Searching for Light at the End of the Tunnel;

Analysis of Bangladeshi women's help-seeking process following intimate partner violence

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“Searching for Light at The End of the Tunnel;

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A thesis submitted in partial fulfilment of the requirement for the degree of Master of Science in Public Health
by
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Declaration:
Where other people’s work has been used (from either a printed or virtual source, or any other source), this has been carefully acknowledged and referenced in accordance with academic requirements.
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Signature: Tonima Islam

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I would like to dedicate this thesis to all those strong Bangladeshi women, whose lives have been impacted by partner violence.

Abbreviations:

ANC: Antenatal care

BBS: Bangladesh Bureau of Statistics

BLAST: Bangladesh Legal Aid Services Trust

BNWLA: Bangladesh National Woman Lawyers Association

CEDAW: Convention on Elimination of All Forms of Discrimination Against Women

CLS: Community Legal Services (CLS),

DV: Domestic violence

GBV: Gender-Based Violence

GO: Government organization

HIC: High-Income country

HRW: Human rights watch

Icddr,b: International Centre for Diarrhoeal Disease Research, Bangladesh

INGO: International non-government organization

IPV: Intimate Partner Violence

LMIC: Lower middle-income country

LIC: Lower income country

MMR: Maternal Mortality rate

MOHFW: Minister of health and family welfare

MSF: Médecins Sans Frontières

MSPVAW: Multisectoral programme on violence against women

NCD: Non-communicable disease

NGO: Non-government organization

ODI: Overseas development institute

PHC: Primary health care

UN: United Nations

UNFPA: United Nations Population Fund

VAW: Violence against women

WHO World Health Organization

Definition/glossary of terms used:

Intimate Partner Violence: According to WHO, Intimate partner violence refers to any behaviour by a current or former male intimate partner within the context of marriage, cohabitation, or any other formal or informal union, that causes physical, sexual, or psychological harm (1).

Lifetime prevalence of intimate partner violence: The proportion of ever-married/partnered women who reported that they had been subjected to one or more acts of physical or sexual violence, or both, by a current or former husband or male intimate partner in their lifetime (defined as since the age of 15 years). (Violence against women's survey by Bangladesh bureau of statistics) (2).

Domestic Violence: "Violence perpetrated by intimate partners and other family members, and manifested through physical, sexual, psychological and economic abuse."(3)

Violence Against Women: "Any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life" (4).

Gender-Based Violence: "GBV is any act of violence that is inflicted upon an individual because of his or her gender or sexual orientation. An umbrella term for any harmful act that is perpetrated against a person's will and that is based on socially ascribed (gender) differences between males and females"(5).

Help-seeking: "Help-seeking is defined as the behaviour of actively seeking help from other people. Which includes, communicating with others to obtain assistance in terms of understanding, advice, information, treatment, and general support in response to a problem or distressing experience" (6).
"help-seeking behaviors involve a request for assistance from informal supports or formalized services for the purpose of resolving emotion, behavioral, or health problems (7).

Formal help/services: In Bangladesh context, formal help can be medical, psychosocial, legal, supportive, monetary/instrumental support, community support services (8).

Access: Access to health care means having "the timely use of personal health services to achieve the best health outcomes". It includes adequacy of supply, affordability, physical accessibility, and acceptability (9).

System interface: Interface is the place at which independent and often unrelated systems meet and act on or communicate with each other. System interface here means where the client and provider meet (10).

Social location: A person's social location refers to socioeconomic class, education, geographic location age, gender, race/ethnicity, and a combination of other factors that determines one's position within the intersectionality of the social system (11).

Cumulative victimization refers to the summation of victimization experiences of women in case of intimate partner violence (12).

Victim and survivor of violence: Both have been exposed to violence; “victim” is a legal term within the criminal justice system, “survivor” can be used as a term of empowerment to convey that a person has started the healing process and may have gained a sense of peace in their life (13).

One-stop crisis center (OCCs): OCCs provide physical and mental treatment, legal assistance, and recovery and rehabilitation, with multidisciplinary teams to help women victims of all forms of violence (8).

Abstract:

Introduction:

Intimate partner violence is highly prevalent in Bangladesh as 73% of women experience this at least once in their lifetime (2). IPV has major consequences for health, society, and development. Despite the high prevalence, help-seeking of IPV victims from formal services is very low. The thesis tries to identify factors influencing the help-seeking of IPV victims from formal sources.

Methods:

A literature review of peer-reviewed and grey literature published in the last 20 years is carried out to meet the study objectives. A conceptual framework adapted from Kennedy's framework for help attainment process is used to guide the analysis.

Results:

Individual violence condoning perception, fear of shame/stigma, difficulty in accessing services due to lack of information, availability, cost, distance, lack of trust in usefulness of services, poor attitude of the providers are the most pronounced immediate factors that affect the steps towards help-seeking. Education, older age and marital age, severity, and frequency of violence are strongly associated with increased help-seeking following IPV. Family, friends, and other support networks influence women's decision to seek help in a negative way, which is rooted in the community's gender inequal views.

Discussion and conclusion:

Help-seeking following IPV is influenced by the interplay between different immediate and contextual factors. According to the findings, targeting the community to address the problems is the best approach. Expanding education, employment, activities to stop child marriage, proper implementation of laws, training of providers are integral in the process of improving help-seeking and response to IPV victims. More research is needed to understand the problem better.

Key terms: Intimate partner violence, spousal abuse, gender-based violence, help-seeking, gender

Word count: 13037

Introduction

"You cannot beat me, I am not your wife, to beat me you need to have rights, that you can only have once you marry me."
This dialogue is from a popular television drama in Bangladesh that I came across not so long ago. I was not surprised. I grew up witnessing people in my community easily accepting the "right" of a man to inflict violence on his wife.

Intimate partner violence affects women globally but in Bangladesh, the rate has been one of the highest. According to the violence against women survey, as high as 73% of ever-married women in Bangladesh have experienced some form of violence from their intimate partner(2). Due to the problem with underreporting, the magnitude is assumed to be higher than it appears. To address the violence Bangladesh government has formulated acts and laws; as well as started a multisectoral programme (MSPVAW) in partnership with the Danish government involving different ministries (20). At the same time, different NGOs run concurrent programmes and services to address this issue in Bangladesh. However, IPV has always slipped through the crack and remained unaddressed due to the duty bearer's perception of treating this as "couple's private matter". A lot of the women suffer in silence and never try to seek help or look out for available services. Evidence suggests receipt of appropriate service enables victims to recover, improve their mental health, and in some cases decrease IPV (14–16). More than most, it is women's right to find help towards well-being when she needs. The government has declared to achieve gender equality in its national development plan. Without ensuring the right of women and addressing IPV, the goals cannot be approached. Therefore, it is essential to ensure proper response to women who are experiencing IPV and offer them help. The first step to this is to find out why women don't go to the formal services and zooming out beyond the individual factors that might be stopping them to search for the light at the end of the tunnel.

I work as a public health researcher in Bangladesh and IPV has always been an area of research interest for me. Literature on IPV is growing in Bangladesh but research related to the help-seeking of IPV victims is scanty. My thesis aims to address the knowledge gap with an ultimate goal to facilitate help-seeking of the victims towards proper response.

I feel fulfilling to be able to dedicate my time and energy on a topic that is not only my research interest but also very close to my heart.

1 Background:

This chapter provides background information on the country's geography, demographic characteristics, economy, health scenario, culture, religion, gender dynamics as well as an overview of violence against women in Bangladesh.

1.1 Geography, demographic characteristics, and economy:

Bangladesh is a developing country. It is located in south Asia where it shares the majority of its border with India. 160 million people live in the country; half of which are women (17). Bangladesh is also home to different ethnic minorities living in the southeast Chittagong hill-tracks and Mymensingh district (17). Bangladesh is categorized as a lower-middle-income country but has achieved rapid economic growth, urbanization, and technological advancement over the recent decade. The success is largely brought by the ready-made garment business and agricultural sectors (18). GDP per capita stands at 1855.7 USD as of 2019 (19). Despite the advancement, huge disparities remain across wealth quintiles and 20.5% of people still live below the poverty line (20).

According to UNESCO, the literacy rate among the adult population is 74%. For women literacy rate has substantially raised from 44% in 2007 to 71% in 2018 (21). However, women's participation in the economy has been comparatively low, especially in managerial positions (Figure 1) (22). Labour force survey reports, only 36% of women participated in income-generating work compared to 81% of men in 2016-17 (22).

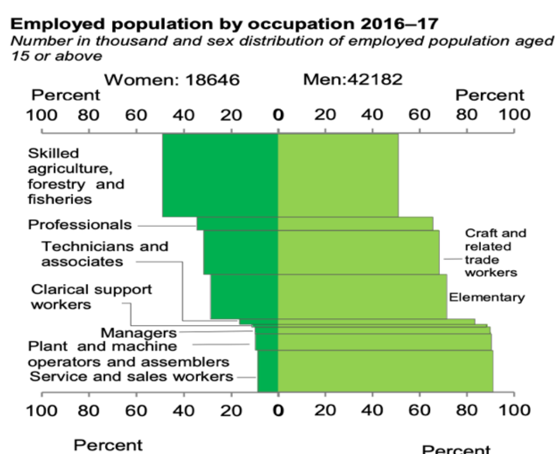

Figure 2 Employed population by occupation (women and men), Labour force survey 2016-17(22)

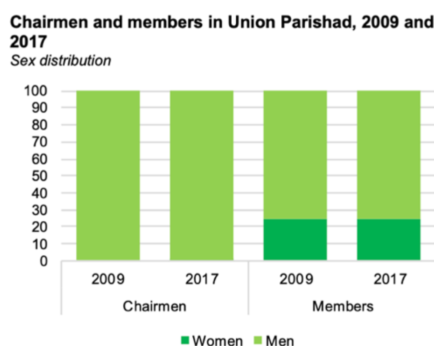

Figure 1 Elected positions at administrative decision making level (women and men) (23)

1.2 Administrative system and health scenario in Bangladesh:

Bangladesh has eight divisions which are, Dhaka (capital), Khulna, Sylhet, Barisal, Chittagong, Mymensingh, Rajshahi and Rangpur. At administrative and societal decision-making level, women are again less participated. For example, among 4500 chairmen elected a year at the local government level, none were female in 2009 and 2017 (Figure 2) (23). Bangladesh government is highly centralized in its administrative system (17). The centralization extends to the health system as well. Most of the secondary and tertiary health services are around the capital. People in rural areas can mostly access primary health care services. Maldistribution of health services and health workers subject the rural residents to acute

health disparities (24). The Health system in Bangladesh is tax-funded with a very low public funding for health (3%) (25). Bangladesh has made progress in lowering maternal mortality and death due to communicable diseases. But, teenage pregnancy is still very high in Bangladesh (81.67%, births per 1000 women aged 15-19years) (26). Even with established laws against it, child marriage is rampant in Bangladesh.

