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Intimate partner violence among Afghan women living in refugee camps in Pakistan

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Abstract

The purpose of this paper is to explore events and factors that lead to conflict in the home in the Afghan refugee setting, and the current status of the health sector's ability to respond to evidence of conflict. Qualitative interviews were conducted with 20 women of reproductive age and 20 health workers serving these women in an Afghan refugee camp near Peshawar, Pakistan, during the summer of 2004. In particular, this paper analyses women's explanations of how various marriage traditions may be linked to conflict in the home and how the interactions of different family members may be related to conflict. The relationships of women with their parents-in-law and husbands are highlighted in particular, and a model developed to explore the choreography of their relationships and the ways in which these dynamics may encourage or inhibit violence. The perspectives of health workers on the ways in which the health system responds to family conflict and violence are also presented. Finally, this paper provides information that helps to frame the issues of family violence and conflict in long-term refugee populations for intervention designers and those who are working to craft a health sector response to this problem.

Keywords: Refugee violence; Violence against women; Health care; Pakistan; Afghanistan; Refugees

Introduction

Stories of violence against Afghan women have been ubiquitous in international news media for almost a decade now. In March 2004, the New York Times ran an article entitled "For More Afghan Women, Immolation Is Escape" prompted by the Afghan Human Rights Commission's discovery of 40 cases of self-immolation over six months in the Herat region (Gall, 2004). These stories illuminate violent episodes of burning, acid-throwing, rape, and suicide, which comprise a deeply disturbing set of phenomena that have continued beyond the fall of the Taliban. More mundane forms of conflict and violence, however, plague the day-to-day lives of many Afghan women as well. The dynamics of family conflict, which can lead to both more extreme and less extreme forms of violence, require greater attention in the scientific health literature.

Although there is evidence in Afghanistan of efforts to assist women who have experienced or are at risk of violence in the home (United Nations

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Economic and Social Council, 2005), the widespread and enduring nature of the problem is also apparent (Amnesty International, 2003). In a review of 50 population-based surveys around the world, between 10% and 50% of women report they have been physically abused by an intimate partner in their lifetime. Most of these women also suffer severe psychological and verbal abuse (Watts & Zimmerman, 2002; World Health Organization, 2000). In addition to being a violation of women's human rights, intimate partner violence is a major cause of injury in women; victims often suffer from a wide spectrum of physical and psychosocial problems, including chronic pain, mental disorders, sexually transmitted diseases, and suicide (Campbell, 2002; Watts & Zimmerman, 2002; World Health Organization, 2000).

Domestic violence may be an even more pressing issue in refugee settings, where women have fewer opportunities to draw attention to their plight. Refugees grapple with poor living conditions, high rates of unemployment, and overcrowding in camps, all of which may increase family tensions (UNHCR Women's Commission for Refugee Women and Children, 2002). Often refugee men feel they have failed to protect their families (Human Rights Watch, 2000; United Nations High Commissioner for Refugees, 1991). Research suggests that the stress of poverty may lead men to use violence within the family in order to reclaim their sense of power and control (Jewkes, 2002).

According to one survey by the International Rescue Committee of 200 women in Afghan refugee camps in Pakistan, and cited in a report by the Reproductive Health for Refugees Consortium, 79% of the women reported having been beaten by their husbands (Ward, 2002). Another study in a district in the Northwest Frontier Province of Pakistan found that there was a "potentially" high rate of domestic violence through discussions with refugees. Some of the men and women justified domestic violence by stating that a man had the right to discipline his wife if she misbehaved or disobeyed. The report also revealed that participants believed that younger brides were more likely to suffer abuse (Ahart, 1997).

Data on violence against women, like those above, are few and limited in scope. In most refugee camps, there is no effective reporting system, and there is still uncertainty about how to respond to such reports from victims (United Nations High Commissioner for Refugees, 2002). In refugee settings, women often do not know where to turn if they need help and are unfamiliar with the host country's laws regarding domestic violence (Human Rights Watch, 2000). Unfortunately for Afghan women refugees, the Pakistani legal procedures regarding domestic violence make it difficult for victims to seek justice. Often the police do not report or investigate these cases because they are deemed family matters and are thus considered private. Many officials working in the criminal system have biases against women and are not trained to properly deal with intimate partner violence, which deters women from reporting the abuse (Human Rights Watch, 1999).

Thus, individual, dyadic, and especially structural level factors appear to jointly produce a risk of intimate partner violence for Afghan refugees. This paper will examine the confluence of these factors in the home, as well as familial dynamics that may influence conflict. We focus on "conflict" as an outcome because, despite its generality as a concept, this was a term that women were comfortable using to describe their experiences relating to distress and violence in the home. "Conflict", as the women used the term during the interviews, most often seemed to refer to emotional distress due to interpersonal issues, verbal arguments, verbal abuse, and occasional physical altercations. When further questioned about "conflict" that they had witnessed or had knowledge of, a few women spoke about more extreme forms of violence, including murder.

