions, thus requiring more attention. Among the common psychosocial factors correlated with IPV, specific social, economic, and cultural factors in South Asian and Middle Eastern countries increase women's vulnerability to face and bear the detrimental consequences of IPV. The review of existing literature and interviews with 16 notable agencies in Pakistan indicate that most of the existing intervention programs in these countries focus on providing legal and psychosocial support to female victims. In addition, there is lack of adequate evaluation or proper documentation of the activities and outcomes of intervention programs. These findings strongly suggest that further research on structured perpetrators programs in this part of the world is needed.

KEYWORDS: intimate partner violence; partner abuse; risk factors; victimization; perpetrator intervention program

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In South Asian societies, intimate partner violence (IPV) is one of the most common forms of family violence that includes physical, sexual, and emotional abuse and controlling behaviors by an intimate partner. IPV occurs in almost all settings, all-socioeconomic, religious, and cultural groups. Although women can equally be violent in relationships with men, and violence also occurs in the same-sex partnerships, in many countries, the most common perpetrators of violence against women are male intimate partners.

The problem is so common and widespread that it has almost become an invisible form of crime and an everyday story in many households. IPV has been found to be a widespread phenomenon in developing countries, as repeatedly indicated by World Health Organization (WHO) survey reports in the past decade (Abramsky et al., 2011; García-Moreno, Jansen, Ellsberg, Heise, & Watts, 2005; Krug, Mercy, Dahlberg & Zwi, 2002; WHO, 2013). Similar findings have been published by local organizations in Pakistan (Aurat Foundation, 2011; Human Rights Commission of Pakistan [HRCP], 2013; National Institute of Population Studies [NIPS] & ICF International, 2013), in South Asian countries (Ministry of Health and Family Welfare, 2007; National Institute of Population Research and Training [NIPORT], 2009; Panda & Agarwal, 2005), and in Middle Eastern countries (Douki, Nacef, Belhadj, Bouasker, & Ghachem, 2003). The Egypt Demographic and Health Survey (EDHS-2005; El-Zanaty & Way, 2006) showed women are at increased risk to face abuse in intimate relations. IPV by women against men is also widespread in developing as well as more developed nations (Esquivel-Santoveña, Lambert, & Hamel, 2013; Straus, 2008); however, very few studies have reported on this phenomenon in Middle Eastern and South Asian countries.

A growing number of population-based surveys have measured the prevalence of IPV, most notably the WHO multicountry study on women's health and domestic violence against women, which collected data on IPV from more than 24, 000 women in 10 countries representing diverse cultural, geographical, and urban/rural settings. The study confirmed that IPV is widespread in all countries studied (Garcia-Moreno et al., 2005). In light of the high and worldwide prevalence of IPV, there has been increased emphasis on identification of overt and covert forms of abuse experienced by women and men in intimate relations, their underlying causes, and impact on their own lives and society at large. According to reports by international organizations, 10%–50% of women from developed and developing countries report being physically assaulted at some point in their lives by a partner (Heise, Ellsberg, & Gottemoeller, 1999; Tjaden & Thoennes, 2000) Similarly, findings of a multicountry study of 24,000 women surveyed in Bangladesh, Brazil, Ethiopia, Japan, Peru, Namibia, Samoa, Serbia and Montenegro, Thailand, and the United Republic of Tanzania showed 15%–75% of the women reported IPV (García-Moreno, Jansen, Ellsberg, Heise, & Watts, 2006). An extensive review of scholarly research on IPV across different regions of the world (Esquivel-Santoveña et al., 2013) also reported high prevalence of IPV in third world countries as compared to United States and English-speaking countries.

Causes and consequences of various forms of violence in intimate relations experienced by women and men are likely to be influenced by specific social, economic, and

cultural settings of people in different regions (Capaldi, Knoble, Shortt, & Kim, 2012; Esquivel-Santoveña et al., 2013).

The following literature review examines and summarizes the findings of the existing research studies on prevalence, risk factors, impact of IPV, and nature and outcomes of interventions for IPV in South Asian (India, Bangladesh, Pakistan) and Middle Eastern countries (Egypt, Iran, Iraq, Israel, Jordan, Kuwait, Lebanon, Oman, Palestine, Qatar, Saudi Arabia, Syria, Turkey, United Arab Emirates, Yemen, Bahrain, and Cyprus). This is an attempt to provide a comprehensive review of literature and thus identify the major gaps in existing research on IPV from these regions.

PREVALENCE OF INTIMATE PARTNER VIOLENCE IN SOUTH ASIAN AND MIDDLE EASTERN COUNTRIES

In the past 2 decades, there has been increased awareness about the issue of domestic violence against women in South Asian and Middle Eastern countries (WHO, 2013).

Pakistan

An annual report published by HRCP (2013) showed that 56 women were killed for giving birth to girls in the year 2013. There were 389 cases of IPV that were reported by the media in the same year. This is not much different from the picture presented by HRCP annual reports in the year 2004 and later in 2008, which also showed that 50% of women in urban areas and 80% of women in rural areas of Pakistan either exposed or are at risk of facing abuse in intimate relations (HRCP, 2004, 2008).

Women in Pakistan commonly experience various broad forms of domestic abuse and violence such as forced marriages; acid attacks; honor killings; marriage to Quran; and physical, emotional, and sexual violence by relatives, besides the abuse by their intimate partners. Statistics released by the Aurat Foundation for 2011 showed that 8,539 cases of domestic abuse were reported by Pakistan media, and IPV was the most commonly experienced form of violence by these women.

In Pakistan, surveys and research on issues of domestic violence have mostly been carried out by individual researchers, voluntary organizations, and international donor agencies; thus, the reliability of these estimates is questionable. However, no serious effort has been made at the national level to obtain more reliable estimates about prevalence rates of various forms of domestic abuse experienced by men and women, underlying causes and outcomes on physical, mental, and social well-being. Most of the available statistics presented in the following text were obtained through cross-sectional studies carried out by individual researchers or nongovernmental organizations (NGOs) in Pakistan.

According to a recent survey (Pakistan Demographic and Health Survey; NIPS & ICF International, 2013) based on a nationally representative sample of 3,687 women, 33% of the women reported experiencing at least one serious incidence of physical and/or emotional abuse from intimate partners in the past 12 months, including 10%

who were abused during their pregnancy. This was the first time that a demographic health survey included a domestic violence module after being intimated by several health care agencies and human rights activists.

A survey was conducted in a selected community of Lahore, as part of Gender Equity Program by Aurat Foundation (Kamal, 2012). Thirty-four percent of women in a sample of 400 reported experience of physical violence at some point in their lives, whereas 15% experienced it at least once a month. Physical injuries were reported by 2.3% of female participants. Verbal conflicts were more commonly reported by intimate partners and equally prevalent in literate and illiterate couples. The main perpetrator of these verbal disputes is usually the husband and frequently encouraged by other family members and in-laws. The most commonly experienced acts of verbal abuse included shouting, criticism, and persistent psychological stress.

This survey also assessed perceptions about various acts of IPV by asking questions from both genders. Analysis of responses revealed that most of the participants do perceive various acts of physical and emotional abuse in line with the accepted definitions of IPV in literature. However, there were differences in the pattern of responses made by male and female participants. Most of the men did not consider keeping their wives short of money, forcing them to act against their will, depriving them of property rights, or limiting their access to education and medical assistance as abusive acts. These acts were considered as violent by female participants. Female participants, interestingly, did not consider insulting remarks, criticism, and isolation to be as serious forms of psychological abuse (Kamal, 2012).

A cross-sectional survey carried out between December 2008 and January 2009 obtained data from eight hospitals in Lahore and Sialkot found that in a sample of (N = 373) women, 22% experienced physical abuse, 27% experienced sexual violence, and 60% reported serious acts of psychological violence in the past 12 months (Zakar, Zakar, Mikolajczyk, & Krämer, 2012). Another community-based study was conducted in urban Karachi, a metropolitan city. Seven hundred fifty-nine married women aged 25–60 years were interviewed. Lifetime prevalence of physical abuse was found to be 57%, and the rates were 54% for sexual abuse and as high as 83% for psychological abuse (Ali, Asad, Mogren, & Krantz, 2011; refer to Table 1).

In a hospital-based survey of (N = 1,369) pregnant women, 20% of the respondents reported physical or sexual violence, and 48% reported verbal abuse (Asad et al., 2010; refer to Table 1).

A review of the literature found rates of IPV against women in Pakistan to range from 30% to 79% (A. J. Khan et al., 2009; refer to Table 1). Nasrullah, Haqqi, and Cummings (2009) reviewed (N = 1,957) cases of honor killings that occurred between years 2004 and 2007, to identify epidemiological patterns of honor killing of women in Pakistan. Findings revealed that 88% of women killed in name of honor were married. In 92% of cases, the underlying reason was suspicion of alleged extramarital relations, and in 43% of cases, the perpetrator was the husband.

The Department of Community Health Sciences at Aga Khan University conducted a case study on domestic violence. All women in a sample of 108 reported to having

TABLE 1. Overview of Studies From Pakistan on Prevalence, Causes, and Consequences of Intimate Partner Violence

Authors	Year	Aim	Study Design	Main Findings
Fikree, Razzak, and Durocher	2005	To explore men's attitudes on wife abuse and examine predictors for the risk of physical abuse in a cohort of Pakistani men	Cross-sectional; community sample of 176 men selected from all socioeconomic strata	Forty-six percent of participants thought that husbands have a right to hit their wives, and 49% approve that they commit wife abuse at times. Low socioeconomic status and childhood abuse appear to be most significant predictors of IPV.
Fikree, Jafarey, Korejo, Afshan, and Durocher	2006	To assess the magnitude and determinants of intimate partner violence before and during pregnancy	Cross-sectional; clinical data of 300 women from gynecological wards in postnatal care	Forty-four percent of women reported lifetime marital physical abuse and 23% during the index pregnancy. Among the 132 women who were ever physically abused, all reported verbal abuse and 36% sexual coercion.
Ali and Bustamante-Gavino	2006	To assess the prevalence and nature of abuse faced by ever-married women in selected community of Karachi	Cross-sectional survey of 400 ever-married women between the ages of 15 and 45 years from lower socioeconomic regions of Karachi	97% of women faced verbal abuse. Physical abuse was reported by 80% of these women attributable to financial issues, infertile status of women, or the birth of a baby girl in the family.
Karmaliani et al.	2008	Assessment of anxiety and depression in pregnant women	Cross-sectional survey	Verbal and physical abuse during pregnancy is the most significant predictor of depression and anxiety among urban women.
Naeem, Irfan, Zaidi, Kingdon, and Ayub	2008	Psychosocial factors associated with domestic violence	Cross-sectional survey of women presenting to primary care physicians	Fifty percent of women were facing abuse; joint family system as significant predictor; abused women were unhappy and more inner anger.