1.3 Religion, culture and gender dynamics:

The majority of the population in Bangladesh is Muslim followed by Hindu. Patriarchy is deep-seated in Bangladeshi culture and is expressed by rigid gender norms. Men are seen as breadwinners and decision-makers of family and women as subordinates to men. Even though girls consistently rate higher in completing primary and secondary education but in upper-secondary, males' completion rate goes 50% higher which implies that early marriage, pregnancy, and other gender-based barriers compel women to drop out (27). Women are reported to work three times more than their male counterparts mostly doing unpaid domestic, agricultural work and caring for the family; which makes them "invisible economic heroes"(23,28). Gender inequality remains in every aspect of society. To address this, the government has made achieving gender equality a goal in its national women development policy and 7th five-year plan of Bangladesh. At the same time, health and gender equality are at the heart of sustainable development goals (SDG3 and SDG 5), which Bangladesh strives to achieve (29).

1.4 Violence against women:

Violence against women is a major problem in Bangladesh. According to violence against women (VAW) survey by Bangladesh bureau of statistics (BBS), a large percentage of women have experienced at least some form of violence and most of which is perpetrated by intimate partners. According to the report, 73% of ever-married women in Bangladesh have experienced some form of violence from their intimate partner during their lifetime (2). To address the violence Bangladesh has formulated acts and laws. Mentionable are the dowry prohibition act, the women and children repression prevention act, and the domestic violence prevention and protection act. Bangladesh also developed a national action plan (2013-2025) to prevent violence against women and children, rehabilitation, and legal aid for woman victims (29,30). Bangladesh made commitments at the convention on "the elimination of all forms of discrimination against women (CEDAW)" and undertook a multisectoral programme (MSPVAW)[1] in partnership with the Danish government involving different ministries (23). The programme established one stop-crisis-centers[2] (OCCs), trauma centers, free-of-cost helplines, violence against women (VAW) database, and other coordinated services to attend to victims (31). Different NGOs also run collateral programmes and services to prevent and respond to violence against women. Despite the efforts, violence against women is rampant, especially intimate partner violence.

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[1] MSPVAW or multisectoral programme on violence against women was established in 2000 through partnership with Danish government. This programme is run under ministry of women and child's affair, with collaboration of ministry of health, ministry of education, ministry of law, justice and parliamentary affairs, ministry of social welfare. The programme has launched one stop crisis centers, national trauma counselling center, government helplines, Violence against women (VAW) database, VAW committee. (31)

[2] One-stop-crisis-centers (OCCs): OCCs provide physical and mental treatment, legal assistance, and recovery and rehabilitation, with multidisciplinary teams to help women victims of all forms of violence (8)

2 Problem Statement, justification, and study objectives:

2.1 Problem statement:

Intimate partner violence[viii] is a type of gender-based violence[viii] and a major public health concern globally. According to a study conducted among 10 countries by WHO, the prevalence of IPV ranges from 4 to 54%, and globally 38% of all murders are committed against women by their intimate partner (32). Even though Intimate partner violence can be found all over the world, it is more prevalent in lower-income countries (33).

In Bangladesh, violence perpetrated on women is mostly done by their intimate partners. According to the VAW survey 2015, lifetime prevalence[viii] of intimate partner violence among ever-married women in Bangladesh is 73% and there is little difference in the prevalence among urban and rural women (2). However, with a 77% prevalence rate, younger women (15-19 years) are at higher risk of being exposed to IPV according to the recent adolescent health survey (34). Because the perpetrator is an intimate partner, this type of violence is underreported, so the magnitude can be a lot more than what appears. Literature body around IPV in Bangladesh refers to young age at marriage, low education, unemployment, poverty, dowry, rigid gender norms as risk factors of being exposed to IPV (8,35–42). The annual economic cost of IPV is estimated by CARE to be 2.3 billion US dollars (43). However, measuring the cost of IPV with monetary value is debatable as IPV is a violation of the human right and has a plethora of intangible costs on society and human lives. Death due to homicide and suicide as a result of IPV is estimated to be high in Bangladesh (44). Since severe penalty is associated with homicide, data obtaining on partner homicide is difficult. At the same time, homicide done by partners can be falsified as suicide (35). A study on intentional deaths of women in a rural area found, 10% of the deaths were attributable to violence inflicted by husbands (45). According to WHO multicountry study, almost 57% of IPV in Bangladesh resulted in severe injury. The same study reports, Bangladeshi women who experience violence by husbands are 6 times more likely to attempt suicide than the women who never experienced IPV (46). This is especially concerning given 37% of all women's deaths in Bangladesh are caused by suicide (44). According to existing literature in Bangladesh, negative consequences as a result of IPV include poor health (46), poor infant feeding (35,47), maternal depression (47,48), low use of sexual and reproductive services (49), depression (50), increased risk of under-5 mortality (51), stillbirth and miscarriage (52), sexually transmitted disease (53) and suicidal ideation (54). The consequences expand beyond individuals and can be debilitating at the family, societal and macro-level (44). Disclosure and help-seeking following IPV are extremely low in Bangladesh. Due to this reason, measuring actual prevalence and responding to the current victim of IPV has been especially a challenge (55,56). The VAW survey reports, over 70% of women who experienced IPV never disclosed to anyone and less than 3% sought any form of formal help (2). The laws and services treat intimate partner violence differently than non-partner violence. In Bangladesh "personal affairs" are governed based on religion (Sharia law[3]); so, the IPV sometimes remains unattended by the system unless has resulted in severe injury (26). Marital rape is also not

[3] Sharia laws are Muslim law of personal affairs. According to Bangladesh constitution; people personal affairs such as marriage, inheritance of property etc are ruled by their religion. According to this law; equal rights are not maintained as males are allowed polygamous marriage and women inherit half of the property than her brother (119)

recognized by the law (27) and amongst the loopholes how the current victims of intimate partner violence navigate towards the support that they need is deserving of further scrutiny.

2.2 Justification:

Whereas it doesn't guarantee to dissolute the problem, international studies suggest, help seeking[viii] is associated with a better chance of receipt of appropriate service which can enable the victim to cope, improve mental health, facilitate recovery and sometimes decrease the IPV itself (14–16). Opposingly low help-seeking means the women in need are not able to access the services, get the support required and the perpetrator is left unaccounted to inflict more violence. The services also remain underutilized and cases remain underreported, making it even harder to address IPV. Without addressing the issue of low help-seeking, the problem will keep adding to health and associated problems stemming from IPV. At the same time, addressing this issue is imperative to achieve government's commitment to addressing violence against women, achieve gender equality and related SDGs.

Factors related to help-seeking of IPV victims are under-researched and poorly understood. Aside from the known complexity created by legal loopholes, some international and national literature indicate factors such as fear of stigma, revenge, and lack of knowledge regarding available services hinder women to seek out help (57,58). Even though literature is growing about IPV in Bangladesh, literature on help-seeking and associated factors is scanty. Given its interplay with women's agency and cultural norms in Bangladesh, it is therefore important to have a comprehensive understanding of the help-seeking process of Bangladeshi women and its influence from the broader context. It is supported by evidence that to address VAW, understanding the broader context and its effect on the issue is always more effective (59).

The paper will attempt to establish a comprehensive understanding of the help-seeking process of IPV victims and analyze factors influencing help-seeking in Bangladesh which will fill the existing knowledge gap in the literature body. The generated insights can guide policymakers and stakeholders to make informed decisions and researchers for future research. This can also work as an evidence-base for planning interventions and improving services that are necessary to respond to IPV and increase service utilization by the victims.

2.3 General Objective:

Identify factors influencing help-seeking from formal services[4] among women following experience of IPV to inform research, policy, and programmes with an ultimate aim to aid in addressing IPV through better response and service utilization in Bangladesh.

2.4 Specific Objectives:

- Understand the individual help-seeking process of IPV victims and analyze immediate factors influencing the steps.
- Analyze the role of contextual factors such as social location, cumulative victimization, community, and situational factors on help-seeking [5].
- Make recommendations on research, intervention, and policy based on findings to improve help-seeking and IPV response.

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[4] Formal help/services: In Bangladesh context, formal help can be medical, psychosocial, legal, supportive, monetary/instrumental support, community support services (8)

[5] The contextual factors can be social location, cumulative victimization, community and situational factors; **Social location** refers to socioeconomic class, education, geographic location age, gender, race/ethnicity and a combination of other factors that determines one's position within the intersectionality of social system (11). **Cumulative victimization** refers to summation of victimization experiences of women in case of intimate partner violence (12).

3 Methods and analytical framework:

3.1 Methodology and search strategy:

Literature review of published peer-reviewed and published/unpublished grey literature is used as a study method to meet the objectives. Published peer-reviewed literature is searched using key search terms (Table 1) in PubMed, Google scholar, and VU library. Relevant articles are also hand searched through snowballing technique from the reference list of included literature. Grey literature (reports) are searched using google and obtained from organizational websites of WHO, World Bank, ODI, Human rights watch (HRW), icddr,b, BRAC, MSF, UNICEF, UN-WOMAN, and Bangladesh-government websites. Both quantitative and qualitative studies are considered for the thesis.

Table 1 Key search terms used alone or in combination with others

Search Engines/ Databases	Keywords used alone or in combination with each other	
PubMed, VU library, Google Scholar, Google and organizational websites (WHO, World bank, MSF, icddr,b, BRAC, ODI, UNICEF, UN-WOMEN) for grey literature.		Intimate partner violence, partner violence, physical violence by husband, sexual violence by husband, violence by husband, domestic violence, spousal violence, family violence, marital violence, violence against women, acid violence, partner abuse, wife beating, battered wife, marital abuse, marital rape
	AND/OR	Help seeking, help attainment, disclosure, legal action, support seeking, support services, mental health services, psychosocial services, formal services, informal support, legal services, programmes
	AND/OR	access, outcomes, experiences, factors, influencing factors, risk factors, protective factors, association, predictor, correlates, prevalence, pattern, nature
	AND/OR	Rural, urban slum, urban
	AND/OR	Bangladesh, India, South Asia, SEAR, Lower middle-income country, LMIC

3.2 Exclusion and Inclusion criteria:

All literature published in the last 20 years are included for the review to maintain the relevancy of the information. Literature considered for review are limited to English and Bangla language. Literature focused on Bangladesh is primarily considered but literature from similar context, LMIC, and global context are also used when local studies are not found or to put the findings in the broader context.

