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Disability status and violence against women in the home in North Kivu, Democratic Republic of Congo

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ABSTRACT

Few studies have investigated how women's disability status may influence violence against women within conflict settings. A mixed-methods analysis of formative qualitative research and cross-sectional baseline pilot data from a violence prevention program in North Kivu, eastern Democratic Republic of Congo (DRC), was used to examine violence against disabled adult women within the home. Logistic regression models were constructed to examine the relationship between past-month physical/sexual intimate partner violence, disability status, and older age ($N = 98$ women). Deductive thematic analysis of focus groups and individual interviews ($N = 57$ men, 59 women) was used to identify community norms and perceptions of violence against women with disabilities in the home. Women who reported mild disability reported higher experiences of past-month physical and/or sexual IPV (85.0%) compared to those who reported severe or no disability (76.5% vs. 70.8%, respectively). Older women with mild disability were more likely to report physical IPV compared to their younger counterparts as well (OR = 1.23, 95%CI: 1.01, 1.49, $p < 0.039$). Qualitative findings suggested family members may be deterred from perpetrating abuse against older women. These findings highlight a complex relationship between women's disability status and violence perpetration, underscoring the importance of having inclusive, contextual violence against women prevention and response programming in conflict settings.

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Violence against women; inclusion; intersectionality; humanitarian; armed conflict

Introduction

Violence against women (VAW) is a serious health and human rights issue that impacts 35% of women worldwide (World Health Organization, 2013). Women living in conflict-affected settings are at higher risk of experiencing intimate partner violence (IPV) and non-partner violence (World Health Organization, 1997). Although no global statistics are available on overall VAW and displacement, one study from South Sudan found approximately 65% of displaced women experienced physical or sexual violence by an intimate partner or non-partner (WhatWorks to Prevent Violence et al., 2017). While VAW and gender inequality precede a humanitarian crisis, shifts in key drivers of VAW may exacerbate such violence, including the normalization of violence, instability, destabilization of gender norms and roles, men's substance abuse, and changes

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in family dynamics (e.g. separation, rapid remarriages and forced marriages) (Stark et al., 2017; Wachter et al., 2018; WhatWorks to Prevent Violence et al., 2017). Further, while there has been documentation of increased VAW among women in conflict-affected areas, VAW with disabilities within these settings has been far less explored. There are indications that displacement may amplify challenges that individuals with disabilities experience, such as increased dependency due to loss or damage of assistive devices, support networks, and lack of environmental assessibility (Norweign Ministry of Foreign Affairs, 2015). However, to date little research has been conducted on VAW experiences and levels of disability among women and less is conducted on women with disabilities in crisis settings.

Research within low and middle-income countries (LMICs) has found that women with disabilities are two to four times more likely to experience IPV than women without disabilities, and individuals with disabilities are 1.5 times more likely to experience non-partner or partner violence compared to individuals without disabilities(Dunkle et al., 2018; Hughes et al., 2012). The need for daily personal assistance, reduced physical and emotional defenses such as coping mechanisms, discrimination and attitudinal, physical and communication barriers may put these individuals at greater risk of IPV or non-partner violence (Nosek et al., 2001; Saxton et al., 2001) and hamper their capacity to disclose situations of abuse and seek support. Another aspect contributing to VAW with disabilities may be societal norms surrounding disability, such as stigmatizing attitudes from family members and/or service providers: testimonies of women with disabilities may be regarded as less reliable, and sometimes there is a reluctance to report rape or other forms of sexual abuse for fear of bringing more shame upon an already stigmatized family (Dunkle et al., 2018; UNICEF Innocenti Research Centre, 2007). Further, older women may also face this stigma and discrimination as disability comes naturally with aging and they may begin to require more assistance from others (World Health Organization, 2011).

Familial and relationship power dynamics that disfavor women may also be exacerbated when she lives with a disability: for example, a recent study in Nepal found that women with disabilities were more likely to experience in-law violence and less social support from in-laws compared to women without disabilities (Gupta et al., 2018). While a small body of evidence illuminates women with disabilities' risk of experiencing violence when her abuser or abuser's family is also a support person (Brownridge, 2006), further research is needed to understand how risk factors related to power, gender, and ability status may coalesce for women with disabilities. In addition to the aforementioned threats faced by women with disabilities, forced displacement puts these individuals at even greater risk of violence, exploitation, exclusion from access to humanitarian assistance, health care access and even legal status (e.g. refugee status) (United Nations High Commissioner for Refugees, 2011).