(Continued)

TABLE 1. Overview of Studies From Pakistan on Prevalence, Causes, and Consequences of Intimate Partner Violence *(Continued)*

Authors	Year	Aim	Study Design	Main Findings
A. J. Khan, Ali, and Khawaja	2009	Review of literature	Review of articles published during 1998–2008 from Pakistan	Incidence of intimate partner violence was reported as in the range of 30%–79%. Common reported injuries were sore muscles, sprains, and head injuries.
Kapadia, Saleem, and Karim	2009	Factors associated with sexual violence	Cross-sectional; 500 women from hospital	One in five women reported spousal sexual abuse, unwanted pregnancy, and conflict with-in laws caused family conflicts and violence episodes.
Karmaliani et al.	2009	Mental health correlates of IPV	Cross-sectional survey	Eighteen percent of the pregnant women had anxiety and/or depression, with physical or sexual and verbal abuse during pregnancy.
Asad et al.	2010	To assess the prevalence of suicidal thoughts and attempts among pregnant Pakistani women	Cross-sectional survey	Women who had anxiety or depression or had experienced verbal, physical, or sexual abuse were significantly more likely to have had suicidal thoughts and to have attempted suicide.
Ali et al.	2011	To assess the prevalence and forms of abuse faced by women	759 women in a community-based cross-sectional study	Rates of physical and sexual abuse are 57.6% and 54.5%, respectively.
Zakar et al.	2011a	Investigated the primary care physicians' response to the victims of spousal violence in Pakistan	Qualitative, in-depth interviews of 24 physicians from different hospitals in Lahore and Sialkot	Physicians lacked interest as well as competence and resources to respond to health care needs of IPV victims.
Zakar et al.	2011b	Investigated the perspectives of Pakistani religious scholars on IPV	Fourteen qualitative, in-depth interviews of religious scholars	Diversity existed in opinion of religious scholars. Some view mild or symbolic violence by a husband to be justified in exceptional circumstances; none of them believed that serious acts of violence are permissible in any condition.

Karmaliani et al.	2012	Review of causes for IPV and suggestions for interventions	Review article	The underlying factors for IPV are acceptability of violence, economic disempowerment, lack of formal education, joint family systems, entrenched patriarchal norms and values, and a lack of awareness of legal and other support systems.
Zakar et al.	2012	Association of IPV with reproductive health outcomes	Cross-sectional survey of 373 women from hospitals in reproductive health care section	Women who experienced severe physical violence were more likely to have unplanned pregnancies because of their husband's noncooperation in using contraceptives, received poor prenatal care, and have poor reproductive health.
Zakar, Zakar, and Krämer	2013	To document the beliefs and attitudes of men toward IPV against women within the context of Pakistani society	Eight in-depth interviews and four focus group discussions (FGDs) conducted in Lahore and Sialkot; the urban middle class	Most of the men wished that their wives should behave like an "ideal wife." If they found that their wives failed to conform to the "ideal standards," most of the men were willing to apply various disciplinary tools; the real and honorable
Zakar, Zakar, Mikolajczyk, and Krämer	2013	To assess the spousal violence against women and its association with women's mental health in Pakistan	373 women selected from hospitals of Lahore and Sialkot and assessed through structured interview schedule	Abused women become more upset, lose interest in daily life activities, and in some cases report suicidal ideation. Higher numbers of women who have experienced physical violence report to feeling chronically nervous, unhappy and worthless, and experiencing headaches, compared to women who have not experienced physical violence.

Note. IPV = intimate partner violence.

being exposed to one or more than one of these acts (abusive language, loud tone, bullying, oral threats, intimidating behavior or gestures, throwing or smashing things) by their husbands. Seventy-six percent of women reported exposure to any one of these (i.e., slapping, pulling hair, pushing or shoving, grabbing, hitting with an object and twisting the arm, kicking, punching, suffocating, intentional burns, hitting that resulted in fracture or injury to a vital organ). Psychological and sexual violence was always reported in combination with other forms of violence by 58% and 12% of study participants, respectively. Thirty-nine percent of women reported that their husbands keep control on their wife's earnings along with their own and that they steal valuable assets such as personal jewelry or land (Rabbani, Qureshi, & Rizvi, 2008).

A cross-sectional survey of 493 women between the ages of 20 and 45 years, selected through convenience sampling from public sector hospitals in Islamabad (capital of Pakistan) and its neighboring city Rawalpindi, revealed that 52.3% had experienced physical or emotional abuse and that 13.6% of these women reported being hit, slapped, kicked, or otherwise physically hurt by their husbands during this current pregnancy. Forced sex was reported by 21.1% of the women, and 45.2% reported feeling fear of their husband's anger (Shaikh, Shaikh, Kamal, & Masood, 2008).

Women are more likely to experience physical violence and psychological abuse around issues related to their reproductive health (Sami & Ali, 2006) and very often even tolerate abuse during their pregnancy (Karmaliani et al., 2008). A study of 300 women accessed from postnatal wards of Agha Khan Hospital, Karachi, found that 80% of women reported verbal abuse, 66% experienced it even during their pregnancy, and 36% of women also suffered sexual abuse along with physical or verbal abuse (Fikree et al., 2006; refer to Table 1).

Ali and Bustamante-Gavino (2006) reported that 97% of women in a sample of 400 ever-married women between the ages of 15 and 45 years from lower socioeconomic regions of Karachi faced verbal abuse. Physical abuse was reported by 80% of these women attributable to financial issues, infertile status of women, or the birth of a baby girl in the family (refer to Table 1).

In a sample of 176 men selected carefully to represent all three socioeconomic strata (a lower income group, a middle-income group, a high-income group), 49.4% reported committing physical violence against wives at any point during their martial lifetime, and 94.9% reported they frequently use abusive language with their wives (Fikree et al., 2005; refer to Table 1).

Another study estimated the prevalence of sexual violence experienced by women in intimate relations by calculating the average number of patients seen by obstetricians and gynecologists with physical injuries related to abuse. Based on reports from the 100 reproductive health care specialists interviewed in this study, it was estimated that 30%–79% of their female patients have experienced any form of abuse ranging from bruises and lacerations to serious vaginal injuries (Fikree, Jafarey, Korejo, Khan, & Durocher, 2004; see Table 1)

The studies on IPV in Pakistan conducted before 2003 reported more or less similar statistics (Fikree & Bhatti, 1999; Shaikh, 2000, 2003).

Bangladesh and India

Studies from Bangladesh have shown that more than 40% of women reported physical violence in intimate relations (Koenig, Ahmed, Hossain, & Mozumder, 2003; NIPORT, 2009). A survey of (N = 1,200) women from six different villages of Bangladesh was conducted during 2001–2002 showed that 35% of women were abused at the hands of their husbands in the past year, and 67% of women had been exposed to domestic abuse at some point in their lives (Bates, Schuler, Islam, & Islam, 2004). Between 42% and 47% of women in Bangladesh have faced physical violence during pregnancy (M. E. Khan, Rob, & Hossain, 2001).

Married women with disabilities in Bangladesh are at increased risk to face IPV. The lifetime prevalence of any form of abuse (physical, emotional, sexual) was found to be 84% among a sample of 226 women with disabilities, selected from four districts in Bangladesh (Hasan, Muhaddes, Camellia, Selim, & Rashid, 2014).

A survey of 29 states in India showed that 37% of women face violence in intimate relations, and prevalence rates were comparatively higher in urban areas as compared to less developed, remote villages (Ministry of Health and Family Welfare, 2007). Other studies showed that prevalence rates for IPV against women in India range between 35% and 60% (Das et al., 2013; Ruikar & Pratinidhi, 2008; Sinha et al., 2012). Twelve percent of women reported past-year psychological victimization and verbal abuse in the past year, according to one study (Chokkanathan, 2012; Esquivel-Santoveña et al., 2013). Between 22% and 28% of women in India (Das et al., 2013) tolerate physical beatings during pregnancy at the hands of their husbands.

Middle Eastern Countries

The Demographic and Health Survey of Egypt for the year 2005 found prevalence rates of IPV to be as high as 47%, and the most common perpetrators were current or previous husbands (El-Zanaty & Way, 2006). A cross-sectional survey of (N = 230) male and female participants in Egypt showed that 30% of men admitted to having committing violence against their wives, and 41% of women reported to have been the victims of physical IPV (Almosaed, 2004). According to the Amnesty International report for year 2007, nearly 250 women were murdered by their intimate partners in Egypt. A review of newspaper reports in that country indicated that most women are killed because of doubts about illegitimate relations, and in 41% of cases, the murderer was the husband (Palvia, Mao, Salam, & Soliman, 2003).

Similar patterns were observed in Turkey and Palestine (Kulwicki, 2002), and very often, the perpetrators are excused from punishments under the patrilineal norms of female–male sexual behavior. IPV against women is also highly prevalent in Tunisia (Douki et al., 2003). A survey conducted in Saudi Arabia showed that 53% of men who committed physical abuse against their wives justified their violence on the basis that they have a right to control their behavior (Almosaed, 2004).