3.3 Screening and Inclusion:

The articles are screened manually after reading the titles, abstract, and then full text. Papers are only included if found relevant after screening (

Figure 3). After that, articles that don't meet the exclusion and inclusion criteria are excluded. The rest of the articles and reports are then selected for final review.

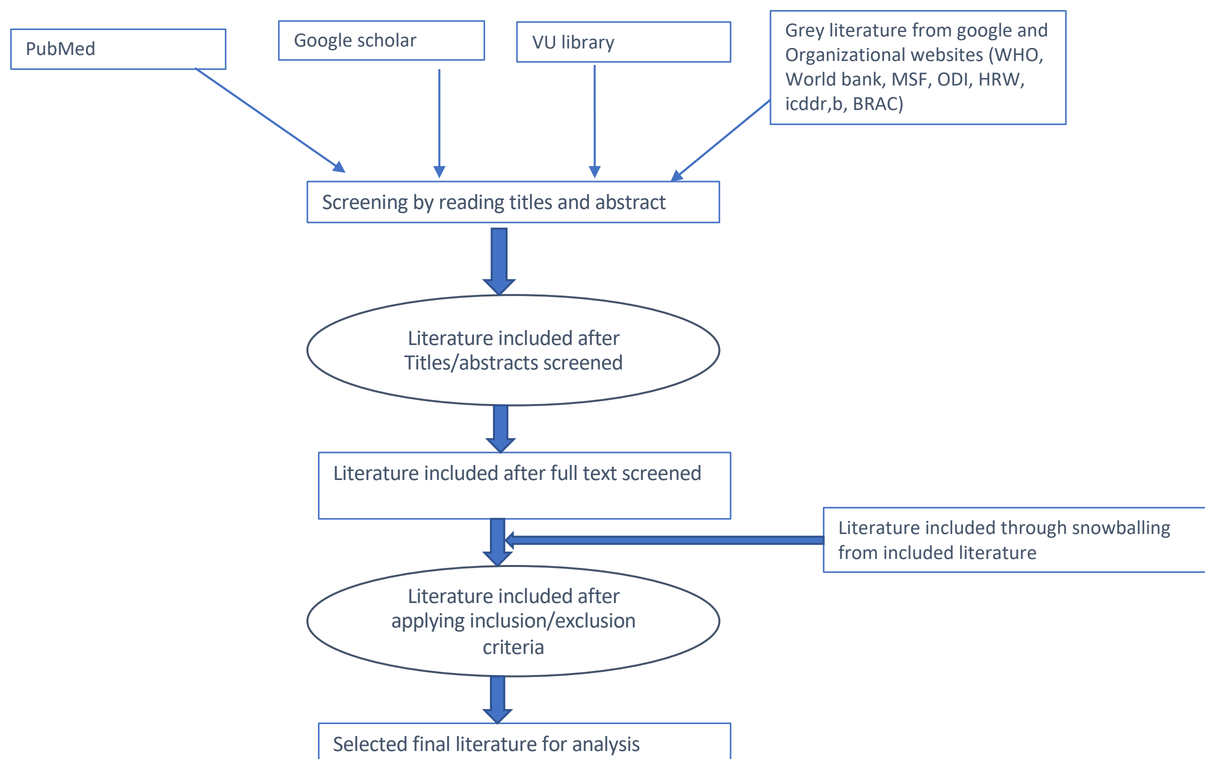

Figure 3 Search and inclusion of literature flow chart

3.4 Definition of Help-seeking:

As there is no one universal definition of "help-seeking" in public health research, the following definitions from literature are noted to conceptualize "help-seeking" in this thesis, "Actively seeking help from other people by communicating to obtain assistance in terms of understanding, advice, information, treatment, and general support in response to a problem or distressing experience" (6).

"A request for assistance from informal supports or formalized services for the purpose of resolving emotion, behavioral, or health problems" (7).

3.5 Definition of Intimate partner violence:

As there is no consensus on the definition of intimate partner violence over literature, the thesis considered two definitions that are mostly used by the included literature.

According to WHO, "Intimate partner violence refers to any behaviour by a current or former intimate partner within the context of marriage, co-habitation or any other formal or informal union, that causes physical, sexual or psychological harm (1). This includes acts of physical aggression, sexual coercion, psychological abuse, and controlling behaviour.

IPV refers to any behaviour within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship. Examples of types of behaviour are listed below.

Acts of physical violence, such as slapping, hitting, kicking and beating.

Sexual violence, including forced sexual intercourse and other forms of sexual coercion.

Emotional (psychological) abuse, such as insults, belittling, constant humiliation, intimidation (e.g. destroying things), threats of harm, threats to take away children.

Controlling behaviours, including isolating a person from family and friends; monitoring their movements; and restricting access to financial resources, employment, education or medical care.

Figure 4 Definition and different forms of IPV (WHO)(1)

VAW Bangladesh report uses the term "partner violence" which refers to a "violent act that has been committed against a woman by their current or previous husband" (2).
In the thesis, "intimate partner violence", "partner violence", "marital violence" and "spousal violence" are used as interchangeable terms. Information on "domestic violence"[viii] is also included in the thesis.

3.6 Limitation of method:

The studies included are limited to English and Bangla language (language bias). At the same time, considering cultural sensitivity and the availability of data in Bangladesh, the focus is limited to only married women's IPV experiences. Additionally, because of the discrepancy in measuring other forms of IPV in literature, only information regarding physical and sexual IPV is considered for this thesis.

3.7 Analytical Frameworks used for similar topic:

Many frameworks were explored on this topic. Hayes' socio-ecological framework (60,61), health belief model (62), Kroeger's (63) and Anderson's (64,65) health behaviour models were used frequently to analyze factors influencing IPV as well as help-seeking of IPV victims. However, three frameworks were found that acknowledge different steps the women go through after IPV that influence women's help-seeking/recovery. Those are the transtheoretical model of change (TTM) (66,67), Liang's framework of help-seeking (14) and Kennedy and colleague's framework (10). Whereas TTM is more applicable for victims living in a shelter (68), Liang's framework for help-seeking analyses victim's help-seeking process in three stages, 1. Problem recognition, 2. Decision to seek help, 3. Support selection (14). Kennedy goes one step further by including what happens after the victims decide to seek help and access the services as according to the author, those experiences have a major influence on the help-seeking of the victim.

3.8 Description of the chosen analytical framework with justification:

A conceptual framework adapted from Kennedy and colleagues on help attainment process of physically and sexually victimized women is selected for the thesis (10). Kennedy's framework builds on Liang's model (14), Anderson's general health-seeking behaviour model (64) and Gelberg's model of health-seeking for vulnerable populations (69). The framework

allows a comprehensive understanding of the help-seeking process, immediate as well as broader contextual factors influencing the process, therefore considered most relevant to guide the analysis for reaching the study objectives.

The framework (Figure 5) is adapted to contextualize for Bangladesh and suit the thesis objectives. In the original model, clear links from broader contextual factors on formal help-seeking were missing; which are added (Figure 5). The first stage is renamed as "appraisal of problem and needs" to clarify the content of the stage better. Immediate factors/challenges are analyzed at each step, except for "formal help-seeking stage", as this is more of a state of mind for victims, and factors linked to this are analyzed at all other sections. The role of intervention is left out to allow more in-depth analysis of influencing factors only. "Perceived fit/availability of services" is omitted, as this can be covered under "access". Additionally, any outcomes received from services/programmes are considered instead of only mental health outcomes. (Original framework is added in ANNEX 8.1)

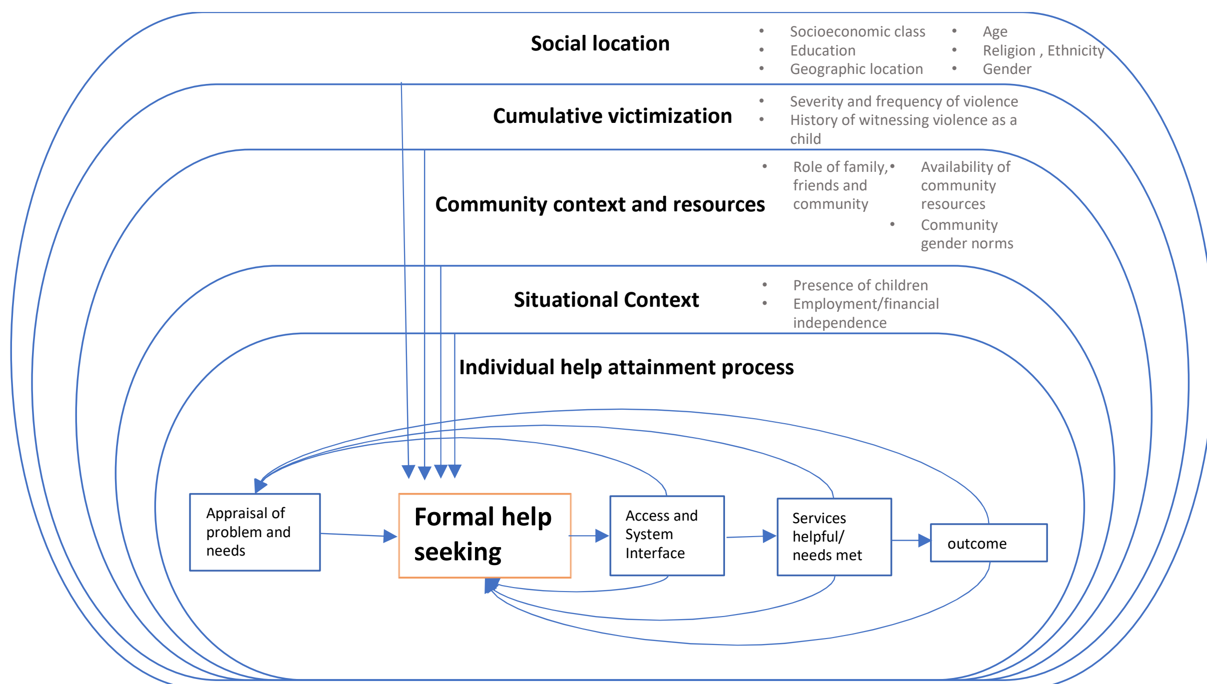

Figure 5 Conceptual Framework of help attainment process for intimate partner violence victim (adapted from Kennedy and colleagues)(10)

4 Study findings:

Narrative analysis is done informed by literature review using the conceptual framework. The findings are presented in two main chapters. Starting with the individual process of help attainment and immediate factors influencing each stage. Then factors in a broader context (social location, cumulative victimization, community context and resources, and situational factors) are analyzed which influence help-seeking of IPV victims. Each factor under the contextual factors is incorporated following the original literature of the framework (10) and contextualizing it for Bangladesh.