The Democratic Republic of the Congo (DRC) has experienced frequent and protracted political and societal instability and civil war; recently, high levels of violence from over 100 armed militia groups in the eastern region of the DRC has resulted in internal displacement of more than 4.5 million people (Central Intelligence Agency, 2019; United Nations Office of the Coordination of Humanitarian Affairs, 2017). Further, roughly 4% of the population of the DRC is internally displaced (Internal Displacement Monitoring Centre, 2018a), and an estimated 11% of the population lives with disability (Sida, 2014), an estimation to be taken with caution, as being below the 15% estimated for the global population (World Health Organization, 2011), and far below higher estimates in conflict-affected areas (Handicap International – Humanity & Inclusion, iMMAP, 2018). National prevalence surveys document high levels of exposure to violence, as more than half of Congolese women (52%) reported ever experiencing physical violence, and more than one-quarter (27%) had ever experienced sexual violence, in 2014 (Ministère du Plan et Suivi de la Mise en œuvre de la Révolution de la Modernité (MPSMRM), Ministère de la Santé & Publique (MSP) and ICF International, 2014). Importantly, the prevalence of exposure to violence is unknown for Congolese women with disabilities.

As noted, women living in conflict-affected areas are already at an increased risk of violence and those living with disabilities may face even more risks, particularly, susceptibility to violence

(Internal Displacement Monitoring Centre, 2018b; United Nations Office of the Coordination of Humanitarian Affairs, 2017). Contrary to the belief that women and adolescent girls living in conflict-affect areas are most at risk of violence by military members or strangers, findings from a study conducted in the DRC found the primary perpetrators of such violence to be intimate partners, along with caregivers for adolescent girls (Myers Tlapek, 2015; Stark et al., 2017). As in other contexts, high rates of IPV in the DRC may be driven in part by social norms that condone VAW and consider violence as a desirable demonstration of masculinity (Myers Tlapek, 2015). For example, a Congolese study found men who experienced trauma during conflict may respond violently to intimate partners and family to reassert their social expectations of manhood (Tankink & Slegh, 2017). Women with disabilities within these settings may be at an increased risk of violence as they face greater barriers in help-seeking. Despite the high levels of IPV and violence among Congolese women being well-documented, little research has been done on VAW with disabilities within the DRC, which may pose additional risks for experiencing violence within the home.

Such research is important in addressing VAW prevention and response programs in humanitarian settings, as well as to meet the Sustainable Development Goals of reducing economic and educational disparities and inequalities among girls and women, including those with disabilities (United Nations, 2015). Specifically, disaggregating data by disability status is a way to strengthen programming aimed at improving quality of life for all (United Nations, 2015). This paper aims to help fill gaps in knowledge of VAW with disabilities within the home through an analysis of formative and baseline data from the International Rescue Committee's (IRC) program, Safe at Home, which seeks to address the shared risk factors of VAW and violence against children (VAC) within the family. This present analysis uses a mixed-methods approach to illuminate intersections of age and disability status in women's exposure to violence in the home. A quantitative exploration of IPV which examines age, disability status, and the interaction of age and disability, is complemented by qualitative data illuminating social norms on VAW with disabilities in the home.

Methods

Study design

The current study used formative and baseline data from the International Rescue Committee's (IRC) 'Safe at Home', a pilot program that seeks to address the shared risk factors for co-occurrence of VAW and VAC in the home.

Quantitative data was drawn from a baseline assessment of the program completed in eastern DRC in September 2018. One hundred couples were invited to participate in the program; all program participants were invited to participate in the baseline assessment. Trained, gender-matched enumerators administered electronic questionnaires. All participants in both stages of research completed informed consent; all interviews occurred in private spaces within the communities. For the purposes of this analysis, only women were included in the sub-sample as questions regarding intimate partner violence were only assessed among female partners.