SURVEYS REPORTING ON MALE AND FEMALE VICTIMIZATION

Comparable rates of physical and psychological IPV perpetration across gender have been found in many countries throughout the world (Esquivel-Santoveña et al., 2013) and especially in the United States (Carney & Barner, 2012; Desmarais, Reeves, Nicholls, Telford, & Fiebert, 2012; Langhinrichsen-Rohling, Selwyn, & Rohling, 2012), where most surveys have been conducted. However, gender-inclusive research on IPV in Middle Eastern and South Asian countries has been limited. A survey of 91 university students in Iran, conducted as part of the 32-nation International Dating Survey (IDS; Straus, 2008) reported somewhat higher prevalence rates of past-year physical abuse against males (96%) as compared to females (71%), and almost all IPV among these students (95%) was found to be bidirectional. The male and female students scored about equally (1.81 vs. 1.86) on a measure of dominance (e.g., endorsing such items as "I need to be in charge"). The International Dating Violence Survey (IDVS) of 84 university students in India reported past-year overall perpetration rates of 35% by men and 31% by women, and 75% of all IPV was bidirectional. Past-year rates of more severe IPV (e.g., punching, kicking, using weapons) were actually found to be used against higher for females (14% vs. 7%; Straus, 2008). As in Iran, dominance scores were about the same across gender. The IDVS survey of 91university students in Israel likewise found comparable IPV rates by men and women and comparable dominance scores (Straus, 2008), and a survey of 1,357 high school students by Sherer (2009) found higher rates of male IPV victimization (41.4%) compared to female victimization (32.8%).

However, it should be noted that student samples are not always indicative of the general population (students are typically more affluent, and better educated, for instance). An emergency room survey of 140 patients from Pakistan reported higher victimization rates for females (64%) as compared to males (36%; Niaz, Hassan, & Tariq, 2002). Higher rates of female victimization were also reported by a sample of 832 Arab adolescents who were asked about IPV by their parents (Haj-Yahia & Dawud-Noursi, 1998). Almost 5 times as many subjects reported seeing their father use moderate levels of IPV against the mother compared to those witnessing IPV by the mother (23% vs. 5%), and psychological abuse, although perpetrated by a high number of women, was perpetrated at an even higher rate by the fathers. In Jordan, the 625 university students who were asked about IPV by their parents reported father-on-mother rates of between 16% and 17% and rates of mother-on-father IPV between 10% and 13% (Araji & Carlson, 2001).

CAUSES AND RISK FACTORS OF INTIMATE PARTNER VIOLENCE IN SOUTH ASIAN AND MIDDLE EASTERN COUNTRIES

Studies on IPV, primarily from the United States and other industrialized English-speaking countries (Capaldi et al., 2012) but also from other world regions (Esquivel-Santovena et al., 2013), indicate that various factors, at the individual, family,

community, and societal levels, interact with each other and increase the risk for partner violence. At the individual level can be found psychological risk factors such as aggressive personality, often the result of childhood neglect or abuse, maladaptive parenting styles, and alcohol abuse in the family of origin. Family-level factors include lack of economic resources and decision-making power by women. The risk for bidirectional violence increases in families with poor communication and conflict management skills. The community level relates to the neighborhoods, workplace, and social networks that are disadvantageous to women, particularly in developing countries. Among the societal-level risk factors are cultural norms such as those that reinforce gender roles and promote male dominance and attitudes supportive of relationship violence (Heise, 2012).

It has been argued that in the United States, where the rates, motives, risk factors, and dynamic of IPV are similar across gender, the problem can best be addressed from a developmental and mental health perspective, rather than from a gendered perspective.

However, similar inferences cannot be drawn for South Asian and Middle Eastern countries in absence of comprehensive gender-inclusive research in this area. Only recently, in these countries have different organizations begun to pay attention on issues of domestic violence affecting women. It may take even longer time by scholars and agencies to show readiness and invest their time and resources on gender-inclusive research. The same cultural and religious beliefs and practices which increase women's vulnerability to face abuse also refrain men from reporting any such kind of experiences because such attitudes as well ideas that men can suffer IPV are disapproved in these societies at large.

In developing countries, the underlying cause for many problems including domestic violence is the poor socioeconomic conditions of people, which is linked with women's lack of empowerment and poor social status (Karmaliani et al., 2012; refer to Table 1).

Pakistan

Women in Pakistani society are taught to believe that marriage is the ultimate destination for successful women and that a satisfied life depends on it. Unless she is seen as a responsible and good wife, career growth or educational achievements are of little value. Hence, almost every woman tries to invest her energies into making her marriage work out successfully, no matter how abusive it might be (Tariq, 2013b). Patriarchal marriage patterns in Pakistan and other South Asian countries promote woman's subordinate position to men and perpetuate violence against weaker women. Wide gender-based disparities promote low social status for women (Raza & Murad, 2010). A common pattern is for husbands to be chosen by elder male family members and for wives, often very young women, to be married into households headed by their husbands' fathers (Alam, 2007; Das et al., 2013; Kamal, 2012). Before marriage, fathers are considered a woman's legal guardian, and this guardianship is passed on to the husband after marriage.

Some notable factors which make women prone to domestic violence in Pakistan are their low education level, low overall empowerment, poverty and the unjust dowry system, and misconceptions about Islamic thoughts and traditional norms, including those justifying honor killings (A. J. Khan et al., 2009; refer to Table 1). A qualitative study carried out by Zakar, Zakar, and Krämer (2011b; see Table 1) on perceptions of IPV against women by primary health care physicians in Pakistan. Researchers conducted in-depth interviews of 24 doctors who were providing services in various hospitals of Punjab. Most of the physicians felt that underlying causes of domestic disputes are the poor social and economic conditions of people in that country. "Women," according to one physician, "are facing existential threats not from their husbands, but from the grinding poverty, humiliating hygienic conditions, and absence of civic facilities and economic resources" (Zakar et al., 2011b; p. 819; refer to Table 1).

A review of studies on causes for domestic violence against women in Pakistan found that disagreements between a wife and husband on family-related issues are the most common. Disagreements over financial issues, for example, lead men to sometimes vent their frustrations by shouting, or even physically hurting wives. An analysis of qualitative data obtained through focus group discussion indicated that most family conflicts revolve around issues related to raising children; failure to meet household responsibilities; relations with other family members; husband's alcohol or drug use; and complaints by husbands that their wives do not cooperate in sexual activities, demand money, and socialize and too much with their parental side of family (Kamal, 2012). These factors in combination with poor socioeconomic condition have emerged as a consistent pattern for perpetration of family violence in South Asian countries. When asked in one study as to why they were unable to end domestic disputes, most respondents identified financial crisis, unemployment, and low frustration tolerance as key reasons. This suggests that other than patriarchal ideology, many situational factors also cause IPV. Situational violence is often motivated by a desire to control the situation rather than the partner (Zakar, Zakar, & Krämer, 2013). Poor anger management and communication problems are likely to escalate conflicts, often leading to IPV.

Physical and emotional abuses against wives are commonly employed tools used by men to show dominance in intimate relations (Narayan, Patel, Schaftt, Rademacher, & Koch-Schulte, 2000). However, the three big denials about cause of IPV are ignoring the bidirectional existence of violence and not realizing that there are multiple and parallel causes for IPV perpetration. As mentioned previously, women can also be IPV perpetrators, and men are not the sole perpetrators of violence and abuse against wives; it is often women who instigate their sons and brothers to commit violence against their wives or who tolerate such abusive acts.

Children who have themselves been exposed to direct or indirect violence, whether boys or girls, are more likely to commit violence themselves (Durose et al., 2005; Fikree et al., 2005). Research has shown a consistent relationship between child abuse and domestic violence victimization and perpetration. A study was completed in a multiethnic city of Pakistan to obtain data about men's attitude toward domestic violence.

Findings revealed that 55% of men who committed violence against their wives have themselves experienced physical violence in their childhood either by their parents, teachers, or a relative. Overall, 46% of male participants had positive attitudes toward wife beating, and most of them had seen their mothers being beaten by their fathers (Fikree et al., 2005). This is true not only for Pakistan but also for other South Asian communities where husbands believe they have the right to exert control over their wives. The poor socioeconomic conditions faced by most people in this region may result in high incidence of family conflicts; thus, more numbers of children are directly or indirectly exposed to violence. Most of the participants of focus group discussions (Kamal, 2012; Zakar, Zakar, & Krämer, 2013) did not consider IPV as a primary problem in Pakistani society and instead considered unemployment, corruption, inflation, and crime as the real problems of the country and the causes of IPV itself.

The legal infrastructure in this region is also responsible for high prevalence of violence committed against women. Men, despite perpetrating serious forms of abuse against women, often find escape from punishment because of discriminatory laws (Zakar, Zakar, & Krämer, 2013). Until 2009, IPV cases were reported under the Criminal Procedure Code (CrPC) as violations of basic human rights under Pakistan law. The National Commission the Status of Women (NCSW), established in 2001, reviewed current legislation and suggested amendments to support women victims. As a consequence, some positive steps were taken. For instance, women can now avail themselves of funds under Ordinance No.1 (National Assembly, 2008), which are released through Women in Distress and Detention Act (1996). Other encouraging steps were the establishment of women's police stations and women's complaints cells. In 2001, some amendments were made in the CrPC to address dowry-related violence because the number of female burn victims was on the rise and perpetrators remained undetected. The medicolegal system was improved to obtain more reliable and strong evidence against perpetrators. In 2012, the Senate finally passed the Domestic Violence against Women and Children (Prevention and Protection) Act, which considered domestic violence as a criminal activity punishable by law. Even so, their humiliating experiences and financial constraints make it difficult for most women to approach police and courts in Pakistan. There is need for reforms that will create a more friendly environment and that will see to it that these laws are duly implemented. The impact of these reforms has been limited, however, because culturally spousal violence is still considered as a private family matter and is rarely reported to the police. There is also need to create more awareness among professionals and masses about these laws, so that success stories can be shared in the hope of reducing the incidence of domestic violence.