4.1 Individual help attainment process and immediate influencing factors:

At the heart of the conceptual framework (Figure 5) are the stages of the individual help attainment process over time and immediate factors influencing each of the stages. The stages are; appraisal of problem and needs, formal help-seeking, factors related to access/system interface, services helpful/needs met and the outcome received based on the experiences of women. The arrows connecting the stages represent feedback loops, which means, experience at any of the stages propels women forward or pushes them backwards to a previous stage. The whole process is further embedded in the broader contextual factors.

4.1.1 Appraisal of problem and needs and women's perception of violence:

Appraisal of problem and need is the first stage of help-seeking. The step includes the women's definition of the problem, which is influenced by her perception and cultural beliefs (10,70).

Women's perception of violence is a strong associating factor that influences their appraisal of the problem (14). In Bangladesh, a study conducted in urban slum areas (n=2604) shows association of violence condoning perception with help-seeking. According to this study, women who have low acceptance of violence are 1.42 times more likely to seek help following IPV than the women who have high acceptance (CI= 1.01-1.99) (43) (71).
This study is conducted among urban slums; therefore, the association may not be representative of rural or general urban women. But, a study from the neighboring country India that analyzed national-level data supports the finding stating women who view violence from husbands as justified, are less likely to seek help (60).

A number of studies in Bangladesh points, violence condoning perception is the most cited reason to not seek help following IPV. Where in the slum, 53% of women referred to this reason (55), population-level VAW survey shows, among women who experienced IPV and didn't disclose (n=7780), 39% of the women exhibit this mindset as a reason to not seek help.

In Bangladesh, the percentage of women who view violence by husbands as justified is high. According to a recent demographic health survey, violence from partners is seen as accepted by 20% of women in Bangladesh (24). Whereas a study in Sylhet denotes, among women who experienced physical IPV in the previous year (n=402), 90% perceived these behaviors as justified (33).

This kind of violence condoning perception has been commonly associated with IPV in different contexts, such as in Sri Lanka and Cambodia (72) and among African American women (73). The individual perception is tied to the community's gender norms (14) which is analyzed in chapter (4.2.3.3).

4.1.2 Perceived fears and women's cost-benefit analysis before seeking help:

According to Liang and Kennedy, before deciding about formal help, women often go through a social cost-benefit analysis in their head, where they weigh the cost of seeking help based on their fears and judge if that outweighs the perceived benefits. (10,14)

According to empirical evidence (both qualitative and quantitative) from Bangladesh and similar context, women refers to fear of bringing dishonour/bad name to family (2,33,46,55,56,71,74,75), stigma/shame (46,55,75) fear of disbelief from provider (46,55), fear of victim blaming (46,55,57), worries regarding children's future (2,71), retaliation from partner (2,71,74,75), fear of abandonment and financial destitution (71,75,76) as factors that obstructed their decision to choose formal help.

Table 2 Reasons for not seeking help from formal sources (Baseline study on urban slum) (71)

Major reasons for not seeking help from formal sources	Women who experienced physical IPV in previous year but did not seek help (n=1276)	Women who experienced sexual IPV in previous year but did not seek help (n=1165)
Violence condoning perception	58%	51%
Bringing dishonour/bad name to family	16%	7%
Lack of knowledge about availability	14%	11%
Doubt about usefulness of service	9%	5%
Shame/stigma/fear of facing disbelief and victim-blaming	8%	31%
Fear of abandonment and financial destitution	4%	3%
Fear of retaliation by partner	2%	1%
Worries about consequences for children	1%	1%
*The total percentages go beyond 100, which can be attributable to participants giving more than one reason.		

Table 2 depicts the reasons shown by victims of physical and sexual IPV for not seeking formal help in urban slums (71). This is visible from the table that, disproportionately more sexual IPV victim attribute shame/stigma/disbelief (31%) than physical (8%) as a reason to not approach formal provider. This can be attributable to the provider's inappropriate response which may be attributable to the legal framework, that does not identify marital rape as an offence (71).

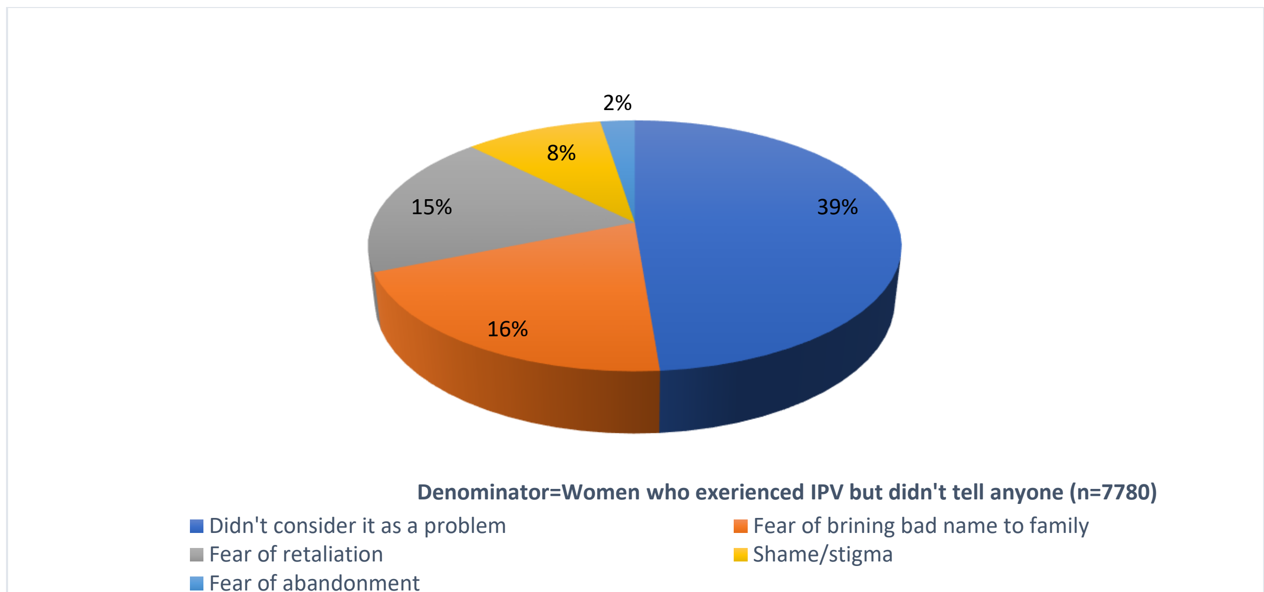

Figure 6 Reasons for non-disclosure to formal and informal sources; by Violence against women survey 2015 (2)

Figure 6 displays reasons showed by both rural and urban women to not disclose, in the VAW survey; which are similar to that of slum areas. The report also presents aggregated results for rural and urban women (not shown in figure 6), where there is minimal regional variation, except for the fact that more percentage of rural women expressed fear of bringing bad name to family than urban (16% vs 13%), indicating more rural than urban women try to protect family's name by not seeking outside help (2).

Studies also note that some women want help but don't necessarily want to end their relationship with the abuser (2,71). Two qualitative studies also indicate that this fear has a link with stigma related to divorce, social challenges, and financial uncertainty (75,76). Many of these perceived fears have roots in contextual factors, which are analyzed in chapter 4.2.

4.1.3 Formal help-seeking prevalence of and pattern:

This is the stage when the woman has decided to seek help from formal services. Since factors influencing formal help-seeking are analyzed in all other sections, this section focuses on the prevalence and pattern of help-seeking in Bangladesh.

4.1.3.1 Prevalence of help seeking:

According to existing literature, prevalence of both disclosure and help seeking is very low in Bangladesh as 66%-72% of women never disclose to anyone about their experience. (2,33,46,56). The help-seeking from formal help ranges from 2%-19% according to local literature (2,55,56). This finding is common among south Asian and developing countries. Neighboring country India from a population study shows only 1% of IPV victims seek any formal help (60). According to a multicountry study by WHO, in developing countries, 55-95% of women never seek help from formal provider (77). The formal help-seeking rates might be lower as a result of underreporting, due to stigma attached to formal help-seeking post IPV. Among sexual IPV victims, the seeking rate is even lower. The baseline study in slums shows, only 6% seek help among all sexual IPV victims (n=1566) (71), where among physical IPV

(n=1566), 19% seek help (55). As the VAW survey does not present rate of help-seeking aggregated by type of violence, if the pattern is generalizable at the population level cannot be affirmed.

4.1.3.2 Pattern of help seeking:

This chapter is to briefly overview the choice of help among urban and rural women following IPV. Findings from Bangladesh suggest women prefer informal sources like family, friends, local leaders more than formal (2,33,55,56). In this study, informal sources are not treated as another type of source but as a factor which can discourage and encourage women to seek formal help. Details in chapter 4.2.3.1.

Table 3 Choice of formal providers following IPV according to Naved and colleagues (n=2702) (56)

Choice of Support informal services	Urban	Rural
Health workers	1.3%	1.3%
Local leader	0.9%	3.2%
Police	0.6%	0.5%
NGO worker	0.2%	0%
Total sought help from formal services	11%	

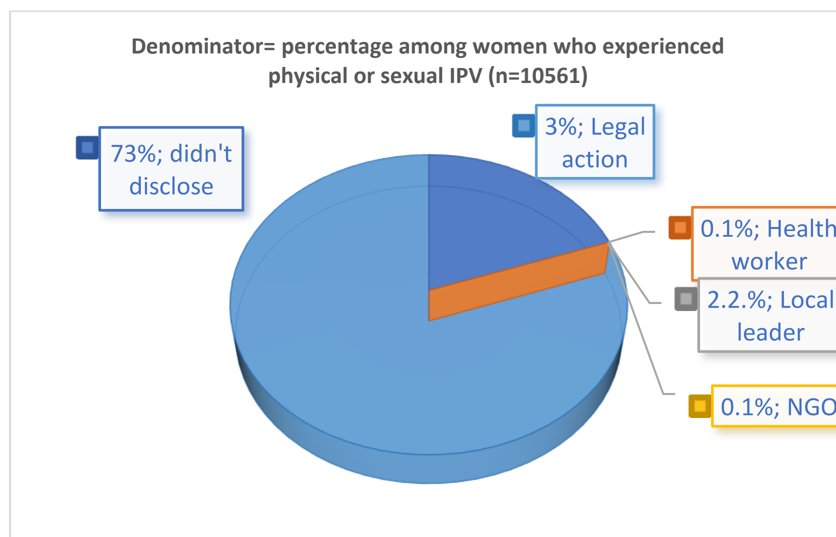

Figure 7 Percentage of women seeking formal help with choices of providers (VAW survey 2015) (2)

Table 3 and Figure 7 present two population-based survey findings on women's choices of formal providers (2,56). It is evident that women seldom go to health and Ngo workers. Not seeking help from healthcare providers is especially concerning as many of the IPV result in physical injury according to respondents in Bangladesh. One study shows, 26% of women had physical injuries as a result of IPV and 73% of them needed hospitalization (55). The rates between urban and rural are not different, except for the choice of local leaders (56). It is brought to light by much evidence that rural women in Bangladesh tend to seek help from

the traditional justice system "Shalish"[6], which are fora med by group of local leaders and influential people (2,33,55,56).