Keeping these different levels of influence on a range of types of "conflict" in mind, this paper will describe how specific events lead to conflict in the home in the Afghan refugee setting, while acknowledging that these events are situated within a set of structural conditions that also contribute to domestic conflict. In particular, the paper will describe women's explanations of how various marriage traditions and family living situations may be linked to conflict in the home. Additionally, the paper will explore some of the specific dynamics of women's relationships with their parents-in-law and husbands, describe the choreography of these dynamics, and explain some ways in which these dynamics may encourage or inhibit violence. Finally, we will discuss the perspective of health workers on the ways in which the health system responds to family conflict and violence.

Methods

This research project was an exploratory, qualitative study in which in-depth interviews were used

to gather information from Afghan refugee women and staff members at health care provider organizations serving refugees. The in-depth interviews with refugee women were loosely structured to allow the respondents to express themselves in their own words. The interviews with women lasted anywhere from 30 min to an hour, and topics for women included current health issues, living arrangements in the camp, their relationships with their husbands, their relationships with their in-laws, marriage practices, pregnancy-related issues, mobility, and conflicts in the home. The interviews with the health workers lasted from 20 to 40 min, and topics included health status of refugees, injury cases, health issues resulting from violence, prevalence of violence in the camp, services available for victims, protocols and procedures for cases of violence, and perceived cultural barriers to providing health care. The purpose of these interviews was to illuminate the response of the health sector to evidence of conflict in the home.

A recent census revealed that more than 3 million Afghans currently reside in Pakistan. Of those 3 million Afghans, over 1.2 million live in refugee camps throughout Pakistan. The majority of refugee camps are situated in the Northwest Frontier Province. We conducted our study in the largest of these refugee camps, Jalozai, which is located just outside the province's capital city Peshawar and which is home to 120,000 Afghans (United Nations High Commissioner for Refugees, 2005). Though we lack demographic data for the Jalozai camp, one study of another Afghan refugee camp in Pakistan found that 25% of females living in the camp were between the ages of 15–29, and that 13% were between the ages of 30–44. The majority of these women were ''homemakers'' and had no formal education (Hyder et al., 2006).

There were a total of three interviewers carrying out the data collection in the camp. Each one had prior training and experience in qualitative research methods and in working directly with the local Pakistani or Afghan refugee population. Investigators carried out training sessions on qualitative interviewing prior to the commencement of data collection to standardize the methodological approach and to discuss possible issues that may arise during interviewing and ways of handling those problems. The three interviewers spoke the local languages (Pashtu and/or Dari) as well as English; no interpreters were needed.

Staff of the collaborating organization, the Pakistan Medical Research Council (PMRC), identified the Jalozai camp since they had strong administrative and personal relationships with camp health professionals and with local residents. Three different health clinic sites were chosen in order to diversify the patient population of the sample. These included a public hospital (with 100 beds and 15 physicians providing emergency care, general surgery, laboratory work, obstetric care, and dentistry), a public health clinic for women and children (providing medical care for non-emergency cases, vaccines, and health education), and a private health clinic (run by a medical technician, pharmacist, and community health worker).

The research team interviewed 20 women over the age of 18 years who were married with at least one child. No more than one woman per household was interviewed. Women who were unmarried, over the age of 50, under the age of 18, had considerable medical problems, were deemed mentally incompetent by clinic staff, or who were not residents of a refugee camp were *excluded* from the study. Given the hierarchical and procedural environment of the health clinics and hospitals, we had to depend on the health workers and physicians to recruit women for our interviews. Using the inclusion criteria, the health workers and physicians typically screened the women they were currently working with when we arrived at the clinic for interviews. If a woman fit the criteria described above, the health worker explained the study to the woman and asked if she would agree to be interviewed. If she assented, the health worker brought the woman to a designated room in the facility for the interview. During the initial introduction, the interviewer confirmed that the criteria were met and conducted an official informed consent process before beginning the interview. Unfortunately, we did not gather information about how many women the health workers screened for our study; we only obtained information about the women we ultimately interviewed.

For the 20 health workers interviewed for this study, the only inclusion criterion was that the respondents work directly with the Afghan refugee population in one of the chosen health care settings. Unlike the recruitment process for the women respondents, we were able to recruit the health workers directly. Given the broad inclusion criterion, we interviewed all of the health workers that we met during our study until we reached our

maximum of 20 interviewees. None of the health workers, who were asked to take part in the study, declined to be interviewed. We used the interviews as an opportunity to explore how conflict and family dynamics impact health as well as to gain a better understanding of how the health sector dealt with family conflict in the refugee camp setting.