Other South Asian and Middle Eastern Countries

Similar findings have been reported by studies in other South Asian regions. Poor social and economic conditions, low educational status for men and women, woman's or

man's early exposure to abuse, mental illness, and women giving birth to a girl child were among the most common risk factors for being in a violent martial relationship (Esquivel-Santoveña et al., 2013). Some studies (e.g., Kocacik, Kutlar, & Erselcan, 2007; Rudd, Elliott, Cresswell, Wilson, & Dwek, 2001) have reported that women in patriarchal societies such as India and Turkey are at greater risk of IPV victimization compared to other societies. The in-depth analysis of qualitative data from a survey in Bangladesh revealed that dowry issues and unregistered marriages increased the risk for abuse by in-laws and marriage partners, whereas better education and economic conditions decrease women vulnerability to abuse (Bates et al., 2004).

Acceptance of wife beating at the societal level, among both men and women, have been identified as strong predictors for physical and sexual abuse against women in a sample of Bangladeshi married men (Sambisa, Angeles, Lance, Naved, & Curtis, 2010). Media reflects the social mores of a society. As shown in films viewed by large audiences in these societies, acts of violence and abuse in intimate relations are often directed toward women (Malley-Morrison, as cited in Esquivel-Santoveña et al., 2013).

Studies from several Middle Eastern countries have identified the following risk factors for wife abuse: disagreements on household issues, dispute with in-laws, a wife's refusal to comply with the demanding and controlling behavior of husbands or to have sex, or wanting to work or engage in any activities which are contrary to traditional roles of women (Hattar-Pollara, Meleis, & Nagaib, 2000; Kocacik et al., 2007). In a small-scale survey of rural women in Egypt ($N = 500$), 22% of women reported that such beatings can occur without any reason (Issa, 2007).

In Muslim communities, sexual abuse is more commonly reported by women with arranged marriage. This is consistent with findings from a survey conducted in Saudi Arabia, where 53% of men who committed physical abuse against their wives considered their obligation to rectify the behavior of their wives even if it involves physical punishment (Almosaed & Alazab, 2015). They also found that nonworking and less educated women, married for a longer time in families with low social status, were the most common victims of violence by intimate partners (Almosaed & Alazab, 2015).

Patriarchal structures and historical tribal feudal system in Southeast Asian societies have a vital role in increasing women's vulnerability for domestic violence; however, this is not the only reason. A notable study on the attitudes and beliefs of men about IPV was conducted in Pakistan (Zakar, Zakar, & Krämer, 2013). Based on their findings that not all patriarchal men have violent attitudes or engage in violence against their wives, the authors suggested a reconsideration of the idea of "bracketing all men as violent due to their patriarchal beliefs." Various psychological, social, economic, and cultural factors interlink with, and are responsible for, the occurrence and acceptance of domestic abuse against women in South Asian and Middle Eastern countries. Women's younger age, husband's prior exposure to abusive relations in the family, involvement in drugs or alcohol abuse, and less stable economic conditions of intimate partners were the most common factors identified after review of several studies in Egypt (Ammar, 2006). Many of these factors coexist

with other psychological risk factors such as proviolent attitudes, poor temperament, and personality disorders which increase vulnerability to engage in violent behaviors toward others.

It is also noted that most of the women victimization studies identified the link between adverse mental health conditions and partner abuse (Esquivel-Santoveña et al., 2013). A study from Bangladesh showed that economic dependency and a social stigma related to women's physical disability also found to increase women's vulnerability to IPV (Hasan et al., 2014). Most of the women (81%) relied on informal networks and family relatives for support in such cases.

Yount, Halim, Head, and Schuler (2012) found that in South Asian countries, disadvantaged social and economic conditions are the strongest factors associated with attitudes accepting of IPV, actual experience of IPV, and the poor help-seeking behaviors of women. Low levels of education and employment, which increase vulnerability for poor psychological well-being for both men and women, have been found as major risk factors for IPV (Ali et al., 2011). The data from advanced countries have also shown similar patterns (Capaldi et al., 2012). These findings, however, have been contradicted by findings of a meta-analysis by Esquivel-Santoveña et al. (2013) on domestic violence studies from different countries of the world, which failed to find a significant correlation between rates of IPV and a country's general level of human development.

It appears that women's disadvantaged socioeconomic conditions interact with poor political and legal infrastructures and cultural factors to perpetuate violence against women. For instance, in many Arab countries including Egypt, there is an unequal divorce system; implementation of obedience laws; and loose implementation of laws related to payment of alimony, child custody, housing, and other financial support to raise children (Lefkow, 2004). Similarly, studies from Bangladesh (Bates et al., 2004; Bhuiya, Sharmin, & Hanifi, 2003) also showed that despite of legal provisions of up-to-death penalty for violence against women in Bangladesh, the rates of violence against women are still high. These legal provisions are only for severe forms of violence committed against women.

Women themselves show acceptance for less severe forms of violence (Schuler & Islam, 2008) and do not seek legal services. Focused group discussions with villagers (Schuler, Lenzi, & Yount, 2011) suggest that IPV against women is sometimes not fully condemned by women themselves, and they also approve violence committed by a husband to control a disobedient wife. These punishments are justified to make women's behaviors consistent with classic patriarchal norms. A study explored underlying motivations for positive attitudes by Bangladeshi women toward domestic violence and found that some women respond to domestic violence questions on the basis of perceived gender norms; therefore, when asked whether wife beating is justified in certain conditions, these women gave socially desirable responses (Yount, Halim, Schuler, & Head, 2013). Among the most common reasons given by divorced women for staying in an abusive relationship include the negative impact on children's well-being because of social stigmas, doubts by others about the character of

divorced women, and the hurdle it might present for her sisters' chance of getting married (Almosaed & Alazab, 2015; Ibrahim & Ferber, 2004).

CONSEQUENCES OF INTIMATE PARTNER VIOLENCE

The series of reports published by WHO based on surveys conducted in developing countries in the last decade have shown that domestic violence impacts women's physical and mental health, and their economic well-being, in several ways (WHO, 2013).

The financial costs of IPV to society, and to the victims themselves, are alarming. According to the American Institute on Domestic Violence (2010), almost 6 billion dollars are spent in health-related costs annually in the United States as a consequence of IPV. According to Baumgarten and Erdelmann (2003), a nationwide study conducted in Canada found that 30% of female victims of IPV terminated employment and 50% were temporarily unfit for employment. The productivity and health-related costs associated with IPV are estimated to be 1.6 billion dollars annually. Women in abusive relationships have restricted economic independence, frequently not allowed to have jobs and thus limited in access to income. The aftereffects of this dependency are borne by abused women in the form of low self-efficacy even after leaving the abuser (Kapadia et al., 2009; refer to Table 1).

A range of mental health problems have been found to be more common among abused women, including depression, posttraumatic stress disorder (PTSD), psychosomatic problems, and poor marital satisfaction (Varma, Chandra, Thomas, & Carey, 2007). Abused women become more upset, lose interest in daily life activities, and in some cases report suicidal ideation. Higher numbers of women who have experienced physical violence report to feeling chronically nervous, unhappy and worthless, and experiencing headaches, compared to women who have not experienced physical violence. Women's current or past history of abuse in intimate relationships significantly predicts poor mental health even after controlling for sociodemographic variables (Zakar, Zakar, Mikolajczyk, et al., 2013).

Several other studies from different parts of world and from South Asian countries have shown that women who face violence and abuse in intimate relations are more at risk of developing mental health problems (Hassan & Malik, 2012; Husain, Creed, & Tomenson, 2000; Kumar, Jeyaseelan, Suresh, & Ahuja, 2005). A review of the literature (Mirza & Jenkins, 2004) showed that family disputes and conflicts were significantly associated with depression and anxiety in women. Violence not only sows the seeds of pathologies but also has an adverse effect on mental well-being. During the process of abuse, the self-esteem of the victim is completely crushed so much so that she lacks the confidence to preserve autonomy (Tariq, 2013a). Domestic abuse has been reported to shrink a woman's self-esteem and individuality (Hague, Mullender, & Aris, 2003). A study from Iran showed that women facing abuse in intimate relations reported low self-esteem (Abidi, Ali, Shah, Abbas, & Ali, 2012). Abused women in Turkey reported 2 times less satisfaction in martial relations and sex lives (Yildizhan et al., 2009) as compared to nonabused women. A study from Palestine

(Haj-Yahia, 2002) reported about high levels of fear, distress, depression, and low self-image among women survivors of violence in intimate relations. A survey of women in prison identified that almost in 12% of cases, women attempted suicide because of domestic violence. According to a recent study (Zakar, Mikolajczyk, & Krämer, et al., 2013), a higher number of women who suffered psychological abuse reported having symptoms of anxiety, tiredness, sleep problems, suicidal ideation, and feelings of worthlessness compared to those who had not experienced psychological abuse.

It has been reported that many mental health professionals view these mental health consequences as "women's problems" and therefore give them less importance (Mubbashar & Farooq, 2001). Among the reasons for this are the high levels of tolerance for violence against women and the massive mental health illiteracy in Pakistan (Mubbashar & Farooq, 2001). A review of studies by Mirza and Jenkins (2004) and other studies from this region (Naeem et al., 2008; Zakar, Zakar, Mikolajczyk, et al., 2013) found that a woman's age is significantly associated with more mental health problems. Women in late ages do face many existential threats and challenges, which in combination with violence in marital relations increase their vulnerability for poor mental health. Migration to the in-laws' city after marriage from their parental city were significantly associated with poor mental health problems in a sample of 373 women randomly selected from Lahore and Sialkot (Zakar, Zakar, Mikolajczyk, et al., 2013; see Table 1). Women who shift to other cities after marriage feel more isolated in absence of parental support and presence of marital violence. This situation further aggravates the threat to women's mental health (Naeem et al., 2008; Zakar, Zakar, Mikolajczyk, et al., 2013).