It is good to note that, in the studies included, respondents who choose formal providers are too little in number to make any conclusion. From the studies, it is also not known if any women choose or are referred to mental/psychosocial support services. In Bangladesh, the tendency to seek mental health is very low in general. According to the national mental health survey 2018-19, among people suffering from mental health issues, 92% didn't seek care (78); so it can be assumed that IPV victims also don't consider seeking help from mental health services.

4.1.4 Factors related to Access:

After the victim has decided to go to a formal provider, her decision can be influenced by problems related to access. Evidence from qualitative and quantitative studies show factors related to "access" [7] such as availability of services, physical and financial access, lack of information, and acceptability; which influence help seeking (2,55,79).

4.1.4.1 Availability of services:

Evidence from Bangladesh confirms rural women lack appropriate services in their vicinities which can influence their help-seeking following IPV (2,76,79). Evidence suggests; NGOs[8] that provide support and legal assistance to victims are not available in many areas due to their limited capacity and coverage. One-stop crisis center (OCCs)[2] which have been very efficient to provide immediate care and legal response, the medico-legal procedures however are only possible in district medical colleges. So women from rural areas are not benefitted from these services (80). More are analyzed in chapter 4.2.3.2.

4.1.4.2 Physical and financial access:

VAW survey points out restrictions on movement and lack of money act as barriers for women accessing services (2). According to a qualitative study, travel distance and lack of transport hinder women's help-seeking. The study adds rural women may have more restrictions on their movements imposed by families (79). Due to the qualitative nature of the study percentage of women who face this kind of barrier is not known. But given the fact that so many women in Bangladesh live under the poverty line and face restrictions from husbands to make their own decision (81), the percentage is likely to be high.
Cost of services is mentioned as another barrier. Even though Government is supposed to provide health and legal services to IPV victims free of cost; this is not known by women and some services include under the table costs and corruption (2,75,79).

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[6] "Shalish" is a local traditional justice system unique to Bangladesh, especially rural community. This is a group formed by a number of influential people in the village; such as religious or local leaders or land owner. Normally many incidents within the village are discussed and solved through mediations by these groups, especially issues regarding land disputes, rape or domestic disputes(79)

[7] Access to health care means having "the timely use of personal health services to achieve the best health outcomes." It includes adequacy of supply, affordability, physical accessibility and acceptability. (9)

[8] Name of NGOs working in Bangladesh for violence against women: Sabolombi Unnon Samity (Self Reliance Organisation or SUS), Alokito Manush (Enlightened Human Being), a program of Concerned Women for Family Development (CWFD), Bangladesh Legal Aid Services Trust (BLAST) and the Community Legal Services (CLS), a program of the Bangladesh Woman Lawyers Association (BNWLA) (80).

4.1.4.3 Access to information about available services:

Many women simply don't know about their rights, assistance, or services available (2,79). The baseline study on urban slums shows, among the women who experience physical IPV (n=1276), 14% of women attribute "not knowing about any service" to not seek help (71). The slum area's finding may not be generalizable but the population level VAW survey also highlights a high percentage of women (60%) have no idea about where to seek help and only 2.4% know about government hotlines (2).

A qualitative study adds access to social media, internet, TV, mobile phones mean better awareness regarding women's rights and available services (79). This is also supported by an international systematic review; where the use of media, distant support by trained counsellors to IPV victims showed effectiveness (15).

Bangladesh has shown exponential growth in digital technology over the last decade. According to multiple-indicator-cluster survey 2019, 96% of the households own a mobile phone and 51% have television (82). BDHS 2017-18 shows, over 60% of women own mobile phones now (24). However, the study does not mention if that influenced women to seek help.

4.1.4.4 Acceptability

Evidence from Bangladesh also adds that many women who know about the services, don't consider them to be useful (2,36,55,57,71). Details on their opinion are not obtained in the studies. Kennedy and colleagues also argue, that women may have other immediate needs like food, money, and security and may perceive the available services as incompatible (10).

4.1.5 Experience at system interface:

This section highlights what happens when women manage to access the services and their experience at the system interface,[9] when they meet the provider. Since the experiences influence women to seek help next time as well as encourage/discourage other women in the community (10).

4.1.5.1 Attitude of providers:

Some evidence from Bangladesh indicates negatives experiences regarding the attitude of providers; especially legal providers when women access the services. A qualitative study by human rights watch[10] (2020) adds respondents face disbelief from legal providers when they complain of physical violence(75). Others note poor attitude, inertia, treating IPV as a private matter, and insensitive response (75,79). One qualitative study adds that usually respondents find community NGO workers' behaviour helpful (75).

These findings are mostly on legal providers, qualitative in nature, and are not triangulated by the providers. In Bangladesh, there is a lack of research on health providers' attitudes towards IPV victims. A researcher adds, in Bangladesh, very few counsellors and health workers are trained to respond to IPV beyond treating physical injuries (44). Lack of provider training on IPV is also supported by a study from Malaysia (83). International studies including

[9] System interface: Interface is the place at which independent and often unrelated systems meet and act on or communicate with each other. System interface here means where the client and provider meet.(9)

[10] Human right watch report 2020 is based on a research that took place from 2017 to 2020 where 29 women acid survivors and 11 key informants like lawyers, NGO workers were interviewed. Many of these women were victims of acid violence, an extreme form of physical violence from their intimate partner or husbands.(75)

a systematic review and WHO guideline inform; sensitiveness, active listening, non-judgmental attitude, safety, privacy from providers, and autonomy to choose own way of support are expected by IPV victims and make them perceive the services as satisfactory in most parts of the world (84–86).

4.1.5.2 Re-traumatization:

One qualitative study from Bangladesh notes, many women feel describing the violence, again and again, retraumatize them (75). This is similar to a study from Tanzania, where many women don't seek help due to fear of getting re-traumatized in the process (57). This is also in line with findings from a global study (70).

4.1.6 Services helpful/needs met and outcome:

This section combines the last two stages of help attainment process. This chapter will analyze women's opinions on the services they received and overall outcomes from the women's perspective; categorized by types of services.

4.1.6.1 Legal services:

VAW survey denotes, among all who seek legal help, around 1% get "any" result (2). A qualitative study adds that the long and complicated nature of legal processes discourages women to choose this option (40). VAW survey further adds, mediation is the most common response from legal services (1.1%). Among the 2.6% who took legal action, 0.5% said to receive a satisfactory result and 0.5% said the opposite. 1% denoted the result as partially satisfactory. More urban women reported of not receiving a satisfactory outcome (1.4%) than rural (09.%) (2). The legal assistance NGOs[8] (BLAST, CLS) are stated as helpful by respondents in a qualitative study, highlighting their assistance in navigating complex legal procedures; but the NGOs are very limited in capacity and coverage (8). Both the population level and qualitative study indicate most women's needs are not met by the legal services.

4.1.6.2 Health, Psychosocial and community support services:

No research evaluated services/outcomes from the existing health/support services on IPV victims in Bangladesh. One women IPV victim who sought counselling services from MSF's women's health clinic stated that the service helped her to get back courage and improved her mental health (87). The community NGOs helped women in places they are active mostly by trying to intervene through the "Shalish" and associated community leaders and ordering the perpetrator to stop the violence. For some women, it stopped the violence temporarily and for some, it didn't bring any result (80). The obtained information lacks external validity as derived from small-scale qualitative interviews.

However, looking at the global context, a systematic review validates using social support services especially using peer support, community support groups improved mental health of the victims (15). The transferability of this kind of intervention in Bangladesh context is not known.

4.1.6.3 Multisectoral programme by Government (MSPVAW):

According to the impact evaluation study of the government's multisectoral programme to address violence against women (MSPVAW) was done among 108 victims who received help from the OCCs service of the programme. 72% of victims said they were more aware of their

rights, 31% said their mental health improved from counselling services and 37% said to become financially independent as a result of getting help from the programme (31). It is important to mention that, this study includes women and children, from any violence (partner-non partner). The study also excluded all victims who didn't get help from the services, so are subjected to bias.
No research in Bangladesh studied how specifically IPV victims are treated by available services and the long-term outcome.

4.2 Contextual factors influencing help-seeking of women following intimate partner violence in Bangladesh:

This chapter consists of factors related to social location, cumulative victimization, community context and resources, and situational factors and analysis of how these influence help seeking among IPV victims of Bangladesh.

4.2.1 Social location of women as enabler or barrier to help seeking:

A person's social location refers to a combination of factors that determine one's position within the intersectionality of social system (11). In Bangladesh, socioeconomic status, education, geographic location, age, religion, ethnicity determine an individual's social location and can have a major influence on their help-seeking (10).

4.2.1.1 Socioeconomic status (SES):

No study from Bangladesh shows a direct association between SES and help-seeking following IPV. However, a secondary analysis of nationally representative data from Bangladesh Demographic health surveys, shows higher SES is a strong predictor for women having less violence condoning attitude. Women from the richest quintile are 40% less likely to condone physical violence by husband than the lowest socioeconomic group (88). As low violence condoning attitude is linked to increased help-seeking following IPV (55), it can be said that women from higher wealth quintile are more likely to seek help. However, concluding on this could be subjected to ecological fallacy as information on help-seeking from the bigger sample was not obtained.
Two studies from neighboring country India gives contradicting result analyzing nationally representative data; one associates higher SES with more help-seeking (60) and one associates it negatively (89). One study from Nigeria; which is an LMIC context states, women from the lowest SES seek more help (90).
Studies from Bangladesh mostly researched relationship of SES and exposure to IPV; which generated variable results (33,47,91).