During the consent process, permission was requested to tape-record the interview. If permission was denied, the interviewer took detailed notes during the interview. Eight of the 20 women interviewed and 11 of the 20 staff members agreed to be tape-recorded. The tape-recording or interview notes were transcribed and translated into English. Since the goal of our work was to begin describing a basic model of intimate partner violence in the Afghan refugee setting, we used an approach inspired by grounded theory, as described by Charmaz (2001) to handle our data. In accordance with this approach, the investigators led daily meetings with the interview team. The initial goal of these meetings was to discuss emerging themes and refocus lines of interview questioning to be used the following day. However, because of the time it took the interviewers to fully adapt to a less structured mode of interviewing (compared to surveys they had helped to conduct in the past), these meetings often focused on interview skill-building and trouble-shooting rather than emerging themes. For this reason, interview topics remained more constant across interviewees than initially planned.

To link data collection and the development of a descriptive model, grounded theory calls for an intensive process of coding interview data. Two members of the research team independently created codes by studying all 40 transcripts. These codes were then discussed, questioned, and reconciled through an ongoing collaborative process until a final set of codes describing the factors involved in and resulting from intimate partner violence in this setting had been generated. Once this set of codes had been defined, the 40 transcripts were reviewed again to identify gaps in the codes, and to continue to flesh out the experience, contexts, and concepts circumscribed by the codes. Intermittent memo-writing assisted in defining these codes, their component parts, and the linkages between them.

This project was conducted with assistance and collaboration from PMRC, and formally approved by the Commissioner for the Afghan Refugees in Peshawar. Verbal approval from the local religious leader was also obtained during a meeting with the team members and PMRC staff. The institutional research ethics committees of PMRC and the Johns Hopkins Bloomberg School of Public Health approved this study.

Protecting confidentiality and privacy was critical to our study, as was developing an open and communicative relationship with local leaders. For this reason, we met with and obtained verbal consent from community leaders, including religious leaders and elders, prior to starting the study. In light of the sensitivity of the research topic and the potential risk that multiple interviews posed to the women, only one interview was conducted with each respondent. A second trip to the clinic or hospital had the potential to raise questions or concerns from other family members and as a result might have placed the woman at risk for negative consequences or retaliatory violence (Ellsberg & Heise, 2002; World Health Organization, 2001). Given the exploratory and qualitative nature of the study and the sensitivity of the topic, we chose to interview only 20 women and 20 health workers. We felt that this would provide sufficient data to help us understand some key facets of domestic conflict in this setting and the health sector's response to such conflict.

Results

In this section, we will first present findings on the common features of women's narratives with some commentary on how these features relate to one another. We will then present additional perspectives offered by the interviews with the health workers. Finally, we will briefly describe some of the events commonly cited as preceding conflict, as identified in the women's and staff members' narratives.

The perspectives of interviewed women

Given the diversity in terms of age of the women we interviewed, the factors implicated in producing conflict in the home were remarkably constant. We interviewed women who ranged in age from 18 to 40 years old, with a mean age of 26 years. The women reported having from 1 to 8 children each; the average number of children per woman was 3.7. All the women, with the exception of one (from the Nasir Bagh refugee camp), were from the Jalozai

Afghan refugee camp. Twelve women were recruited from the public health clinic, while seven women were recruited from the hospital. Given the few patients visiting the private clinic and our limited time at the refugee camps, only one woman was interviewed at that site. During the interviews, discussions of conflict were most frequently entangled with discussions of marriage practices, physical family living situations in the camps after marriage, and a range of familial dynamics taking place within these physical living situations.

Features of marriages

Afghan marriage traditions have long been of interest to outsiders, and most recently have been examined by NGOs (Ahart, 1997; Amnesty International, 2003; UNICEF Inocenti Research Centre, 2001), academics (Tapper, 1991), and journalists (Sinclair & Bearak, 2006). These traditions govern how men and women are paired for marriage, the economic incentives for marriage, and the typical ways in which married couples and the families in which they are embedded behave. Early marriage and the marriage of children to each other or to their elders has emerged as a particular concern recently, as evidenced by United Nations workshops with religious leaders in Afghanistan in 2005 and a recent photo essay in the New York Times magazine (Sinclair & Bearak, 2006). One UNICEF report indicates that 54% of girls in Afghanistan are married by the age of 18 (UNICEF Inocenti Research Centre, 2001). More generally, the denial of the right to choose a spouse remains the norm (Amnesty International, 2003), though some news reports indicate that a growing backlash against forced marriage has recently begun (McGivering, 2005).