Qualitative formative research was gathered between March and April 2018 in North Kivu, DRC with 59 women and 57 men aged 18 and older. Participants were selected based on a maximum variation sampling strategy by IRC program staff who identified adult male and female participants across age and disability spectrums. Trained, gender-matched interviewers and translators conducted six gender-segregated focus groups ($N = 22$ men, 23 women) and 71 individual interviews ($N = 35$ men, 36 women) at private and confidential locations. Due to the low literacy rates, verbal consent was obtained from each participant. Interviews were conducted in Swahili or Kinyarwanda.

Ethical approval was obtained from the International Rescue Committee Institutional Review Board (WPE 1.00.011), and the Comité National d'Ethique de la Santé (CNES)- Direction Provinciale du Sud-Kivu (CNES) in DRC.

Measures

Quantitative

Quantitative baseline surveys were conducted with both male and female participants and included 14 sections. This analysis utilized sections on demographics, disability status yes/no and experiences of IPV. Six items of the Washington Group Short Questionnaire were used to assess respondents' disability status (Washington Group on Disability Statistics, 2017). For each item, possible responses included 'no – no difficulty', 'yes – some difficulty', 'yes – a lot of difficulty', 'cannot do at all', and 'no response'. A three-level categorical variable was created for disability to assess the severity of the disability (Gupta et al., 2018; WhatWorks to Prevent Violence et al., 2017). A woman was coded as having no disability if she selected 'no-no difficulty' to all six questions, living with mild disability is she selected 'yes – some difficulty' to any of the six questions or 'yes – a lot of difficulty' to any of the six questions and living with severe disability if she selected 'cannot do at all' to any of the six questions.

Past-month IPV experiences were assessed via adapted questions from the WHO Multi-country Study on VAW (WHO, 2005). Response selections for each IPV question were 'no', 'yes', or 'no response'. Dichotomous variables were created for the following IPV categories: IPV (physical and/or sexual), physical IPV, and sexual IPV. A woman was coded as having experienced IPV if she responded 'yes' to any of the eight items regarding physical IPV and/or sexual IPV; coded as having experienced physical IPV if she responded 'yes' to of the six items regarding physical IPV; and coded as having experienced sexual IPV, if she responded 'yes' to any of the two items regarding sexual IPV. A woman was coded as not experiencing IPV if she responded 'no' to all IPV questions.

Qualitative

Semi-structured qualitative interviews used a vignette of a hypothetical family to elicit beliefs about community norms related to family violence. To assess perceptions and attitudes towards persons with disabilities, the vignette described a married couple living with the husband's older sister with a physical disability and three children, one of whom also had a physical disability. Participants were asked about perceptions of caring for persons with disabilities across the life course, expectations of children and women with disabilities, as well as about how a husband or wife would respond to scenarios that might garner frustration or discord between different persons within in the home. Interviews were audio-recoded and transcribed into the local language and then English. Translations were verified for accuracy at each stage of translation.

Data analysis

Descriptive statistics were utilized to examine the frequencies of all variables. Bivariate associations used Pearson's χ^2 tests to assess the associations between dichotomous demographic variables and disability status, and dichotomous demographic variables and outcomes measures, while *t*-Tests were used for continuous demographic variables. Unadjusted logistic regression was used to assess the relationship between the three-level categorical disability status and IPV experienced. We then ran adjusted logistic regression, controlling for sociodemographic variables. An interaction term was generated between age (assessed continuously) and the categorical disability indicators to assess the association between disability status, age and violence. Stata (version 15.1) was used for all quantitative analyses.

Deductive thematic analysis was used for qualitative data. The codebook was designed to capture social norms related to violence against persons in the home, with some codes assigned a priori to reflect global literature on shared norms driving VAW and VAC, and additional codes added to reflect prominent themes identified by participants. To facilitate intersectional analysis (e.g. examining the intersection of social structures and identities, such as gender, disability, race, ethnicities, etc. and power and how it may result in heightened inequality), excerpts were also coded by subject

of discussion in the vignette, such as age, disability status, and gender (Christensen & Qvotrup Jensen, 2012; Williams Crenshaw, 1994). The second author reviewed all data coded to reflect discussion of the adult woman with disabilities in the vignette to identify prominent themes. Identified themes were validated through review by the research and program team in the DRC.