4.2.1.2 Education:

Evidence from Bangladesh suggests education is a strong enabler of help seeking following IPV (55,56,74,88). Parvin and colleagues found help seeking following IPV increases with duration of education. According to their study in Dhaka slum (n= 2604), the odds of seeking help are 2.24 times (CI=1.37-3.63) more among women who have more than 5 years of education and 1.66 times (CI=1.37-3.63) more among women who have education ranging 1-5 years than women with no education (55). Another population-level study strengthens this

finding which shows women studied beyond 10th grade are 3 times more likely to seek help than women with no education (56).
An indirect link between education and increased help seeking also exists. According to a secondary analysis study, highly educated women are 50% less and secondary education recipients are 20% less likely to accept physical violence from husbands than women with no education(88). This perception is a key enabler at the stage of problem appraisal of help seeking process (14). As low acceptance of violence is associated with more help-seeking (55), it can be said that educated women are more likely to seek help.
Two studies from India, that studied a nationally representative sample of 19125 women, also confirm education to be a strong predictor of help seeking following IPV (60,92).

4.2.1.3 Geographical location:

According to Bangladeshi literature, IPV prevalence is slightly higher in rural areas but highest in urban slums (93,94). Urban slums also have a higher rate of help seeking from "formal providers" than general urban areas (94). 11% of women from urban slums seek help in comparison to 2% of urban women according to a population-based study (n=2702) (56). This result is contradicting to a study from India and Nigeria, that shows women from communities having a high prevalence of violence seek less help (90,95).

Urban slum women seeking more help in Bangladesh may be attributable to having more information or resources available to them (55). Another perspective is added by a qualitative study, that says people living in urban slums lack the social network like rural people. They don't know each other and are forced to live with each other; making them rely more on formal sources for support (8).

An analysis of BDHS suggests women from the Barisal division justify IPV most and women from Dhaka justify IPV least (88). As violence condoning attitude is linked to low help-seeking (55), Barisal women may be less likely to seek help after experiencing IPV.

4.2.1.4 Age:

Parvin's study on urban slums shows older age is positively associated with help seeking. 25-29 years old women were 1.80 times more likely to seek help than women aged 15-19 years (CI=0.64–4.99) in the study. The long range of CI is maybe attributable to the small sample of women who ever sought help (55). Findings from global studies show contradicting results as a study from Nicaragua (96) shows, women who seek help are older (97) and another study among Pakistani, Indian and Filipino women shows help-seeking is more among youngers (98).

In Bangladesh, an analysis from BDHS data shows, marital age is a major influencing factor on the perception of IPV. Women who marry at a legal age (18 years+) are 20% less like to accept violence from husbands (88). As less acceptance of violence leads to more help seeking (55), it can be said, there is a positive link of "older marital age" with help seeking in Bangladesh. Two population-level studies from India also proves older marital age (21+ year) as a protective factor for help seeking (60,95).
Child marriage is a pressing problem in Bangladesh and according to existing knowledge, the risk of being exposed to IPV is also higher among younger women than older. According to Bangladesh adolescent health survey, the prevalence of IPV among young women (15-

19years) is 77% (34), which is higher than the prevalence for general women 73% (2). Another study shows, among the youngest (15-19 years), almost 50% are not allowed to go alone to health facilities if needed (23). These findings suggest that women who are older and married older are in a better position to seek help following IPV if they want to.

4.2.1.5 Gender:

IPV is a form of gender-based violence. The thesis only focuses on women's experiences of IPV. In Bangladesh, a very low percentage of women have the power to decide on their own healthcare and care-seeking. According to DHS, less than 20% of married women can decide on their own health care (81). So, the gender factor already puts women on a discriminated spot that doesn't hold good prospects for help-seeking due to IPV. How gender norms influence help seeking is analyzed in chapter 4.2.3.3.

4.2.1.6 Ethnicity:

Bangladesh is a home to different ethnic minorities, but no study in Bangladesh researched the relationship between help-seeking and ethnicity. However, in some communities, conservative norms are followed, which can restrict them to seek help outside. A qualitative study respondent from an ethnic minority group (GARO) adds that her community detests seeking help outside or legal interference in "family matters" (76). In a high-income country setting, racial minorities are found to be associated with low help seeking behaviour following IPV (99). However, such relationship is yet to prove among ethnic minorities in Bangladesh.

4.2.1.7 Religion:

Muslim women are reported to have a higher prevalence of exposure to IPV than other religions according to Bangladesh studies (33,55,100). However, no study identified a direct relationship between Muslim women and help seeking following IPV. A study suggests Muslim women are subjected to overall less freedom of movement than members of other religions, which limits their access (100). The same reason may lead to low help seeking among Muslim women. A BDHS analysis paper presents, Muslim women, express 20-30% more violence accepting attitudes than others religions (88). This can expose them to a greater risk of low help-seeking following IPV (55).

4.2.2 Cumulative victimization:

Cumulative victimization means the summation of recurrent and severe exposure to violence which is identified as one of the strongest predictors of help seeking following IPV according to many Bangladeshi and international studies (55,56,74,95,98,101).

4.2.2.1 Severity and frequency of violence:

In line with the findings of many international studies (95,98,101), a number of studies from Bangladesh, reports severity and frequency are strong predictors of help-seeking following IPV (55,56,74). The study among slum women shows severity of violence increases help-seeking 5.3 times (CI 3.48-8.05) and being frequently exposed to violence increases help seeking 1.83 times (CI = 1.28–2.65)(55).

A population-based study also shows severely abused urban women are 3 times more and rural women are 8 times more likely to disclose than moderately abused women. Similarly,

women who are exposed to violence frequently are 5 times more likely to seek help (urban and rural) (56). An international study also supports the finding (102).

However, it isn't clear from the studies, what measurements were used to decide severe and moderate abuse. According to some studies in Bangladesh, "could not tolerate anymore" was shown as a reason to not seek help by many women. A population-based study and the urban slum study both show among all women who seek formal help, over 80% do it because "they can't tolerate anymore" (55,56). Despite being a subjective measure depending on women's personal level, it has links with severity and frequency of violence.
As one author notes, a combination of frequent and severe violence with presence of a controlling partner increases the likelihood of help-seeking, as this might make things intolerable for the women (55). This finding is also supported by some studies from India which used a nationally representative sample (60,89,95).
Culture is also found to have a role on women's perception of the severity of violence; which makes them see some forms of violence as severe. A Tanzanian study gives the example of insulting publicly and anal sex which is unacceptably severe according to Tanzanian culture (57). In Bangladesh however, no study defined what is severe according to Bangladeshi culture and did not explain severity beyond severe physical injuries.

4.2.2.2 History of experiencing and witnessing violence as children:

In Bangladesh, no study researched a relationship between history of witnessing violence as a child and help-seeking behaviour. Studies from similar contexts present variable results. According to an Indian study, witnessing violence as a child is not associated with help-seeking (89). Another Indian study finds, witnessing violence on mother as a child is negatively associated with help-seeking for IPV victims (60). This finding is further contradicted by findings from Nigeria, where help-seeking odds are higher among women who witness family violence in childhood (90).

4.2.3 Community contexts and resources:

In this chapter, community factors such as role of family, friends and, community members, community resources, community gender norms and, their influence on help seeking of IPV victims are analyzed.

4.2.3.1 Role of family, friends and, community response to violence:

Family, friends and, relatives play a major role in encouraging/discouraging women to seek help according to Bangladeshi literature. It is a common finding among studies, that Bangladeshi women mostly seek help from informal sources such as family and neighbors (2,55,56). Even some studies treat formal sources as an alternative choice to formal help. This isn't quite the case, as the women first seek help from informal sources as an immediate step; and sometimes they influence women's decision on whether they seek further formal help or not.

A population-based study (n=2702) reports, women who perceive support from maternal family are twice more likely to disclose than women who don't feel the support (56). Studies from different contexts also support this as one study from South Africa finds social support leads the victims towards psychological resilience (103).

Despite the encouraging role families can play, discouragement is reported more in the empirical evidence in Bangladesh (2,56,71,76,80,87). A qualitative study adds perspective to this problem by pointing out the belief shared by Bangladeshi communities that it is important to make a marriage work at any cost. Two quotes are added below from the study, which allows insight into the usual response by family members to IPV victims;

"My parents said that you can only come back [to your parents' house] when you are dead. That is why I, at any cost, try to maintain my marital life"
"My parents' said husband is everything for a Bengali woman, and making marriage work is your responsibility"
"My mother said never go out of your husband's home, if he batters you, accept it – even he kills you, you will go to heaven"

Figure 8 Quotes from intimate partner violence victims interviewed in eight rural areas of Bangladesh(76)

Two qualitative studies also add that the community perceives IPV as a private matter and seeking outside help is believed to bring dishonour to family (75,79). This justifiably creates perceived fear among women and stops them from seeking help as mentioned in chapter 4.1.2. This finding is very similar to the Tanzanian context, where one study highlights shame/stigma associated with exposing experiences of violence and not violence itself (57).

The baseline study on urban slums also highlights; fear of shame/stigma blocks 42.8% of sexual IPV victims from disclosing to friends and families where the fear only stops 13.2% of physical IPV victims. And among those who sought help from formal providers after sexual IPV, 22% of them did so due to encouragement from family (71). This indicates; community attaches more stigma with sexual violence by partner than physical as well as the powerful role family can play to encourage victims to go seek formal services.

4.2.3.2 Availability of community resources:

Community resources refer to groups, structures, or services that are present to meet certain needs of people in that particular area (104). Evidence from Bangladesh and the globe suggests availability of resources in the community enables women to get help following IPV (10,76,105,106). A qualitative study from Bangladesh suggests the women who choose to get help; it is because of the community NGOs working nearby (76). Some international studies also highlight how community resources improve help-seeking of IPV victims in some communities around the globe; such as community churches for African American women (105) and community hotlines for Korean American women (106). Research is scanty in this regard but according to qualitative evidence, the community NGOs[8] and NGO funded clinics have been mentioned as "helpful" by Bangladeshi women. However, they are limited in availability, coverage, capacity, and details on their way of work are not researched (76).

In Bangladesh, especially rural women lack appropriate resources in their vicinity (more in chapter 4.1.4.1). Services from the government programmes such as OCCs are only fully functional in district regions and provide limited level of counselling services (80). Mental

health services are not integrated yet at Primary care levels; which leaves women in rural areas with limited options (44,107). One study from icddr,b that trained paramedics for counselling services adds that as trained professionals are reluctant to work in rural areas, health workers at primary health care level centers can be successfully trained to provide basic counselling services to IPV victims (44).

A recent qualitative study notes that rural areas are more protected by their social network than urban slums. In the slums, people are forced to live with each other, therefore they lack responsibility towards each other (79). Another qualitative study adds, rural women despite being more protected by informal networks, don't automatically have positive outcomes from this as people from their informal network are not always helpful or know how to help (76).