Marriage arrangements that are made by the heads of the bride's and groom's respective households have been customary since well before the current refugees living in Pakistan began moving from Afghanistan. As Tapper (1991) describes in her account of marriage practices in an Afghan tribal group living in the northern part of the country in the early 1970s, marriage arrangements involving exchanges of money and of women can take multiple forms. In Tapper's study, the form utilized in any given marriage was determined by the sex ratio of siblings in a given family, the negotiating ability of the families, as well as the wealth of each family, the social distance between the families, and personal characteristics of the families. However, even during the 1970s these practices were changing as a result of changing economic and social conditions. Tapper wrote, "As the population has grown and available resources have declined relative to the number of individuals competing for their control, so too the meaning of notions of equality and the meaning of brideprice and exchange marriage forms have changed" (p. 19).

Our data show that these forms are used even more flexibly in the Afghan refugee setting, in which people from a variety of different backgrounds (in terms of geography, ethnicity, past socioeconomic status, among other characteristics) live in close proximity. Women in this study described several different types of marriage, each of which influenced the production of conflict in its own way. The role that these types of marriage played in a woman's interactions with her in-laws and husband—and thus also in conflict she may experience with them—was frequently alluded to. The types of marriage and marriage-related topics mentioned most frequently in interviews included second marriages, exchange marriages, young brides, brideprice and dowry, and the role of the wife in a family.

Women described second marriages on the part of the husband as typically related to childbearing. That is, childbearing problems—including not bearing sons—may merit the acquisition of a second wife. One woman, sharing her fear of a second wife, stated, "That is why I want to produce more male kids, to protect myself from a second wife." Another woman's husband threatened her by saying, "You have not produced many children, so maybe I will get a second wife." However, in some cases, second wives were acquired simply because the husband could afford to do so. As one respondent noted, "The males in our society who have money are always in search of a second wife." Regardless of the reason for the incorporation of a second wife into the family, the presence of a second wife was described as creating tension around power distribution within the family and between the two wives. As one woman stated, "One female cannot tolerate another female." In many of these cases, conflicts were described as occurring between the wives themselves and often were related to the amount of time and attention given by the husband to each wife.

Dowries and money exchanged for brides were also a common practice. Women spoke of the amount of the brideprice as being related to the

wife's future treatment in the husband's home. As one interviewee told us, "The in-laws think that the girl whose worth is high is more precious. The father has taken a lot of money for her. The girl that is not sold has no worth." The in-laws may consider the mistreatment of the bride as justified if they did not pay money for her. A dowry (money given by the bride's family to the groom's family) is also seen as a "safety factor" for brides in their in-laws' household. As another woman said, "When they are not able to give dowry then it becomes difficult for the daughter to survive the in-laws. The in-laws always tell her that 'you have not carried a dowry with you.'" The in-laws seemed to use the topics of dowry and brideprice against the bride during conflicts, especially for women whose marriages did not involve a significant exchange of money or other resources. In some cases where there are insufficient funds to pay dowry (or brideprice), siblings or other family members may be exchanged for marriage with another family. These "exchange marriages" were frequently mentioned in conjunction with reciprocal violence—that is, when one daughter-in-law is beaten, the daughter-in-law in the other family may also be beaten as a consequence. One woman described these marriages as follows: "Exchange marriages are not good, but it is the custom in our families. People do exchange marriages in order to avoid giving money for a girl. They don't think about the result of the exchange or whether the families will be happy or not."

Women described the role of wives in the family as follows: to produce children, to carry out domestic work, and to obey the husband's family. When these expectations are not met, conflict can follow. According to the interviews, these expectations seem to be an especially significant problem for married adolescent girls—a not uncommon phenomenon (UNICEF Inocenti Research Centre, 2001)—who may have insufficient knowledge about their role as a wife. As one woman said, "Early marriages affect it [the husband–wife relationship] more because they [young brides] do not know about married life."

Living structure

Family living structure was also mentioned frequently in conjunction with conflict in the home. The majority of the women interviewed lived in joint families, usually with their husband's family. Though the positive features of living in a joint family were apparent in the interviews (shared resources, emotional support, closeness to family), the negative aspects of these features, like competition for resources and crowding within the home, were often cited as sources of conflict. Sisters-in-law in particular seem to be key actors in playing out these joint family tensions as conflict. As one woman said, "There are some conflicts in every home. Sometimes a quarrel is due to children beating each other up and then the mothers get involved. Ten days ago, I had a quarrel with my sister-in-law about our children and we beat each other up." Besides fighting between their children, conflict between sisters-in-law was said to be preceded by quarrels over shared domestic work, or quarrels over the distribution of resources between their children (like food). These conflicts were reported to be largely verbal, only occasionally escalating to physical violence. One woman stated, "A little conflict is everywhere and it always has to do with domestic work. Sometimes when I don't work more than my sister-in-law, she quarrels with me. It is only an argument, not a physical fight."