Aside from physical injuries and mental health consequences, women's reproductive and sexual health is seriously affected by IPV because high number of women in abusive relations report sexually transmitted infections and unwanted pregnancies (Zakar et al., 2012; refer to Table 1). Women from lower socioeconomic classes are unable to access quality health care services and often opt for unsafe abortions. This increases their vulnerability for complex reproductive health problems and death. Tinker (2000) reported that women in less developed countries are frequently exposed to these adversities and thus have shorter life expectancies (WHO, 2002). A study collected data from women attending tertiary care hospitals in Pakistan and found that abused women had high rates of poor reproductive health regardless of the kind of abuse experienced by them (Zakar et al., 2012). A study from Bangladesh (Silverman, Gupta, Decker, Kapur, & Raj, 2009) showed negative impacts of domestic violence on physical health of women and their young children. These women reported high rates of respiratory tract infections, and their children came to the health care setting with more frequent complaints of diarrhea. The rates of sexually transmitted diseases (STDs) are also high among women who face IPV as indicated by study from Bangladesh (Sambisa et al., 2010) and India (Gaikwad, Madhukumar, & Sudeepa, 2011). Findings from studies conducted in Middle Eastern regions (Ibrahim & Ferber, 2004) showed that many women in Muslim communities refrained from using contraceptives because of fear of being blamed for infidelity by their husbands.

Women in less developed countries have little control over their own sexuality; thus, studies have found that women exposed to violence often do not make use of contraceptive methods and are subject to poor prenatal/postnatal care, affecting their overall health (Farid, Saleem, Karim, & Hatcher, 2008; Zakar et al., 2012; see Table 1). Previous studies have shown that in Pakistan, 18% of the pregnant women are more likely to have anxiety and/or depression, linked with physical or sexual and verbal abuse during pregnancy (Karmaliani et al., 2009; see Table 1). Also, the rates of suicidal thoughts and suicide attempts in pregnant women were high; 11% of the women who participated in this study had considered suicide, and 45% actually attempted it. Women who had anxiety or depression, or had experienced verbal, physical, or sexual abuse, were significantly more likely to have had suicidal thoughts and to have attempted suicide (Karmaliani et al., 2009; see Table 1).

The analysis of quantitative data from a household survey and focus group discussions of community members in Pakistan revealed that domestic violence leaves negative emotional consequences for everyone in the family including the husband, wife, and children (Kamal, 2012). Children are the worst sufferers as acknowledged by participants. Parents reported that children lose interest in their studies and develop behavioral and psychological problems if they grow up in families with high levels of conflict and violence (Kamal, 2012). Children of abused mothers display problems in behavioral, emotional, cognitive, and physical domains (Martin, 2002). Studies from other parts of world have also reported that children who witnessed abuse in the home often experienced emotional trauma, reduced academic success, and were at increased risk of physical injury (Cunningham et al., 1998). Baumgarten and Erdelmann (2003) found that children who witnessed violence were more likely to develop behavioral problems. They were more likely to be aggressive, noncompliant, irritable, and easily angered and develop anxiety, depression, and low self-esteem, with some meeting the criteria for PTSD.

Social and behavioral problems are more noticeable in children growing up in abusive families (McFarlane et al., 2007). Violence has been proven to be a significant environmental factor, independent of genetic contribution, that can affect child behavior (Jaffee, Moffitt, Caspi, Taylor, & Arseneault, 2002). Researchers found that children between 6 and 18 years of age whose mothers experience domestic violence demonstrate significantly more negative behaviors (i.e., aggression and depression) compared to children of mothers who were not victimized (McFarlane, Groff, O'Brien, & Watson, 2003). It also has been observed that children of mothers who report both physical and sexual violence from intimate partners demonstrate more behavioral problems than the children of women who only report physical violence (McFarlane et al., 2007). The effect of family conflicts and violence are not limited to women and children but also influence men themselves. Even when they are the perpetrators and not the victims, family conflict and violence leads men to become more aggressive, less cooperative, and to lose interest in their work and other activities (Kamal, 2012).

The negative consequences also increase the children's chances for being engaged in a similar kind of abusive relation in the future. IPV is a cause of suffering at the

individual, familial, and societal level because it is associated with lower levels of life satisfaction, disintegration of family system, high rates of disharmony, and unhappiness in the communities.

THE EFFECTIVENESS OF INTERVENTION PROGRAMS IN SOUTH ASIAN COUNTRIES

There is limited scientific data available on the effectiveness of intervention programs for IPV in Southeast Asian countries. Solotaroff and Pande (2014) reviewed the characteristics and outcomes of intervention programs in Southeast Asian countries and reported that most of these programs in this region are offered by NGOs and funded by international donors such as Oxfam, United Nations Development Program (UNDP), Asia Foundation, and so forth. The intervention strategies for IPV are done at the primary and secondary level. The focus of primary interventions is the prevention of violence by addressing underlying attitudes and cultural norms. These programs are implemented on a large scale through awareness-raising campaigns that employ mass communication—that is, social media, radio, television, and print media. A formal evaluation of prevention programs has not yet found to be feasible. However, the largely positive response toward these programs suggests that they are successful in terms of gaining the attention of the masses, including men and women, and in challenging the general acceptance of violence at the societal level.

Bell Bajao, started in 2008 (Table 2) was very much successful in promoting awareness about IPV in India (Lapsansky & Chatterjee, 2013). This campaign used existing community networks and employed innovative ways to deliver information. A combination of activism, mass media, and community involvement played an important role in achieving significant positive outcomes (Breakthrough, 2016). Suriya Development Organization in Sri Lanka ran a campaign, "Clothesline" (see Table 2), to raise awareness about IPV. It was initially perceived negatively but was later found to be successful in raising awareness, resulting in more talk among masses on how to address the problem of IPV.

A program, "We Can," by Oxfam (Rakib & Razan, 2013; see Table 2), was launched in India, Pakistan, Bangladesh, Nepal, Afghanistan, and Sri Lanka. This campaign was also found to create greater public awareness about IPV (Rakib & Razan, as cited in Solotaroff & Pande, 2014). Another campaign was implemented on large scale in India, "The Men's Action to Stop Violence against Women" (MASVAW; see Table 2). Evaluated many times, it was found to have had a positive effect in changing attitudes. One outcome was that men who were exposed to the intervention showed more gender-egalitarian attitudes as a result, when compared with those who were not exposed (Solotaroff & Pande, 2014).

In Muslim countries, the involvement of religious leaders has often been found to be effective. In Afghanistan and other Muslim countries (Malaysia and Turkey), a newsletter was developed in collaboration with the Ministry of Hajj and Religious Affairs (MOHRA; see Table 2). The training of religious leaders to deliver the

TABLE 2. Intimate Partner Violence Intervention Programs in South Asian Countries

Intervention Programs	Country	Aim	Outcomes
Bell Bajao	India	Changing attitudes toward IPV as a private family matter	Successful in raising awareness
Clothesline	Sri Lanka	Changing attitudes toward IPV as a private family matter	Positive acceptance of such activities
We Can	Afghanistan, Bangladesh, India, Nepal, Pakistan, Sri Lanka	Nonacceptance of violence against women in their own lives and in the lives of those around them	Positive outcomes toward primary and secondary prevention of IPV
The Men's Action to Stop Violence Against Women (MASVAW)	India	To promote gender equitable attitudes	Positive results in selected group of men exposed to intervention than control group
Gender Equity Program (GEP)	Afghanistan, Malaysia, Turkey	Involve religious leaders to promote gender equitable attitudes	Successful in achieving positive change
Hamqadam	Pakistan	Underlying attitudes about masculinity	Positive change in attitudes toward masculinity and IPV
Yari Dosti	India	Underlying attitudes about masculinity	Positive change in attitudes toward masculinity and IPV
Saathi	Nepal	Sports program as entry point to address IPV	Attitude and behavior change among coaches and athletes
Parivartan	India	Sports program as entry point to address IPV	Attitude and behavior change among coaches and athletes

(Continued)

TABLE 2. Intimate Partner Violence Intervention Programs in South Asian Countries *(Continued)*

Intervention Programs	Country	Aim	Outcomes
Dil Mil	India	Focused on violence by in-laws	Women's empowerment-based intervention that engages with young women (daughters-in-law) and their mothers-in-law to mitigate domestic violence and its adverse health-related outcomes
Multi-Sectoral Program on Violence Against Women	Bangladesh	Medical, psychological, and legal services at one place	Rehabilitate women and empower them to deal with issue of domestic violence through collaboration between all stakeholders
Rabta	Pakistan	Training of police departments, thus facilitating female victims of abuse who want to report and seek help	Increased sensitization resulted in deployment of women police officers and police stations
One Stop Crisis Management Centers	Nepal	Medical, psychological, and legal services at one place	Rehabilitate women and empower them to deal with issue of domestic violence through collaboration between all stakeholders
Dilassa	India	Training of health care professionals to identify and refer women for further counseling and help	Positive outcomes in terms of understanding and responding to women's health care needs related to IPV
Shahid Benazir Bhutto Centers for Women	Pakistan	Medical, psychological, and legal services at one place	Few centers are working, and most of them are nonfunctional because of nonavailability of trained human and other resources.

Note. IPV = intimate partner violence.

true teachings of Islam on gender issues apparently resulted in positive outcomes (Rodriguez & Anwari, 2011), although formal evaluation data has not yet been made available (Solotaroff & Pande, 2014). There are some community-based primary prevention programs implemented by NGOs in this region for both boys and girls. Life skills program for girls empowers them to deal with IPV, and for men, education and advocacy programs on gender roles and sexuality are intended to stop them from committing abuse against their intimate partners (Solotaroff & Pande, 2014).

In Southeast Asian countries, women often experience abuse from in-laws. A program with name of "Dil Mil" (hearts together; see Table 2) was initiated in India in 2012, which specifically focused on abuse from mothers-in-law. A pilot survey showed positive responses, and long-term outcomes will be assessed through a randomized controlled trial (Krishnan, Subbiah, Khanum, Chandra, & Padian, 2012).

The secondary type of intervention program for IPV focuses on strategies to provide service to victims such as shelter homes, hotlines, crisis centers, and legal and financial aid. In developing countries including Pakistan, most of the secondary domestic violence intervention programs focus on women victims and are funded by external donors. In Pakistan, some organizations like Panah, a shelter home for battered women, and other NGOs are providing psychosocial and legal services to support women victims of violence. However, there is no scientific evidence available to determine the effectiveness of their services and programs. The shelter homes and crisis centers in South Asian countries do provide short-term solutions; however, the quality of services is not always very good because of meager resources. Many times, women are revictimized because of the unavailability of long-term support. Karmaliani et al. (2012) stressed that NGOs have a large network in Pakistan, which can be mobilized more efficiently to stop violence and to support abused women. In the past few years, Pakistan has been frequently struck by natural and man-made disasters, resulting in an increase in donations by international donors. These funds can be used to offer effective intervention programs in affected areas to prevent IPV (refer to Table 1).