Results

Quantitative

Demographics

Table 1 presents demographic information on the quantitative study sample. The sample consisted of 98 women from the DRC. On average the women were 33.3 years old and the average household size was 7.4. Roughly 16% of the women within the sample were currently displaced at the time of the survey.

Bivariate associations between disability and demographic variables and IPV experiences and demographic variables

Disability (mild/severe) was reported among 75.51% of women. Roughly 40% of the women reported some degree of functional difficulty, while a little over a third (34.69%) of the women reported severe difficulties. No significant associations emerged among disability and the demographic variables. IPV experiences (physical and/or sexual violence) was reported by 78.57% of the women in the sample. Individually, 60.20% reported physical IPV and 73.47% reported experiencing sexual IPV. No significant associations emerged among IPV experiences and demographic variables.

Unadjusted and adjusted regression analyses of associations between disability and IPV experiences

As shown in Table 2, 85.0% of women with mild disability and 76.5% of women with severe disability reported experiencing past-month physical and/or sexual IPV compared to the 70.8% of women without disability. Further, while the differences were not statistically significant, women with mild or severe disabilities were more likely to experience physical and/or sexual IPV in both the unadjusted and adjusted models (OR = 2.33, CI: 0.68, 8.03; AOR = 1.23, CI: 0.99, 1.54; OR = 1.34, CI: 0.41, 4.3; AOR = 1.13, CI: 0.92, 1.40, respectively) compared to women without disabilities.

Separately, 67.5% of women with mild disability and 47.1% of women with severe disability reported experiencing past-month physical IPV compared to the 66.7% of women without disabilities. Women with mild disability were also at greater risk of experiencing past-month physical IPV (OR = 1.04, CI: 0.35, 3.05; AOR = 1.09, CI: 0.35, 3.38) with a significant interaction term between aging and disability ($p = 0.039$), indicating the association between IPV and disability status varies by age. Further, more than 3 out of 4 women with mild disability reported experiencing sexual IPV and were at a slightly elevated risk of experiencing sexual IPV (OR = 1.42, CI: 0.45, 4.49; AOR = 1.23, CI: 0.034, 4.42) compared to women without disability. In contrast to women with mild disability, women with severe disability were similarly likely to experience physical IPV (OR = 0.44, CI: 0.15, 1.31; AOR = 0.45, CI: 0.14, 1.42) and sexual IPV (OR = 0.99, CI: 0.31, 3.12; AOR = 0.88, CI: 0.24, 3.22) as women without disability.

Qualitative

Demographics

Table 3 presents demographic information on the qualitative study sample. The sample consisted of 59 women and 57 men who were interviewed. On average the women were 34.6 years old and 43.0

Table 1. Bivariate associations between demographics and disability status, and intimate partner violence (IPV) for quantitative portion in South Kivu, DRC.

Demographic variables	Sample *N* (%)	No disability	Mild disability	Severe disability	*p*-value	IPV (Physical and/or Sexual)	*p*-value	Physical IPV	*p*-value	Sexual IPV	*p*-value
Total sample	98 (100.0)	24 (24.49)	40 (40.82)	34 (34.69)		77 (78.57)		59 (60.20)		72 (73.47)	
Age (mean)	33.3	33.2	32.8	34.1	0.916	31.8	<0.001	31.5	0.014	31.8	0.006
Education (mean)	0.54	0.5	0.55	0.56	0.88	0.44	0.116	0.42	0.235	0.42	0.087
Household size (mena)	7.4	6.8	7.5	7.8	0.16	7.5	0.497	7.2	0.256	7.6	0.190
Currently displaced (%)	16.33%	20.83%	10%	20.59%	0.37	16.88%	0.78	16.95%	0.84	15.28%	0.64

Table 2. Unadjusted and adjusted logistic regressions for associations between disability status and intimate partner violence (IPV) ($N = 98$).