Parents-in-law as decision makers

In joint households, elders and parents-in-law usually serve as decision-makers for the family. For example, decisions regarding the number of children a woman bears are often made by her mother-in-law. In addition to making household decisions, the older generations settle conflicts and disputes among family members. For the women in our study, husbands typically made it clear to their wives that they were to obey the wishes of the parents-in-law—an idea that is reinforced by the cultural norms surrounding interactions between daughters-in-law and parents-in law. As one woman described: "Most of the decision-making power lies with my father-in-law. He makes most of the decisions. However, decisions about marriages or making something for ourselves or for our children are made by us jointly. My father-in-law has the final say and we all obey him because he is the elder. He acts as our father." This is less the case for women living in nuclear families. Three of the four women respondents who lived in nuclear families stated that they were able to make decisions about family issues, such as the number of children they were going to have and household chore allocation.

The positioning of parents-in-law in this role of authority seemed to both exacerbate and protect against violence. Sometimes the in-laws served as an instigating factor in conflicts between couples. For

instance, the father-in-law may be responsible for the way the wife is treated by the husband. One woman respondent claimed that her father-in-law told her husband "to beat me because women should not be given respect. They should be considered like shoes. They must be afraid of you." However, decision makers may also play a mediator role. During conflicts among sister-in-laws, the mother was usually the one to intervene. As one woman described, "The relationship is good with the in-laws, but sometimes we [the sisters-in-law] quarrel because of the children fighting with each other. It is only verbal quarrels, not physical. After some time we will talk to each other. My mother-in-law has the role of making us agree after a situation like that." Occasionally, however, in the name of stopping conflict, mothers-in-law may create further tensions; for instance, by reporting the incident to the husband (her son) who then may engage in conflict with his wife. Thus, even in cases in which a decision maker may be protecting one party against conflict and violence, additional conflict may be created for another party.

The role of the mother-in-law

As the examples above attest, the mother-in-law can serve as both a protector against and a creator of conflict within the family. In our interviews, conflict between mothers-in-law and daughters-in-law often stemmed from arguments that involved questioning the amount of domestic work that the daughter-in-law had completed or the quality of that work, as shown in Table 1. In these cases, verbal conflicts and/or beating might ensue.

Interestingly, conflicts between mothers-in-law and daughters-in-law were also said to arise when the daughter-in-law and her husband had a "love marriage". The concept of "love marriage" was never defined explicitly in the interviews, but seems to be characterized by love and respect between the husband and the wife, as the term would indicate. Thus, love marriages can be contrasted with the majority of other marriages, which are typically arranged for economic or other reasons. One interviewee described this type of conflict as follows: "She [my mother-in-law] never was good with me because my husband and I had a love marriage. Whenever he bought me something, she would get angry and quarreled with me. I did all the domestic work at home. But she would get angry if I did not cook well. She also abused my family. But in front of her son she would keep quiet."

Table 1
Events reported to precede conflict between wife/daughter-in-law and other family members

Conflict between woman and…	Examples of preceding events
Mother-in-law	Domestic work Woman beats children Demonstrations of "love marriage" between woman and her husband
Sisters-in-law	Domestic work Distribution of resources (especially among children) Children fighting
Husband	Woman beats children Mother-in-law and woman quarrel Husband dissatisfied with meal

As this excerpt demonstrates, conflicts related to a "love marriage" appear to stem from the mother-in-law's jealousy of the daughter-in-law's relationship with the husband, and result in conflict not only with the daughter-in-law, but with other family members as well. In love marriages, there were fewer arguments between the wife and the husband. The wives were vested with more decision-making power and were less likely to be held to strict, traditional roles. As this same woman described, "My husband has a love marriage with me. So he says the number of children is according to my will. He never forces me to have more children."

The role of the husband

Interviewees characterized conflict between women and their husbands as having two major drivers: peace-making, in which the husband makes an effort to resolve some pre-existing dispute within the family, and punishment, for failure on the part of the wife to appropriately cater to the husband's preferences. As listed in Table 1, events preceding conflict between husbands and wives include the wife's beating of the children, quarrels between the mother-in-law and daughter-in-law in which the husband takes the mother-in-law's side, as well as quarrels over the husband's meals or other preferences.