There is some published data available from Pakistan on the effectiveness of community-based education programs, focused on economic and life skills building (Karmaliani et al., 2011). A team of researchers (Hirani et al., 2010) combined two globally tested interventions for IPV—group counseling and economic skill building—which had been previously tested in other countries (Ali, Rahber, Naeem, & Gul, 2003; Bass et al., 2006; Pick, Contreras, & Barker-Aguilar, 2006) and offered this program to women enrolled in adult literacy classes in selected communities in Pakistan. The program taught empathic listening, communication skills, and problem-solving strategies. Outcomes were assessed by comparing the responses of women who were exposed to this program with a control group of women who were only offered the literacy classes. Trained community health workers carried out intervention sessions in the form of biweekly group counseling sessions for almost 1 year. They educated the women about personal hygiene and grooming, effective communication skills required for conflict resolution, how to deal with abuse and harassment

in intimate relations, job search, improving self-efficacy by effective time management, and effective parenting.

Hirani et al. (2010) reported a positive impact of these programs on women's and children's general well-being and ability to deal with everyday issues. Women who received this intervention reported that learning about appropriate communication strategies and self-management of emotions helped them better deal with IPV in the short term. The intervention package resulted in enhanced self-efficacy and lowered anxiety and depression symptoms in women, less incidents of domestic abuse, and effective parenting associated with less reporting of behavioral problems in children (Hirani et al., 2010). However, the findings cannot be generalized, keeping in view the small sample size (17 women) and short follow-up period.

There is need to generate information about the long-term implications of interventions offered to women living in adverse socioeconomic conditions. Hirani et al. (2010) suggested that integration of these interventions in primary health care settings will increase their sustainability and positive outcomes on a large scale. It is important to note that qualitative feedback obtained about these interventions was limited to women participants, so it is likely that this evaluation missed some other factors which might have a role to play in determining outcomes. Some women reported that control and resistance by their husbands and in-laws were major barriers to self-efficacy, financial decision making, education, and socialization with other women (Hirani et al., 2010; Karmaliani et al., 2011). Other constraints reported were poor education and lack of skills necessary for employment, making it difficult to obtain and retain jobs, and environmental safety issues can make it difficult to go to and from work. Women often struggle to balance work and with other life areas, mostly such as meeting their husband's and in-laws' expectations to fulfill marital and child care responsibilities.

Zakar, Zakar, Mikolajczyk, et al. (2013) found that women who were engaged in paid jobs and had experienced physical violence had poorer mental health than women who were housewives (refer to Table 1). They suggested that some culturally specific and structural reasons have a role to play because most women from low socioeconomic classes are involved in low-paid jobs (e.g., housemaids, sew clothes, beautician, etc.). They carry these jobs to support their children and other family members but with minimal control over their own income. Such employment opportunities, therefore, sometimes fail to empower them to achieve social and economic autonomy. Low salaries with poor work conditions, dual responsibilities at workplace and home, along with physical violence from their partners, place them in stressful situations that increase their vulnerability for depression and anxiety disorders. It is necessary for the economic skill-building programs to address these factors. Targeting women alone may not change their situation, and there should be a focus made on changing men's attitudes and behaviors in this part of the world.

Overall, government and health care agencies have poorly responded to the issue of domestic violence against women. This can be estimated from high reported rates of stove burnings and acid burn incidents in domestic disputes. More than 15,000 cases were reported in 10 years (1996–2006) in Pakistan alone (HRCP, 2008), and in most

cases, the perpetrator was the husband or a close relative. Limited resources were found to be available to provide treatment for serious burn cases, and there were only few burn hospitals, located only in large metropolitan cities.

Intervention programs offered to women and men often fail to take account of deeply rooted cultural norms and misinterpreted religious teachings. Consequently, the NGO sector is facing serious challenges because it is commonly perceived that these organizations are serving some Western agendas. No serious efforts are made at the government level to address the problem of domestic violence. Governments lack the resources to address some of the major domestic violence risk factors, such as women's poor education and health and lack of gender equity. Small-scale intervention programs offered by NGOs achieve limited success because of women's low decision-making power and high dependence on other family members (Hirani et al., 2010).

The Egypt Demographic Health Survey (El-Zanaty & Way, 2005) reported that less than 1% of abused women sought any help for IPV victimization. Financial constraints and weak social support systems keep women from taking action. In many cases, women are unable to keep control over their own earnings. In developing countries, women's limited access to money, inability to trust available legal support systems, along with the stigmas associated with divorce and remarriage, keep women entangled in abusive relationships. According to one survey (Buchanan, 2002), 42% of women accept violence, 33% see themselves as helpless, and only 4% actually take any action to stop it.

Women's help-seeking behaviors are influenced by local social, and cultural norms. Women in Arab and South Asian countries are usually reluctant to seek help for issues such as IPV because of social stigmas associated with such victimization and mental health problems generally (El-Islam, 2001). The social stigma associated with seeking services from the NGO sector, combined with the poor responses of the existing legal and health care system, leave women with no choice except to tolerate abusive relationships. Only some serious crimes against women attract the attention of media. Zakar et al. (2011b) demonstrated the common response of different agencies and experiences of a woman who has been exposed to spousal violence (Figure 1).

It is commonly suggested by researchers that IPV interventions need to be integrated into the existing health care system (Karmaliani et al., 2011). However, as one qualitative study found (Zakar et al., 2011b), there are several constraints in Pakistan, both at an individual and institutional level, that limit the integration of IPV interventions in existing health care systems. The same limitations have been reported in Arab communities, and health care professionals themselves are not often open to offering help (Douki, Zineb, Nacef, & Halbreich, 2007; Zakar et al., 2011b). Physicians generally lack the positive attitudes and skills to deal with women who report abuse in intimate relations. They prefer to stay within a biomedical model of treatment and refrain from attending to the social and medico-legal matters in these cases. Most of them view domestic violence as a private family matter. They believe that dealing with the social aspects of medical problems is like opening a "Pandora's box" and therefore feel that medical doctors should not intervene in any way (Zakar et al., 2011b; see Table 1).

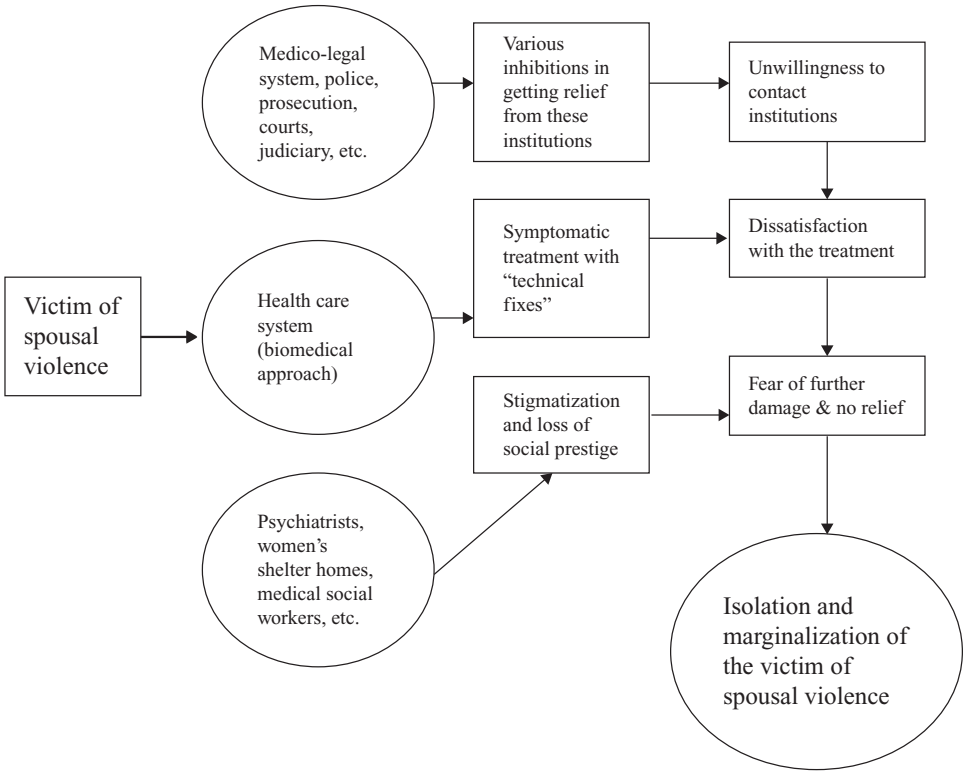

Figure 1. Structural limitations of domestic violence cases in Pakistan. (Zakar, R., Zakar, M. Z., & Krämer, A. [2011a]. Primary health care physicians' response to the victims of spousal violence against women in Pakistan. *Health Care for Women International*, *32*[9], 811–832.)

Interviews with 24 doctors selected from government and private hospitals in Punjab showed that not a single primary care physician made available any information leaflets on domestic violence, nor were they aware of any screening protocols used for the identification and treatment of victims. One middle-aged physician said. "In a high violence society like in Pakistan where people are murdered for petty things, where terrorists kill hundreds of people, and where people are dying because of hepatitis C and contaminated water, spousal violence is not a problem to be worried about" (Zakar et al., 2011b). Because of international exposure, two physicians who participated in this study had some awareness of the problem but were not different in terms of their attitudes. In their view, the Western model of responding to IPV cannot be applied in Pakistan because intimate partner abuse is a family matter and intervening in these problems is waste of time (Zakar et al., 2011b).

The needs of IPV victims in South Asia are mostly addressed by crisis centers and shelter homes managed by volunteers and NGOs. There is a lack of published data on the effectiveness of services offered to women through these centers. Also, factors

such as poor communication and coordination among stakeholders, improper training of professionals to provide psychosocial services, poor understanding of cultural and social factors, and follow-ups limited to a short period compromise the quality of care and services provided to women who approach these shelter homes and centers.