Disability status	IPV (Physical and/or Sexual) (%)	OR (95% CI)	Adjusted OR[a] (95% CI)	Interaction (disability*age)	Physical IPV (%)	OR (95% CI)	Adjusted OR[a] (95% CI)	Interaction (disability*age)	Sexual IPV (%)	OR (95% CI)	Adjusted OR[a] (95% CI)	Interaction (disability*age)
No disability	70.8	Referent	Referent	Referent	66.7	Referent	Referent	Referent	70.8	Referent	Referent	Referent
Mild disability	85.0	2.33 (0.68, 8.03)	2.36 (0.59, 9.43)	1.23 (0.99, 1.54)	67.5	1.04 (0.35, 3.05)	1.09 (0.35, 3.38)	1.23 (1.01, 1.49)[b]	77.5	1.42 (0.45, 4.49)	1.23 (0.34, 4.42)	1.23 (1.00, 1.52)
Severe disability	76.5	1.34 (0.41, 4.3)	1.36 (0.35, 5.34)	1.13 (0.92, 1.40)	47.1	0.44 (0.15, 1.31)	0.45 (0.14, 1.42)	1.15 (0.95, 1.40)	70.6	0.99 (0.31, 3.12)	0.88 (0.24, 3.22)	1.17 (0.95, 1.43)

[a]Adjusted ORs controlling for age, education, household size, and displacement.
[b]Significant at $\alpha = 0.05$ level.

Table 3. Demographics of qualitative participants.

	Men	Women
Demographic variable	Mean (SD)	Mean (SD)
Age	43.0 (16.6)	34.6 (14.2)
Years of education	6.2 (4.6)	3.8 (4.6)
Number of children	5.4 (4.2)	4.6 (3.0)
	% (*N*)	% (*N*)
Married	89.5% (51)	71.2% (42)
Single	7.0% (4)	11.9% (7)
Widowed	3.5% (2)	10.2% (6)
Have a disability (self-identified)	19 (33.3)	10 (16.9)
Activity		
Focus group	22 (38.6)	23 (39.0)
Individual interview	35 (61.4)	36 (61.0)
Total	57	59

for men. Roughly 30% of men self-identified having a disability and 15% of women self-identified having a disability.

Findings

Qualitative findings revealed perceptions that having a disability led to dependence on others for care and obligated family members to provide such care, which sat in opposition to expectations that adult women contribute to household chores. Dependence, familial obligation, and unfulfilled expectations were thought to contribute to resentment towards adult women with disabilities within the home. Use of physical violence as a manifestation of such resentment was deterred by perceived social or cultural norms dictating respect for adults of increasing age within the home; instead, this resentment was thought to result in greater levels of emotional violence against women with disabilities, including scapegoating of blame for interpersonal conflicts between other family members or economic stress.

Perceptions of dependence, familial obligations, and gendered expectations

Interviews with adult men and women revealed perceptions that persons with disabilities were dependent on others for care. A 23-year-old man explained that it would be unreasonable to rely on a woman with disabilities to work or complete errands, and another person would be responsible for providing for her needs:

> You know that, sometimes there are women who are there and she cannot work. As she does not work, you cannot say that you are going to rely on her because she can bring something to you, she is going to buy food. She is unable. That is how you are also going to make efforts to buy food for her so that she can be feed together with children because she is unable.

Specifically, participants placed the responsibility for caring for a woman who was unable to care for herself with her family members. Participants almost universally stated that this familial obligation to care for relatives with disabilities existed. A 58-year-old man in the DRC emphasized familial relationships when explaining his view that the community would look down upon a man who neglected to care for a sibling with disabilities:

> Who can he cooperate with if he despises a disabled. You will have despised the population if you despise a disabled. That is why you must be closer [to] him. You should avoid to hurt his heart for the second time. Like those who go to Birere, Majengo and Kirijwe. They spend a whole day begging. Neighbors serve them. If as neighbor and any other person who they come across give them [food], why can you fail to give him although you are from the same womb?

In addition to perceptions of dependence, interviews also illuminated expectations that women should manage household chores and duties. Women were expected to contribute to household chores such as cooking, cleaning, and caring for children, which would frequently require some

level of physical labor. Despite the perception that women with disabilities would be dependent on others for care, several participants also explicitly stated that having a disability was not an exemption to such expectations. For example, a 41-year-old woman in the DRC stated, 'if there is food in the house and that the wife doesn't want to cook, you [wife's sister-in-law] could also get into the kitchen and make something even if you are disabled'.