Women reported the majority of conflict with husbands as being verbal, and only occasionally escalating into physical violence. Additionally, as in the following quote, many women indicated that there is an expectation of some level of conflict in

every marriage. "I have a good relationship with him [my husband]. Sometimes there is a little quarrel in every home. Once when I beat my children, he quarreled with me verbally. Only once did he beat me and I got injured. After that he began talking to me so that there are no big conflicts between us."

It should be noted, however, that the involvement of the husband in conflicts between mothers-in-law and daughters-in-law may serve to increase the level of violence. As one interviewee described: "Once when I was 6 months pregnant she [my mother-in-law] quarreled with me. It was a verbal quarrel. Even though it was her fault, she told my husband that I quarreled with her and didn't obey her. My husband beat me and I had a little bleeding. Thank God my child was protected." As in the case of the husband siding with the mother-in-law, conflicts between sisters-in-law may also be escalated by the involvement of husbands. As one interviewee described: "Once my two sisters-in-law quarreled with each other. They physically fought with each other but no one got injured. When the husbands came home, the one who was at fault was beaten by her husband. He said he did not want that to happen again and he wants peace in the home." The role of the husband in situations like this one may seem at first contradictory—he creates violence in the name of fostering peace in the home—but may actually provide insight into the narrative trajectory of these conflicts. The husband may see his role as that of putting an end to the conflict, resolving it by deciding who is in the wrong and exercising his power, as a male member of the household, to punish that person, thus ending the conflict.

In light of the physical violence that could be part of these conflicts, many women respondents spoke about strategies they used to avoid conflicts or to prevent the escalation of conflicts with their husbands. These strategies included obeying the husband, keeping quiet, and stopping verbal conflicts before they escalated. As one woman said, "Sometimes if he is angry, then I keep quiet." While keeping quiet or not speaking back to the husband was a strategy employed by women during the actual argument to prevent further escalation of the conflict, obeying the husband was seen as preventive strategy. These ideas are consistent with the expectation that women stay close to their traditional roles as wives and that they not question the husband or his decisions. According to the women, any deviation from this role gives the man an "opportunity" to incite conflict.

Interestingly, this assumes that conflicts with the husband are, for the most part, expected and predictable. Stopping verbal conflicts before they escalated was a preventive strategy that was primarily an option for women who had "good" and seemingly more communicative relationships with their husbands. As one woman described: "My husband is good. Sometimes when we argue verbally I say that I am sorry. The quarrels are over me not cooking his choice of meal. He becomes angry but I never allow the talk to increase."

Perhaps not surprisingly, the way these husband-initiated dynamics played out was often significantly mediated by the degree to which he was present in the home. In this particular setting, many refugee men ventured out of the refugee camps for employment. Women whose husbands were away for work seemed to indicate that they had comparatively low conflict relationships with their husbands because of the husbands' absence. As one woman said, "We never quarrel with each other since my husband is usually away. I think if he were at home we would have some quarrels." In addition to the absence of the husband, the improvement in economic status may reduce some of the financial burden many families face living in the refugee camps. In turn, better economic status may have the effect of minimizing the kinds of conflict resulting from competition for shared resources in joint living arrangements.

The perspectives of interviewed health workers and clinic staff

To learn about how the health sector responds to family conflict and violence among Afghan refugees, we interviewed four physicians (including one director), four nurses, one nursing assistant, one Lady Health Worker (a local health worker who has undergone a year or more of training in maternal and child health), two vaccine health workers, two traditional birthing attendants, three pharmacists, one health educator, one lab technician, and one groundskeeper.

Access to health care, restrictions on the mobility of women, and the role of the parents-in-law in enforcing this were frequently mentioned by staff as barriers to care. Some workers categorized these mobility restrictions as a form of violence, particularly when they prevented access to care in

emergencies. Mobility restrictions typically require that women get permission from their in-laws or husband in order to visit the health center. However, as evidenced by the following quote, economic realities, distrust of the health system on the part of the mother-in-law, and a desire to preserve health traditions may also serve as barriers to care. As one staff member said, "Mother-in-laws tell the women to have the baby at home. Sometimes they will have a daya [traditional birthing attendant] present to help with the delivery. The women suffer from bleeding and infections. There was one girl that was brought in last week. She was so pale when they brought her. She had lost a lot of blood during the delivery of her baby at home. When I asked the mother-in-law why they did not bring her here since they lived very close to the hospital, she told me she did not know she was in labor. I find that difficult to believe especially since they live in the same place. The girl ended up dying."

According to the health workers, responses to family conflict and violence in the health setting were typically limited to treatment of physical ailments. Privacy and the sensitivity of addressing family affairs were cited as some of the key barriers to dealing more comprehensively with violence. As one staff member said, "They [health workers] ask the women about abuse but they can only treat their physical injuries. They cannot meddle into their personal affairs. People do not like to have others involved in their personal lives. Most of the issues are resolved among the family. Therefore we can't do much to help the women except treat their injuries." The belief that family affairs should be kept private prevented many health workers from asking women about violence. Despite these attitudes, most of the health workers acknowledged awareness and knowledge of such cases among the refugees.