From several studies, an informal community resource, named "Shalish"[6] is evident, especially in rural communities. One study notes, decisions from this kind of informal justice system, almost always go against women, and women are advised to stay with the abusive partner to protect marriage and family reputation (79). One study also mentions, the community NGOs sometimes collaborate with these informal groups to mediate IPV; which only solves the problem temporarily or didn't help at all (80) (more in chapter 4.1.6.2).
Some studies show in developing countries integration of IPV services in the existing health system, especially in primary health care, emergency care or ante-natal care can enable people in the rural community to receive care, given it is followed up with proper coordination, training, and functional referral system (85,108).
From the findings, it can be said that the lack of appropriate community resources hinders Bangladeshi women's help-seeking and the present resources are not sufficient.

4.2.3.3 Community Gender norms and cultural beliefs:

Many studies across globe (77,109,110) and Bangladesh (8,33,39,55,75,94,111–113) identified acceptance of violence by husband as a key risk factor for intimate partner violence. Bangladesh has a patriarchal culture and defined gender norms for men and women. Aggression and violence are seen as the natural expression of masculinity and women are expected to be subordinate to men in marriage (79). Even though influencing factors of IPV are different from factors related to help seeking; community gender norms have strong links with both. Community norms influence women's perception of violence and stop them at the very beginning of help-seeking by keeping them from recognizing it as a problem (10).

A qualitative research in rural areas of Bangladesh published reports that present inequitable gender perspectives of people where many participants agree that violence can be used as a tool by the husband to discipline the wife (8,79,114). In the reports, violence is seen justified by the participants when the women don't do household chores, don't obey their husbands, don't take proper care of in-laws and children, refuse sex, and argue with husbands (79). Sometimes the participants also tried to validate these behaviours using religious references. Quotes from the study are cited below (Figure 9).

> 'Parts of the body hit by the husband will go to heaven.'
>
> 'A woman who disobeys a husband or does not appreciate him will have a place even in Jahannam (hell)"

Figure 9 Text box; Quotes cited by married women in focus group discussion, Mymensingh (79)

Not to just disciple wife, violence is associated with the socially constructed idea of masculinity in Bangladesh, and men who conform to that are more respected. Men who don't exercise power over wives are called "Menda" (less of a man) (79). Men's role is seen as the breadwinner and decision-maker and their needs are expected to meet by wives at all times. Any deviation from this is a socially justified reason to inflict violence on the wives (8,79). According to a multicounty study by WHO, in Bangladesh, 53% urban and 79% rural women support the idea of wife-beating under some circumstances (46). Studies from some LMICs also have the same findings (57).

A review paper further adds as Bangladeshi people grow up watching parents using violence on their family, teachers being violent with students they end up being "institutionalized" to accept violence (111). The urban slum study further testifies this. Even though all participants (99% women and 98% men) agreed that women and men should be treated equally. Follow-up statements markedly contradicted that (given in table 2); which proves how violence condoning perception and gender inequitable views are prevalent in all communities.

Table 4 Percentage of women and men from urban slum condoning to gender-biased and violence condoning statements from baseline report of the SAFE study (2012) (71)

Gender biased and violence condoning statements	Percentage of women agreeing (total, n=4458)	Percentage of men agreeing (total, n=1617)
Women should obey their husbands	90%	96%
Men should have final say in decisions	54%	64%
Force can be used as a response to insult or protect honour	48%	66%
There are times when women deserve to be beaten	49%	67%
Women should endure violence to protect family	64%	64%
Women cannot refuse sex	54%	43%
Women should be held responsible for sexual violence/rape	38%	51%

The presented finding (Table 1) also highlights the distorted perception of sexual violence. This further confirms women's fear of victim-blaming (mentioned in chapter 4.1.2) which stops them to seek help (71). Gaps in legal framework, which does not recognize marital rape is also responsible for this problem (115).

This is important to note that, the participant's answers are not always genuine, as they are aware of the activities of NGOs, who conducted the studies. So, the violence condoning perception maybe even higher. As high violence condoning attitude is linked with low help seeking (55), the findings give clear insights on how the perception hinders the whole community to recognize violence as an offence and violation of human rights. These findings are further supported by other studies in Bangladesh (91,93,116).

4.2.4 Situational context influencing help seeking of IPV victims

In this chapter, the role of situational factors such as presence of children and financial dependency on women's help seeking are analyzed.

4.2.4.1 Presence of children:

While according to some studies, women's perceived insecurity regarding children's future acts as a barrier to seeking help (2,71), according to most studies in Bangladesh having children is strongly associated with help-seeking (55). Women with children living in urban slums are 1.83 times more likely to seek help (CI = 1.17–2.86) than women with no children (55). The result may not be generalizable among women living in other areas. However, according to WHO multicountry study, one-third of Bangladeshi IPV victims only seek help because their children are at risk of exposure to violence (77). A population-level study also notes that women only seek help when their husbands start harming the children (56).

A study from India, which is of similar cultural context shows, help seeking increases with higher mean number of children (89). Another author from India analyzed the same database, associated having children and help-seeking negatively (60).

The mixed results signify that different situation such as if the children are also exposed to violence or not; plays a role than just having children.

4.2.4.2 Employment/financial independence:

Quantitative and qualitative studies in Bangladesh show women referring to "financial insecurity" as a reason to not seek help (71,79,80). Studies from India using a nationally representative sample, identify "employment" as a major predictor for increased help seeking following IPV (60,92,95). One study shows, employment increases help-seeking by 11% (95), other associates having financial independence with help-seeking (89).

Research on Bangladeshi garments workers, however, shows; when women earn more than their husbands or have access to assets, this precipitates disputes which result in violence by husbands (91). Data on help-seeking of those women were not obtained in the study.

Some rural women as a part of a qualitative study associate being financially independent with having more power in decision making (79). Another report from the same study suggests, women's financial dependency on men is the biggest barrier to come out of the violent relationship (80). In the human rights watch report, acid violence survivors state many of them didn't report about the ongoing violence due to fear of separation and resultant financial insecurity, as they were dependent on their abusers (75). The report also adds, that because of financial insecurity, many women choose to endure violence and not seek help until something severe happens (75). This can further clouds women's acceptability about available services (chapter 4.1.4.4) as Kennedy adds, women who are worried about their survival related basic needs, may feel like the available services don't have anything to offer that can help them (10). This is further supported by a recent qualitative study on rural women; a quote from the study participant is given below (Figure 10).

> "I want to see how much suffering I can endure, but if I leave him, my suffering will increase rapidly since I have three children. My mother cannot support us. At least now my children and I have three meals without problem"

Figure 10 Quotes from rural women interviewed in a qualitative study by Khan(76)

A recent population-based study (n=3355) shows that providing women "instrumental support (money, help in work, etc.)" decreases IPV. If this is applicable in the case of improving help-seeking by women victims, is not yet studied (58).

5 Discussion:

This section consists of discussions on the major findings, interlinkages of different factors, potential interventions, and gaps found in knowledge which are sectioned according to specific objectives.

5.1 Individual help attainment process and immediate factors:

5.1.1 Factors blocking women's decision to seek help prior to access:

Despite the high prevalence of IPV in Bangladesh, help seeking following IPV from formal services is alarmingly low. The biggest barrier to individual help seeking process is violence condoning perception of women. This perception is highly prevalent among Bangladeshi women which can affect their help-seeking at the very first stage by not letting them recognize IPV as a problem. Most women in the included studies refer to this reason for not seeking help and this is in alignment with findings from international studies (60). This perception has strong links with the cultural beliefs of Bangladeshi communities, which are characterized by rigid gender norms and high violence condoning attitude when it comes to IPV.

The major factors blocking women before the next step of formal help-seeking are perceived fear of shame/stigma and bringing so-called "bad name" to family. These two factors are not only empirically supported by literature from Bangladesh, this is also a common phenomenon in many south Asian and African countries, where the victim is stigmatized and not the violence or perpetrator (57,60,73,95). The fears are not just individual perceptions, rather have ties with community context, where the disordered community response mentally jeopardizes the victim by labeling her as "someone unable to work her marriage out by herself" instead of providing her support and holding the perpetrator accountable. Another major finding is "sexual IPV" is less disclosed to informal as well as formal services than physical. This is attributable to more stigma attached to it and the community as well as the providers' failure to recognize sexual IPV as an offence. Aside from the rigid gender norms, this is also attributable to the fact that the law on domestic violence, does not acknowledge marital rape.

5.1.2 Factors related to access:

Strong evidence from both quantitative and qualitative studies suggests women face different barriers when they finally decide to seek help. Lack of services, cost, distance, lack of transport, lack of information about services and not considering the existing services compatible with their needs are more pronounced than others. Community resources are found to improve help-seeking according to some international evidence (105,106). However, in Bangladesh, especially women living in rural areas have less access to resources. Additionally, restricted movement whether imposed by the husband or lack of transport makes it even harder for them to access formal help. The government's OCCs and mental health services are also unavailable in rural areas. Reluctancy of trained professionals to work in rural areas is another problem spotted. Training paramedics to provide basic counselling and integration of IPV services in existing health system at entry points such as PHC, ANC is suggested by a number of local and international studies (16,35,86,117) to improve access for, especially rural women. The studies also note that a functional referral system, proper

training, and coordination with other actors are integral to make integration of IPV services effective.

Lack of information about available services also hinders women's access to formal services. One of the promising findings is access to digital tools/media being associated with having more possibility of being aware of available services. This hold promises for Bangladesh considering the large percentage of women have access to mobile phones and television. A systematic review also highlights the effectiveness of distant services by trained counselors to support IPV victims; which can be tested and replicated for Bangladesh setting. Factors related to acceptability need more research to find out women's expectations to tailor the services accordingly for improved service uptake. Existing literature on this topic emphasizes on providing instrumental support, considering religious and community factors to provide culturally appropriate responses.

5.1.3 Factors at system interface

Research in Bangladesh on IPV victim's service-related experiences is very rare. Most of the findings are based on small-scale qualitative studies. Nonetheless, poor attitude of the providers and fear of getting retraumatized in the process are at the forefront of barriers mentioned by women from both local and international studies. While available data only draws on women's dissatisfactions regarding attitudes of legal providers. Findings also suggest an alarmingly low percentage of women choosing a healthcare provider; despite having physical injuries. Reasons for not choosing a health provider are not understood from the studies. Whereas data can be under-reported for stigma attached to help seeking following IPV, this can be also attributed to attitudes of healthcare providers. A Bangladeshi and another study from Asia further attest to this by mentioning insufficient training of healthcare providers to deal with sensitive issues like IPV. WHO in its GBV response guideline emphasizes that providers need to be trained to be empathetic, non-judgmental, respectful, ensure safety, privacy and provide support accordingly; this is aligned with what the women expect from the services (86).