Resentment: the convergence of familial obligations, gendered responsibilities, and dependence

Interviews demonstrated that perceptions of women with disabilities' dependence on others for care and resulting familial obligations sat in opposition to gendered expectations of responsibilities within the home; the convergence of these different perceptions could breed resentment towards a woman with disabilities living in the home. Inability to complete the expected household chores described above was cited as a driving force of resentment from both adult men and women in the home:

> He [her brother] can despise and he knows that she does not help him in something. She also gets in [her] mind that he is despising her, that he does not care of her. And she will keep the sadness in her heart. (Man with disabilities, 45 years)

> Hum … but what he always think of is to know when she would die so that she could leave him alone (Interviewer: if she could die) Heh (yes) so that she could leave him alone because she is just there to waste his money when she never does anything for him, because his kids are troubling him, his wife is driving him crazy, and now his sister wants to disturb him so he doesn't know what to do then, or he could be worrying about her all the time, and so wherever he would be he would not be in peace because he would always be thinking: now this one does not help me in anything, what benefit does he bring me anyway? Why should I even care about her? (Woman, 50 years)

While participants were not asked directly about the severity of disabilities, a 19-year-old woman described how perceptions of the degree of disability would influence expectations and behavior towards a woman with disabilities. When explaining her belief that the man in the vignette would beat his sister with disabilities, she claimed that the sister 'is not as disabled as others. It is because of old age that she does not leave home'.

Similarly, a few participants described that the relational position of a woman with disabilities in the home could further expose her to violence as a scapegoat for conflict between other family members. For example, if a woman with disabilities was the sister of a married man, tensions in the relationship between the man and his wife could affect the behavior between the wife and her sister-in-law. As a 60-year-old woman in the DRC explained, '[if I were] in misunderstandings with my husband, would I really love that disabled sister?' In addition to potential resentment from another adult woman in the home, some participants also stated that a woman with disabilities might become the target of physical violence as a result of disputes between a husband and wife that were related to completion of household chores. A 41-year-old woman with disabilities explained that a woman witnessing violence toward someone else in the home might take steps to moderate her own behavior: 'That sister would also tell herself: let me be quiet otherwise he would also beat me up'.

Emotional violence as a manifestation of resentment, and deterrence to use of physical violence

Tensions between perceptions of dependency and expectations of contribution to the home, and associated resentments, were most frequently believed to result in emotional VAW with disabilities from other family members. Similar to the quote above, participants frequently stated that resentment and emotional violence may come from other women living in the home. A 41-year-old woman with a disability in the DRC provided an example of verbal abuse that might lead to feelings of hopelessness for a woman with disabilities:

> … because whenever they would be seated at home she [the wife] would start telling her [the woman with disabilities]: you just came here to make me uncomfortable with your disability; so and so … and that disabled sister could feel sad … and she could be lamenting: 'God, let me just die and leave this world, I can't take it anymore that people are always talking about me when I didn't choose to be disabled'; she could feel really bad.

Contrary to the quantitative findings, participants frequently believed that cultural norms dictating respect for older people in the community would deter family members from using physical violence against an older woman with disabilities. A 19-year-old woman explained that while physical violence was an acceptable means of punishment for younger women, a man would be subject to ridicule from other people within his community if he beat his older sister:

> They could say Justin is stupid because no one can beat his old sister. He can beat her if she is still an unmarried young girl. When she misbehaves, because girls are always disobedient, for example she refuses to go to farm or you misbehave against your mother, Justin can beat you. But, it is bad if he beats her although she is guilty of nothing.

Similarly, a 40-year-old man noted age as the predominant factor in others' responsibility of caring for an older woman with disabilities:

> If that old woman cannot move from home, you who have got two feet and two arms, you must know how you can go to struggle. It is you who must take care of that old woman. Because she has no other means since she is old.