In severe cases in which the woman's immediate safety or well-being was obviously threatened, interviewees reported that there would be an attempt to respond on the part of the health system. However, without a standard protocol or formal training for dealing with these issues, the nature and types of responses were extremely variable. Interviewees indicated that providers may talk about conflict in the home with the patient's family members if they are present, but these discussions do not follow any evidence-based guidelines. Interviewees also mentioned that severe episodes of violence were occasionally reported to community organizations, or that a case of violence might be referred to senior physicians at the clinic. It is unclear how these responses helped the women or how they served to reduce family conflict and violence.

Discussion

The data from these interviews point towards an ecological model of conflict for Afghan refugee women, which incorporates individual, dyadic, familial, and structural influences. These influences are pictured in Fig. 1. Type of marriage, living structure, and family dynamics are portrayed as "risk regulators" (Glass & McAtee, 2006). Risk regulators were proposed by Glass and McAtee as intermediaries between social conditions and health. They "index the *structured contingencies* [italics in the original] in the social and built environment as experienced by social actors in discrete action settings—structured because they are specific, stable dimensions that exist external to individuals, and contingent in the sense that contexts within each dimension are varied, and likely to affect patterns of risk depending on personal, community, and historical processes" (p. 1659). In the model presented here, the social, economic, and political conditions affecting refugees are not shown explicitly (since they were not examined in the interviews), though they strongly influence all other levels of the model, especially the risk regulators (Fig. 1).

The risk regulators we show in this model may serve to increase or decrease risk of conflict (via the dyadic relationship) in a variety of ways. Closely linked with the risk regulators we identified are several established theoretical concepts. Theorists have explored the ways in which the blurring of public and private spheres, fluctuations in temporariness and permanence, and the muddling of set gender roles may impact life for refugees (Camino & Krulfeld, 1994; Khattak, 2002). In an essay for the Social Science Research Council, Khattak describes the way the home (a space connoting privacy and safety) may be violated by the public sphere (a space connoting vulnerability and danger during times of war) through bombings and other types of violence. Khattak extends these descriptions to the refugee setting in which families often share small, rented living quarters with multiple other families. In these situations, the former identity and security associated with "home"

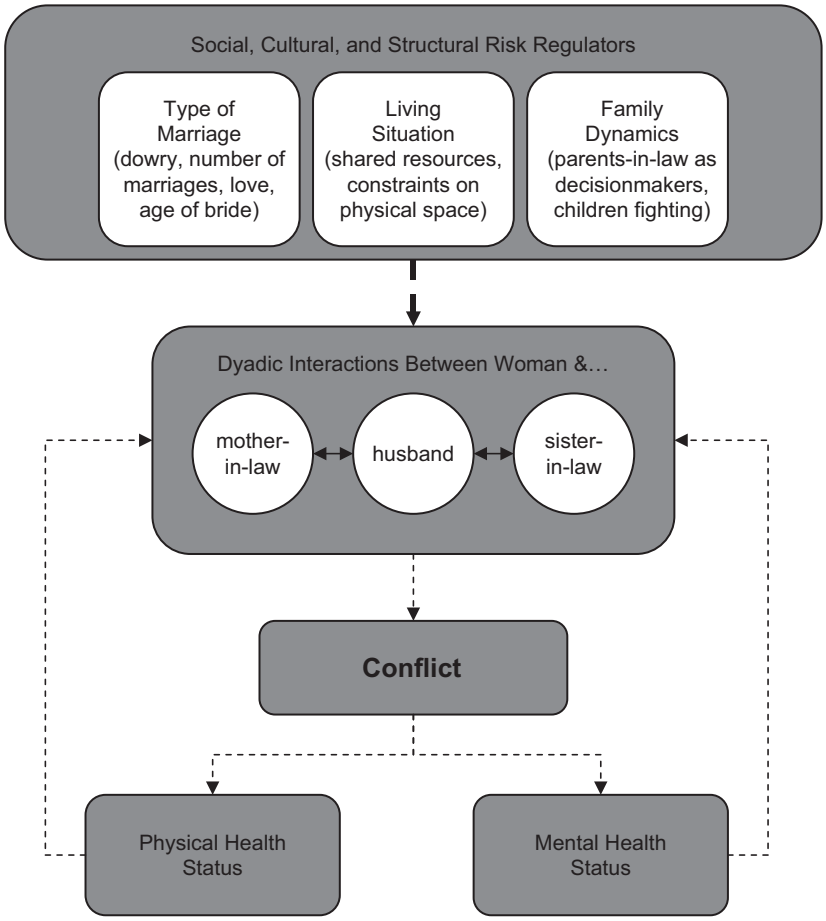

Fig. 1. Model of family conflict for Afghan refugee women.