One of the more successful programs in Bangladesh is the Multisectoral Program on Violence Against Women (see Table 2), which provides medical attention, crisis management, counseling, and legal aid. Similar kinds of services are being offered by Panah Shelter Home in Pakistan. In Nepal, one-stop crisis management centers also provide multisectoral services (medical treatment, psychosocial counseling, legal aid, and rehabilitation services) to address the negative outcomes of gender-based violence (Solotaroff & Pande, 2014).

The review of documentation and desk reviews by the South Asian Development Forum (Solotaroff & Pande, 2014) identified one hospital-based program, "Dilaasa" (see Table 2) that trained health care professionals to screen victims of abuse and refer them to well-trained counselors, who then linked them with other services. In Pakistan, a similar model was found to be effective in responding to the needs of women at the Shahid Benazir Bhutto Centers for Women (see Table 2). However, the quality of care varies in different cases, thus effecting intervention outcome s. Because of poor infrastructure and organizational constraints, half of the centers were not functioning at all. The shelter home services were not found to be very successful in Afghanistan because of similar reasons (Vazirova, 2011).

As previously noted, abused women in developing countries often do not report abuse nor seek legal services because of financial constraints and the poor judicial system response (Abramsky et al., 2011). To address this problem, some intervention programs focus on training of police, to sensitize them about issues related to domestic violence. One example is "Rabta," a program in Pakistan. Quantitative and qualitative evaluations of program outcomes showed positive results when women police officers were hired to deal with female domestic abuse victims (Khalique et al., 2011). Women police stations and special cells within existing police stations were developed in Afghanistan, India, and Sri Lanka, although they do not always function well because of inadequate resources and the improper training of personnel to handle such cases (Solotaroff & Pande, 2014).

There are community-based programs offered by some NGOs in India, Pakistan, Bangladesh, and Afghanistan. These include Bangladesh Legal Aid and Services Trust, Legal and Cultural Services for Women and Children of Afghanistan, and Alternate Dispute Resolution Mechanism (Musalihat Anjuman) in Pakistan (see Table 2). They approach women within their own communities and provide legal and counseling services to help them deal with violence and abuse in their intimate relations. These programs have never been formally assessed, but informal assessments found positive responses to these programs (International Center for Research on Women, 2002; Vazirova, 2011)

Karmaliani et al. (2012) suggested health-based, microfinance, and family-based models as better strategies to target IPV, particularly women living in adverse

conditions. Women in poor communities can be helped to start a small business, generate income, and progress toward self-sufficiency through microfinance programs. This can be more effective when combined with other interventions such as economic skill building and life skills education. Studies from Bangladesh and sub-Saharan African countries have shown that microcredit programs increase the economic and social independence of abused women, thereby lowering the incidence of IPV and increasing the psychological well-being of women and children (Pronyk, Hargeaves, & Morduch, 2007; Schuler, Hashemi, Riley, & Akhter, 1996).

The literature on interventions for IPV from this region indicate a lack of rigorous evaluation or proper documentation of program activities and outcomes (Solotaroff & Pande, 2014), making it difficult to determine what factors are most relevant to achieve positive outcomes and changes in behavior. Some evidence suggests that prevention programs are more successful when they use community networks and change agents (e.g., religious leaders in Muslim communities) and make effective use of media with stimulating messages that increase awareness and change attitudes toward domestic violence.

More coordination among stakeholders and the integration of educational strategies with legal and health services are required to prevent the secondary victimization of women who seek help. Kamal (2012) recommended more involvement from community members. South Asian communities are collectivist societies. People can be taught to change their attitudes and to view violence in intimate relations not as a private matter but as a societal problem. They can be taught that they all have an important role to play in condemning these acts. The literature from the West has also shown that people do report martial abuse to religious leaders (Levitt & Ware, 2006), although they usually are not adequately trained to intervene in cases of IPV (Bruns et al., 2005; Knickmeyer, Levitt, & Horne, 2010). It has been commonly observed that in Muslim communities of South Asia, religious leaders usually evaluate and address the problem from within their traditional patriarchal perspective, which keeps women in disadvantaged positions. However, to date, no published data are available from developing countries on the type and quality of counseling services provided to victims by religious leaders (Zakar, Zakar, & Krämer, 2011a). The shelter home services do provide temporary relief to domestic violence victims; however, in the long run, these women are not readily accepted when they go back to their communities. Increased involvement will thus be needed by community elders and local councils to provide shelter and support to victims and address the underlying reasons for abusive relations, so victims are not isolated and avoid a recurrence of their abuse experiences.

CHARACTERISTICS OF DOMESTIC VIOLENCE PERPETRATOR PROGRAMS IN SOUTH ASIA

In comparison to the research available on IPV intervention programs for victims, there is much less known about the nature and outcomes of interventions for perpetrators offered by the different local and international organizations in South Asia.

Although quantitative evidence is lacking, some anecdotal data indicates that in South Asian communities, men are usually the perpetrators of violence in intimate relations. For example, in a household survey of both men and women, 75% of female respondents held men responsible for domestic disputes and violence, and an in-depth exploration through focus group discussions also revealed that women are more likely to be victimized (Kamal, 2012). It is not yet completely understood how the mechanism by which social structures and gendered beliefs influence rates of abuse perpetration in developing nations (Esquivel-Santoveña et al., 2013), but there is no doubt that they are very important. A survey of 3,446 women in India, for example, found "patriarchal ideology," as defined as jealous behaviors by husbands and attempts to isolate the partner from family and friends, to be a significant predictor of IPV (Chokkanathan, 2012). Likewise, in Nepal, a survey of 1,536 women found correlations between sexual victimization and women's lack of power in their relationship (Adhikari & Tamang, 2010).

There is growing evidence that family-based models which also involve male perpetrators are more effective in addressing IPV (Eckhardt, Murphy, Black, & Suhr, 2006). However, designing and conducting interventions for male perpetrators of IPV in South Asian and Middle Eastern communities is particularly challenging. A WHO descriptive study of batterer intervention programs identified 56 programs, including 23 in developing countries. Most of the programs were established in the 1990s, most commonly motivated by the frustration of IPV counseling or advocacy service providers who were unable to stop IPV at what they believed to be the source. A review of available literature suggests that worldwide, several intervention programs are being offered which focus on men and target underlying gender norms to stop IPV.

Western preventive intervention programs for IPV have sometimes been adapted for developing countries with high prevalence of IPV. For instance, the White Ribbon Campaign from Canada, Stepping Stones in sub-Saharan Africa (and adapted for use Asia, Latin and North America, and Europe), Project H from Brazil, and Choose Your Future developed in the United States (adapted under different names in other countries, such as New Visions for Boys in Egypt).

Studies from developing countries suggest that negative gender stereotypes and traditional gender ideology have an important role to play in domestic violence perpetration (Zakar, Zakar, Mikolajczyk, et al., 2013). A report by the WHO evaluated the effectiveness of IPV preventive interventions programs. The aim of these programs was to engage men and boys in achieving gender equality and equity in health. Almost one-third of the 58 programs evaluated were successful in encouraging men to end violence against women, care for their pregnant wives and children, and take steps to avoid infecting their partners with HIV or becoming infected themselves. However, relatively few of the programs went beyond a short-term pilot phase.

Providing legal and counseling services to women victims is not enough. Men need to be educated about the harmful effects of violence and coercion against women and the benefits of women's social and economic empowerment for the whole family. The primary intervention programs launched in South Asia that target attitudes and perceptions of males about masculinity and gender norms, as previously discussed, have led to

positive outcomes. For example, Program H, which has been adapted in several parts of the world, focuses on helping young men develop gender-equitable norms and behaviors through a tested and validated set of interventions that work at two levels: promoting attitude and behavior change among individual young men and promoting changes in social or community norms that influence these individual attitudes and behaviors.

An attempt was made by the authors to identify IPV perpetrator programs in Pakistan and to administer a survey adapted from the one used by Buttell, Hamel, Ferreira, and Cannon (2016) with batterer intervention programs in the United States and Canada. We contacted concerned authorities of 16 NGOs in Pakistan to obtain data from these organizations; however, not a single organization was found to have any extensive perpetrators intervention programs and thus were not in a position to provide information on all the questions asked in this extensive survey (see Appendix). We therefore asked some open-ended questions to inquire about the availability and nature of other intervention programs offered by these organizations that address the needs of male IPV perpetrators.

One successful program in Pakistan, "Hamqadam," focuses on men's belief and attitudes about masculinity (see Table 2), and a similar program, "Yarri Dosti" (see Table 2), was implemented in India. Quasi-experimental evaluations of both programs showed positive outcomes (Solotaroff & Pande, 2014). The postevaluation of the Yarri Dosti program from rural areas reported that the percentage of men reporting recent partner violence declined from 50% to 37% in this region (Verma et al., 2008).

Some programs in Nepal and India have used sports as an entry point to interact with young men and address their attitudes toward violence and abuse against women. The "Saathi" program (see Table 2) in Nepal and the "Parivartan" program in India engage coaches and athletes to promote gender-egalitarian attitudes, leading to a decline in abusive acts against women (Das et al., 2012). Keeping in view the existence of deeply-rooted cultural norms, more commitment and collaboration is required between government and civil society organizations, media, religious leaders, and other social institutions.