Thus, while participants believed that adult women with disabilities in the home could be the subject of physical violence, the most frequently thought women with disabilities would be subject to emotional violence. These beliefs, however, shifted with perceptions of age and possibly gradations of disability, and could be further complicated by the relational position of a woman with disabilities to others in the home. Notably, sexual VAW with disabilities was not mentioned by participants in qualitative interviews.

Discussion

The current study presents new qualitative and quantitative insight towards the drivers and frequencies of violence against women as it relates to disability and older age identities. Overall, the levels of IPV experienced by partnered women living in North Kivu, DRC, regardless of disability status, is alarmingly high, with over 3 out of 4 of the total sample experiencing physical and/or sexual IPV. It should be noted our study population was drawn from highly conflict-affected communities in North Kivu and it is possible these communities experience more IPV, due to the hypothesized linkages between instability, war experiences, and IPV (Kohli et al., 2015; Stark & Ager, 2011). In addition, the data was drawn from a baseline survey of a pilot program and it is possible that women thought increased reporting of IPV may have resulted in increased access to aid and services from the implementing organization. This frequency is higher than a national, probability-based sample of women within the DRC conducted by the 2013–2014 Demographic and Health survey statistics results which found 57% of ever-married women experienced spousal violence (Ministère du Plan et Suivi de la Mise en œuvre de la Révolution de la Modernité (MPSMRM), Ministère de la Santé & Publique (MSP) and ICF International, 2014). Among studies conducted in eastern DRC, previous research has found the frequency of past-year physical and/or sexual IPV to be almost 50% (Vaillant et al., 2020).

Our study found high levels of disability reported among women within the sample. The high levels may be reflective of the communities in which the program is running, or an artifact of the recruitment strategy. However, we found women with disabilities reported higher levels of IPV compared to women without disabilities. This finding is consistent with the handful of other studies examining IPV and disability status which found women with disabilities are at greater risk of IPV victimization compared to women without disabilities (Brownridge, 2006; Kohli et al., 2015).

Further, the levels of disability and IPV experiences found women with mild disabilities were more likely to report IPV compared to women without disabilities, which is similar to results found in another study examining the associations between severity of impairment and past-year IPV and in-law violence in Nepal (Gupta et al., 2018). The findings from our research emphasize that women with disabilities within the DRC are just as likely, if not more likely to experience IPV compared women without disabilities and should be addressed accordingly through disability inclusion within IPV programming and research.

Risk of IPV and forms of violence within the home also varied by severity of disability. For instance, women with mild disabilities reported higher levels of IPV experiences compared to women with severe disabilities and women without disabilities. While differences in past-month exposure to IPV between women with mild disabilities and women without disabilities lacked significance, the trend in higher risks for women with mild disabilities are mirrored in the qualitative findings regarding family violence. Qualitative perceptions of persons with disabilities as dependent and 'useless' sat in opposition to expectations that women should contribute to management of the home, which may make women with disabilities especially exposed to experiencing violence within the home. Indeed, qualitative participants frequently explained that women with disabilities were not fulfilling their gendered responsibilities to the family, and there were indications that expectations of how a woman should contribute were related to perceptions of the severity of her disabilities. Our findings indicate women with mild disabilities are at an increased risk of IPV or violence perpetrated by family members and may be further driven by the natural relationship between aging and disability. For instance, qualitative findings suggested disabilities related to age may be viewed as an excuse to not participate in household responsibilities by members of the family and expectations for completing chores may be higher for a person who exhibits fewer external signs of disability. This may result in more frustration and resentment rooted in the inability of women with disabilities to contribute to the home through some sort of physical labor, which may be deemed of higher value in the cultural context. This increased risk may be explained by family members and in-laws acting as the main providers of support and care for these women and may also be the main perpetrators of this violence. A Nepalese study found similar findings that women with disabilities, or increasing disability due to age, reported higher rates of family and intimate partner violence due to inability to complete household chores and increased need for assistance (Puri et al., 2015).