may be substantially undermined. Furthermore, the physical home to which the refugee hopes to return may have been severely damaged or destroyed, and may thus no longer exist from a physical or conceptual standpoint, producing uncertainty about the extent to which returning would be worthwhile. Shifts in gender role identity in refugee settings are another well-documented facet of refugee life, and have been identified as critical to understanding life in refugee societies (Camino & Krulfeld, 1994). These shifts typically occur as a result of environmental pressures (the host country or refugee camp) to adapt gender roles in order to survive economically and/or socially. In the refugee camp setting, camp services and programs may, to some extent, take over the man's traditional role as provider, and may teach women income-generating skills. These kinds of changes may disrupt patterned ways of interacting around the economic well-being of the household, as well as important aspects of past identity.

Taken together with the findings from our data and the preliminary model proposed here, these theoretical perspectives indicate several directions for future work on intimate partner violence in the Afghan refugee setting. One familial dynamic highlighted in our work, which we feel should be explored further, is that of the ways in which peace-making within the family can occasionally perpetuate violence. An example of this would be the situation described in the body of this paper in which sisters-in-law argue, their husbands find out, and then the sister-in-law who is "at fault" is beaten by her husband as a way to further resolve the situation. We heard of a number of situations like this one in which ending a conflict, resolving it, or creating some sense of justice within the family involved resorting to further violence. We believe this phenomenon has the potential to help refocus intervention efforts on the rationale for violence rather than simply the act of violence. We would be

interested in exploring the ability of educational programs and role-playing exercises to convey the logic of not perpetuating conflict with additional violence in this setting.

Our work also indicates a strong tendency on the part of women to accept some degree of conflict (potentially involving physical violence) within their family and marital relationships, and a need for programs that can respond sensitively to this kind of acceptance. When women spoke of day-to-day conflicts, many prefaced these stories with comments such as "there is some conflict in every home". Such comments raise important questions about the kinds of conflict that are viewed as permissible within the boundaries of family life. While we could not explore this topic in the context of this study, we feel that women's acceptance of day-to-day conflict should be the starting premise of further work, especially intervention activities.

Our work also points to several areas in which the refugee health sector's response to evidence of conflict could be improved. The interviews with health workers indicated that, while they demonstrated knowledge and awareness of the problem of violence in the refugee camps, they lacked protocols and training to deal with such cases. With no formal system to address violence, many health workers felt helpless and often unwilling to ask women about conflict in their homes. Recently, UNHCR constituted a working group to address sexual and gender-based violence (SGBV) in Pakistan (Rehman, 2005). The goals of UNHCR and the working group are to promote awareness of SGBV and to establish a multi-sectoral referral and response system to combat SGBV. This is in line with the UNHCR's "Sexual and Gender-Based Violence against Refugees, Returnees and Internally Displaced Persons: Guidelines for Prevention and Response" (United Nations High Commissioner for Refugees, 2003). In addition to the establishment of such a system, we believe that training for health workers around gender sensitivity and violence in the refugee setting, specific guidelines and protocols for health workers, and a data system to document cases of violence would dramatically improve the health sector's response to family conflict and violence.

This study had several limitations, which were primarily in the areas of recruitment and timing. Given the unstable environment of the refugee clinics and hospital, we had to rely on the assistance of health workers for recruitment of women for the study. We were not able to control for the biases of the health workers when they recruited women for the study. It is likely that the use of health workers to recruit women rather than a randomized recruitment protocol influenced the data we have gathered. However, given the exploratory nature of this study and the difficulties of establishing a system for random selection of interviewees in this setting, we feel that our recruitment methods were appropriate. Additionally, the importance of establishing trust when gathering information about women's lives and domestic conflict was apparent to us from the outset, but was difficult to prioritize in this study given timing limitations, the unstable environment of refugee camps, and the safety of the participating women. More valid, nuanced, and extensive data may have been obtained if we had been able to conduct multiple interviews with the same women. However, we could not place the women at increased risk by having them return to the clinic for subsequent interviews.

This study provides insights into the role and consequences of conflict in the lives of Afghan women living in refugee camps. From the interviews, it is evident that women do experience violence during day-to-day conflict, and that conflict occurs not only between women and their husbands but also between women and other family members. It is also clear that health workers have little training or support to deal with cases of violence, and that further exploration of the issues surrounding day-to-day conflict is necessary in order to develop culturally appropriate interventions.

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