It is important to consider that men are not the sole perpetrators of IPV in South Asian countries. As previously discussed, there is some research suggesting that women, especially young women, can be as physically and psychologically abusive as their male partners. Furthermore, mothers-in-law and sisters-in-law are also involved either by initiating or provoking others to commit abuse (Kamal, 2012). The intervention programs need to consider these elements because targeting men alone may not work well in these communities. At present, there is no research literature available from Pakistan about the implementation and effectiveness of such gender-inclusive models. Recently, an intervention program in India was started with the name of Dil Mil (Hearts Together), which focused on women's empowerment and domestic abuse prevention through the involvement of mothers-in-law (see Table 2). Results of this intervention are not available in published form at present (Krishnan et al., 2012). Karmaliani et al. (2011) also proposed that integration of family-based approaches at the primary health care level will expand the scope and positive outcomes of these

TABLE 3. Geographical Distribution, Duration, and Dimensions of Batterer Programs

WHO World Region	Percentage of Programs by WHO Region	Year Established (Average)	Size of Program (Average New Cases per Year)
America	34 (19)	1997	288
Europe	36 (20)	1994	233
Africa	11 (6)	1995	135
Southeast Asia	5 (3)	1997	617
Eastern Mediterranean	2 (1)	2002	N/A
Western Pacific	13 (7)	1997	155

Note. WHO = World Health Organization.
Rothman, E. F., Butchart, A., & Cerdá, M. (2003). *Intervening with perpetrators of intimate partner violence: A global perspective*. Geneva, Switzerland: World Health Organization.

interventions; however, there is a gap in available literature, and no scientific evidence is available about their effectiveness in South Asian communities.

Rothman, Butchart, and Cerdá (2003) conducted an extensive review of perpetrator intervention programs for IPV (Table 3). The first program offered in a developing country was the Family and Marriage Association of South Africa started in 1990. According to their review, in 1997, very few batterer programs were found in Southeast Asian countries, compared to those in Europe and America. Seventy-four IPV intervention programs were identified in 38 countries. Of these, 56 were classified as "batterer intervention programs." The 22 programs were excluded from their study because their focus was on prevention-oriented efforts.

Researchers (Rothman et al., 2003) were unable to find any programs at all in Central Africa, the Eastern Mediterranean region, and Eastern Europe. After making multiple contacts with women's rights agencies, law enforcement, health, and other nongovernmental and governmental agencies in these regions, the researchers failed to identify any programs that could have been described as working with men who beat or abuse their wives, girlfriends, or dating partners. On average, the European and African programs that participated in the survey had accumulated more years of operating experience than programs in other regions. Those that participated in this survey ranged widely in terms of size, from serving an average of 7–200 clients per year. Most of the programs (70%) serve less than 100 abusers per year, but 5 serve upward of 1,000. Six programs serve as few as 10 clients per year. Out of all the programs surveyed, only 5% were located in South Asia.

Given the high rates of IPV against women in Pakistan and other South Asian countries as well as the existence of rigid patriarchal norms that limit women's rights and freedoms, it has been emphasized that the basis of intervention programs should be resocialization regarding gender differences (Rothman et al., 2003). This involves targeting

people's negative attitudes and perceptions about gender roles. A campaign with the name of "We Can" was launched by Oxfam in Bangladesh, India, Sri Lanka, and Pakistan in 2004–2005 with a follow-up in 2010 (see Table 2). The campaign identified four major positive outcomes: reduced tolerance of violence against women by community members; more acceptance of women who speak out against IPV; increased awareness of the benefits of violence-free relationships for women, men and families; and evidence that community members are taking responsibility to strengthen violence-free relationships. Similarly, the campaign "16 Days of Activism Against Gender Violence" has provided an annual platform for local groups in this region to sponsor events, engage the media, and increase active participation from communities to address IPV.

The review of 19 domestic violence perpetrator programs in developing countries showed that 100% of them address issues of masculinity, and 74% talked about cultural traditions. Other topics discussed in these programs are healthy and unhealthy intimate relations, fatherhood skills, conflict resolution, trauma, drug and alcohol abuse, sexual health, and oppression (Rothman et al., 2003).

In Muslim communities of South Asia, one important step toward this could be educating the masses about core values of religion in a very down to earth, sensible manner. Simply challenging misinterpreted religious teachings and religious leaders will not bring forth any reform and may in fact result in greater upheaval. There is a need to bring together people with contradicting views to promote Islamic teachings that emphasize respecting women's rights in intimate relationships. Effective use of means of mass communication can bring change in societal attitudes. Mass media in Pakistan is now playing an important role in creating public consciousness about the negative social impact of domestic violence against women (Ahmar, 2004). For example, the Women's Rights Association has worked for 7 years with men and women in a village near Multan and has succeeded in making this village free from cases of IPV as reported by its inhabitants.

Talk shows as well as dramas and telefilms on this subject matter are likely to grab the attention of the common viewer. A popular series, *Shareek-e-Hayat*, was telecasted by a local private channel in Pakistan. It highlighted important IPV issues and provided its viewers an opportunity to reflect on many of the problems related to IPV, identify the sources of relationship conflict and violence, and learn more positive attitudes and behaviors to resolve IPV issues. Another program, *Aghaz-e-Safar*, has played an important role in creating awareness among men and women about IPV. Both victim and perpetrators invited on this show are linked to available resources, and the educational strategies and counseling services have helped many participants to live healthy intimate relationships.

DISCUSSION

This review has reflected and deliberated on the prevalence, risk factors, and consequences of IPV on victims in South Asian and Middle Eastern countries. It also provides a detailed, analytical review on the current existing intervention programs in these

regions along with their strengths and limitations. We have stressed the need for structured perpetrator programs in the South Asian region and have highlighted the limitations of research on existing IPV intervention programs because of lack of resources and low-quality assurance, thus putting the reliability and validity of their findings in doubt. This review has provided strong evidence that the proper handling of IPV cases is critical because help-seeking efforts may aggravate the violence, which usually considered a private family matter. Women are themselves reluctant to seek help because of the lack of social acceptance, and the stigma attached to IPV victim services increases the chances of further victimization and family breakup (Surtees & Somach, 2008)

Although women perpetrators have been found to exist throughout the world, the literature has not identified sufficient evidence of IPV victimization among males in South Asia. This may be because of the underreporting of IPV victimization by men because of the fear of their masculinity being questioned. The research data in this part of the world is focused on male perpetrators and services for victimized women and children. Reports published by NGOs and other local agencies are important in terms of policymaking and providing accurate statistics on prevalence and impact of IPV violence. However, current gaps in knowledge about the psychology of female perpetrators and the impact of IPV on male victims strongly indicate a need for research to develop intervention programs for male victims.

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APPENDIX. Identified Programs

1. Bedari Foundation is an Islamabad-based organization. A representative of Bedari told us about one informal program which was completed about a year ago. The program included male perpetrators and focused on general awareness about the impact of domestic abuse.
2. All Pakistan Women Association (APWA) is a national association with several offices around the country. The organization has a list of different awareness campaigns and workshops, which focus on women's rights and social and economic development. However, there are at present no perpetrator intervention programs in place or on their agenda.
3. Sexual Harassment Watch is an Islamabad-based organization which is working for women's rights and helps protect women from public and workplace harassment. They usually aim at primary prevention by raising awareness about issues and with legal reform campaigns. They do not have any specific project on perpetrators intervention.
4. Aurat Foundation is also an Islamabad-based organization focused on women's development issues. The representative of this organization tried to provide information on a modified form of the questionnaire used in the survey (Buttell et al., 2016), but she was not able to complete most of its sections because of an absence of a structured perpetrator program in her organization. They offer other programs, focused on economic development in women thus to prevent their risk for victimization.
5. Plan Pakistan Vehari is an organization in the Multan Division. The representative from this organization was the manager of one of their IPV prevention programs, which used to invite men to address domestic violence issues and discuss ways to become equal partners for a violence-free community. The project was composed of workshops and awareness sessions for male participants. It did not, however, offer specific therapies or psychological treatment. It was completed last year and discontinued because of an absence of funding.
6. Sustainable Participatory Organization (SPO) is a collaborative organization, working with the Aurat Foundation and other national organizations to promote participatory development in society. They do have one domestic violence program which engages both male and female members of the household to address issues related to domestic abuse. This includes conflict resolution and communication skills components. However, it does not follow any standard procedures and is not an evidence-based perpetrator intervention program.
7. Struggle for Change (SACH), along with Aurat Foundation and Acid Organization, is working in the field of domestic violence. With women the most common victim, they report limited participation by men, who are usually perpetrators.
8. Awaz-e-niswan is a Punjab-based organization working on women development programs. According to their representative, they do not have any programs for males, or IPV perpetrators.

9. Women Shade is a Balochistan-based organization that works with female issues. This organization focuses on providing awareness to women about their role and rights, through electronic media. They do not have any on-site or online perpetrator intervention programs.
10. Depliex Smile Foundation: The major emphasis of this organization is on providing free reconstructive surgeries, psychotherapy, shelter, and all kinds of support to female acid survivors and other burn attack victims in Pakistan. They do not have any specific batterer intervention programs.
11. White Ribbon Campaign Pakistan: They do not have any specific intervention program for perpetrators of IPV. However, some of their programs do focus on providing psychosocial support to women victims and conduct joint sessions with men as well.
12. Anjuman Falah-e-Moashra Mianwali is a Khyber Pakhtoon Khan (KPK)-based organization that works with both male and female populations. They have a huge network in two districts with almost 130 community based organizations (CBOs). They offer financial resource plans for women, are working to raise awareness of women's rights, and involve men as partners for women's development. They also conduct individual and group sessions, to promote understanding about family conflict–related topics and women's empowerment.
13. Women's Rights Association is a Punjab-based organization in the Multan District. Its goal is to overcome domestic violence, as suggested by its various slogans: *Tashudad sy pak ghar* (violence-free home), *tashudad sy pak gali* (violence-free street), and *tashudad sy pak gayon* (violence-free village). Although funding ran out after 1 year, the organization representative reported that results of this 1-year project were outstanding.
14. Rozan is an Islamabad-based organization and, according to one official, the pioneer organization for working on male-perpetrated domestic violence. The organization offers different programs, but its major focus is on creating domestic violence awareness among youth. A program of Humqadam was specifically launched to target young men and focuses on men as potential perpetrators (e.g., fathers, husbands, brothers, teachers, shopkeepers). They are working to engage young adults to help create a violence-free community. At present, they do not have any separate program for married males or perpetrators of violence.
15. Da Hawwa Lur Organization is a KPK-based organization in Peshawar. The representative from this organization shared that their organization, in collaboration with WAR (War Against Rape), offers a new project named "Nari," organized and launched to provide psychological counseling to male members of society. They are in the process of launching the program.
16. WAR is a Punjab-based organization that works with rape victims.