While women with mild disabilities reported higher exposure to IPV overall, women with severe disabilities reported similar levels as women without disabilities. However, while women with severe disabilities appeared to be less likely to experience physical IPV compared to those with mild disabilities, large percentages of women with both severe disabilities and no disabilities reported experiencing such violence. Lower prevalence of past-month physical violence among women with severe disabilities coincides with qualitative perceptions that physical violence against women with disabilities was inappropriate. Participants attributed non-acceptance of physical violence against women with disabilities to pity for women who were perceived to be incapable of handling daily tasks and dependent on others for care. Women with mild disabilities may be at an increased risk compared to those living with severe disabilities because their needs may not be recognized: for example, mild disabilities may impact their ability to participate in physically laborious household work, but lower participation in such housework may be attributed to laziness rather than presence of a functional limitation. Qualitative participants also described resentment related to obligations to care for women with disabilities. Similar research has found societal attitudes or the lack of assistive devices may make it harder for women with disabilities to care for themselves, thus increasing their dependency on their husbands, relatives or in-laws, and the likelihood of violence (Gupta et al., 2018; Hahn et al., n.d.; Shakespeare, 2006).

Contrary to the qualitative findings, quantitative findings found aging women with mild disabilities reported higher frequencies of IPV compared to their younger counterparts. This finding varies from previous research conducted on risk factors associated with violence against women with disabilities which found age and disability to be negatively related to IPV experiences (Brownridge,

2006). However, the aforementioned study was conducted in a high-income country, whereas our study was conducted in a lower-income conflict-affected setting, thus results are likely to differ. These findings indicate age may act as a deterrent to abuse when the woman with disabilities is a sibling, whereas, age may increase experiences of abuse if the woman with disabilities is the wife/partner. This increased abuse may be due to the perception shift between the woman with disabilities being a sibling versus being a partner/wife. A sibling may not be expected to fulfil all household roles and the burden may then fall upon the woman's sister-in-law, thus she may not experience as many violent experiences as the household roles would still be completed. Whereas, a wife/partner with disabilities may be unable to fulfill her household tasks and without another to help relieve this burden, her chances of experiencing violence within the home increase.

Our study found some divergence between social norms indicating respect for older persons in the community in the qualitative portion and self-reported experiences of physical violence among women who were locally perceived to be older. Differences in experiences of physical and sexual violence across the life course should be explored further through additional research to understand and identify potential levers to prevent VAW with disabilities.

Our study's outcomes should be viewed in the context of certain limitations. First, the outcomes were self-reported, and therefore, may be subject to social desirability bias that may lead to under or over reporting. As mentioned previously, the alarmingly high frequency of IPV may have been over-reported as part of a baseline assessment if women thought it could yield further services. However, the study team took measures to reduce this by taking the appropriate channels to address the ethical and privacy concerns of the women, including clarifying their participation in the survey had no bearing on access to programming. Second, the sample size was small, and did not allow for sufficient statistical power, which may explain the lack of significant findings. Qualitatively, the study used purposive sampling and did not explicitly ask about IPV experiences for women with disabilities, which limits generalizability to other contexts and illumination of pathways by which women might experience violence from an intimate partner. Additionally, since interviews were subject to multiple rounds of translation, some nuances in perceptions of violence against persons with disabilities may have been lost in translation; the study team attempted to limit this through selecting native speakers of local languages for translation, verifying translations, and validating results with Congolese data collectors and staff.

These limitations notwithstanding, our study has implications for disability, age and IPV research and programming. Future research, specifically in conflict-affected areas is needed to better understand how levels of disability among women, and in particular, different types of disability, may impact IPV outcomes within these settings. In particular, the intersections of disability status and older age and potential magnified risk for IPV warrants further exploration. The present study also demonstrates the importance of asking women with disabilities about experiences of sexual IPV and further identifying their experiences in help-seeking and the type of barriers they may encounter when trying to access GBV or protective services. Identification of these barriers may help strengthen the response and accountability of service providers towards diverse women and girls, including those with disabilities. Findings indicate that women with disabilities experience as much IPV as women without disabilities, yet programmatically, few VAW interventions adequately incorporate the needs of women living with disabilities and the barriers they face when seeking for support in conflict-setting. Future intervention research must also account for potential heterogeneity of treatment effects by different identities of women. Funding to adapt existing programming and develop new programs to meaningfully include persons with disabilities as well as aging populations is critical to preventing and addressing violence against women.

Disclosure statement

No potential conflict of interest was reported by the author(s).

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