5.1.4 Factors related to service and outcome level:

Service-related findings are mostly available for legal services. A very little percentage of people were satisfied with legal services, while many awaited "any outcome". More percentage of urban women expressed their dissatisfaction towards legal services, which can be due to the fact that they have better awareness about their rights and what they deserve and therefore are more disappointed with the outcomes. However, strong and generalizable findings are not achieved through the review related to services. Most findings are sourced from small-scale studies or reports. Data are not segregated according to the type of services and findings are also only based on the client's experience and not triangulated by the service providers.

When it comes to outcome, it is difficult to attest that the problem can be "solved" as a result of help-seeking. But appropriate supportive services and interventions can improve women's mental health, coping process as well as decrease IPV (16,57). Some participants from the studies spoke of improvement in mental health as a result of counselling services by NGOs and GO services, but this information does not form a strong evidence base. It can be therefore said that no specific outcome of IPV victims through using services is known. The need for more quantitative and qualitative research is paramount which analyzes service-

related factors that includes both client and providers' perspectives to generate robust evidence.

5.2 Role of broader contextual factors on help seeking:

5.2.1 Role of Social location:

Roles of some of the variables of social locations are more well-established than others in the review. Education, older age, older marital age, financial independence is strongly associated with help seeking following IPV. The findings are also supported by international studies from similar contexts. From the background it is known that women drop out a lot more than their male counterparts from upper-secondary level schooling; which maybe attributable to early marriage, pregnancy, and restrictions from husbands. The government's efforts to stop child marriage and ensure education for women; need to be strengthened and public service roles for women should be expanded at this point. Additionally, education/empowerment of only women is not enough, it is also important to teach men how to deal with empowered women. Findings also testify to the fact that having more education, assets, income than husband sometimes subject women to more risk of experiencing violence by husbands. The study informs government that it is important to educate both men and women to address VAW and achieve the SDG related to gender equality; therefore, involving men as allies to address IPV is crucial. The scope of involving men in Bangladesh is discussed further in the report by Samuels and colleagues (114).

The relationship between SES and help-seeking remains inconclusive; as both Bangladeshi and global studies generated variable results. Financial independence is a stronger predictor of help seeking than just SES. This gives insight that even if a woman belongs to higher socioeconomic class, she still may be financially dependent on her husband; which may alter her decision of help-seeking. Financial uncertainty is also linked with perceived fears about children's future and abandonment which are setbacks in the way of seeking help. This finding suggests ensuring financial support and long-term protection by the government can encourage women to seek more help. However, operationalizing this in an LMIC-high prevalent context is questionable. Expanding and strongly implementing government's women empowerment and advocacy activities are, therefore, necessary to facilitate women's financial independence than just giving them monetary support.

Muslim women, in general, are found to have more violence condoning attitudes but from this review, a strong link between help-seeking with religion is not established. Muslim women's lives governed by Sharia law[3] and not by the constitution have implications for government's goals of achieving gender equality. This needs attention from gender researchers and lawmakers. More research is also needed to see the relationship between ethnicity and help seeking.

Geographical area makes minimal difference in the prevalence of help seeking. However, area definitely influences nature of help seeking. Urban slum dwellers seek more help from formal resources than rural. A nice perspective added by qualitative studies is; urban slums dwellers may need more formal support due to the lack of informal support networks that the rural people enjoy. However; lack of options for services; as found in a number of studies, maybe the reason why rural women rely on informal sources. Women in rural area also turn to local leaders (Shalish) more. Regardless of areas, seeking help from formal sources in all studies is

alarmingly low. This is further strengthened by studies from LMICs and neighboring countries; that show a similar pattern of the victim having a low preference for formal services.

5.2.2 Role of Community Factors:

The role of community factors is found to be strong and has interlinkages with other factors. A substantial percentage of community members are found to be plagued with gender inequitable and violence condoning views; which fails to acknowledge the rights of women. Without addressing the perception of community members, individual or service level approaches will not work, as the perception needs to be changed first to recognize IPV as a problem. Engaging community members to educate on violence against women, gender equality, and challenging gender norms are the most appropriate way to address the problem from the root. At the same time, involving men in the current multisectoral strategy to address VAW is essential. Empirical studies denote, interventions that target community norms to address IPV are more effective than targeting individuals (15,59,118). Government's MSPVAW programme includes education and awareness regarding violence; however, the education material doesn't necessarily include content specific to "IPV".

An interesting insight gained from the analysis is the relationship of informal networks with formal help-seeking. Unlike other theory (70) that treats the informal source as an alternative choice to formal source; the conceptual framework helps to see informal sources as a factor, that encourages/discourages women to choose formal services (10). From the evidence of Bangladesh, it is quite clear that women's decision to seek formal help is majorly influenced by the victim's family, friends, and informal network. Unfortunately, they most times discourage formal help-seeking and advise women to tolerate the abuse to protect the marriage. This is a common trait of the culture, that holds marriage over women's well-being. The relationship of informal support network with formal services from the review is understood to be not black and white. Even though informal support network averts women from seeking formal help by discouraging, they sometimes also provide instrumental or psychosocial support, as noted in some studies. These delay formal help seeking but at least the women receive help which they fail to get from formal services.

The strong contribution of informal networks needs to be taken into account while planning interventions. A systematic review shows using informal support networks (especially peer support groups) is effective to provide support to victims in many settings which improves their mental health (15). Engaging and educating community members on IPV is however the first step before implementing such interventions.

5.2.3 Cumulative victimization and Situational factors:

Severity and frequency of violence are one of the strongest predictors of seeking formal help, which is supported by Bangladeshi and international studies. However, in the literature included, measurement of severity of abuse is not explained and many studies also interpret women's comments on "not being able to endure anymore" as the abuse being severe. Despite issues related to women's subjectivity and cultural variation on what is defined as "severe", it is clear that in Bangladesh, a combination of severe physical injuries, subsequent exposure to violence, and presence of highly controlling partners compels women to seek help. The information also unpacks what is communicated between the services and victims. The victims may think they need visible signs of injury to get any help from providers. This is

not without reason; as many studies present from Bangladesh and other countries that health workers are not trained to deal with IPV issues beyond treating injuries.

Presence of children is found to influence help seeking both positively and negatively in local and international studies. Compiling variable results, it can be said that, the relationship between presence of children and help seeking is not that linear as presented by some quantitative studies. This may not be an independent factor and many other situations need to be taken into account before concluding on a positive association. It can be that mothers try to endure violence considering children's difficult future without a father figure, but when the children are also exposed to violence; they decide to seek formal help regardless of the consequences. This also deserves to be reflected upon that the society of Bangladesh is not a favorable place for divorcees and single mothers, as highlighted by some qualitative studies; which makes the women more fearful of the consequences before they seek formal help.

5.3 Relevance and limitation of the framework:

The conceptual framework provides a good understanding of the pathway of help-seeking over time and how actors at every step can influence help seeking. Unlike other models of health seeking behaviour (64,65); this model shows that factors related to “access” come at a much later stage, after the woman has decided to seek formal help. This also helped to convey how different contextual factors can influence help seeking process in a theory-informed way. The framework also helps to see informal sources as a factor and not just an alternative choice to formal services, which put the important role of informal support network in perspective. However, the framework doesn’t take into consideration different macro factors like policy, environment, and institutions which can influence the problem. The framework also provides limited opportunity to analyze service-related factors as most are limited to client’s experience. Some factors are also overlapping with each other (eg; community resources and access). Nonetheless, the framework helps to guide the analysis sufficiently and in-depth according to the study objectives.

5.4 Limitation and strength of the study:

This study is not without limitations. As mentioned before, analysis of service-related factors doesn’t include provider’s perspective. The study also includes data regarding help seeking which are sometimes not segregated by formal and informal. Disclosure related data are also included assuming women disclose to formal providers to seek help. Prevalence can also be higher than reported due to underreporting. Additionally, respondent’s answers sometimes can be biased as they are aware of the activities of the organizations that conducted those studies. The qualitative studies included mainly focus on rural areas; so, an in-depth understanding of urban women’s struggles to seek help is not known from the review. The study also doesn’t focus on other coping responses adopted by women who don’t seek help.

6 Conclusion and Recommendations:

6.1 Conclusion:

Intimate partner violence is pervasive in Bangladesh and a major public health concern. Despite the high number of victims, a very low percentage of people disclose and seek help from formal services. Prevalence of disclosure ranges from 66-72%, while 2-19% of victims seek help from formal providers. Low help seeking does not only underrepresent the magnitude of the problem, it also means that victims of intimate partner violence are unable to access help which is fundamental for their recovery. The study adds an important contribution to the literature body by explaining the complex help-seeking process of an IPV victim and analyzing factors that influence the steps.

From the review, violence condoning perception, fear of stigma/shame, access related factors such as availability of services, financial and physical access, lack of information, and unacceptability are found to be the major blockers in the pathway of help seeking. Poor attitude is the most pronounced negative experience faced by women from the providers that discourages them to seek help. Further information on if the available services meet the victim's self-identified needs and their impact on long-term outcomes on the victims remain unknown due to lack of research in this respect. All of the factors in the help-seeking steps are intertwined with each other and contextual factors in the outer layer of the model.

Social locations and situation factors such as education, older age, and marital age, financial independence/employment have a strong association with increased help seeking; proving these factors provide women agency to decide what's best for themselves. This also signifies that ensuring education, policies on legal age marriage, and employment need to be strengthened and incorporated in strategies to address IPV. Geographical location doesn't make a difference to prevalence of help seeking but reveals rural women relying more on informal support networks and local justice system than urban.

Severity and frequency of violence are found strongly associated with increased help seeking. This reflects their understanding regarding the health provider of Bangladesh, who are not trained to deal with IPV victims beyond just treating injuries. The review also points out women are most likely to seek help when they cannot tolerate anymore and their children are also harmed by the violence. Similar to presence of children, socioeconomic status, religion, and their link to help seeking is limitedly understood. It draws on the fact that studying influence of factors on help-seeking in the case of IPV based on statistical associations is sufficient and the interplay between different factors as well as further exploration needs to be considered at all times.

The role of community is major. The community's strict gender norms and violence condoning attitude do not only allow perpetration of violence but also interferes with women's ability to appraise the problem. The culture in Bangladesh shames the victim and not the perpetrator, which is the first thing that needs to be addressed on the way to addressing IPV. The role of informal support networks such as family and friends are found as strong influencers of women's formal help-seeking. The strong influence of community norms and community members demand inclusion of community-based approach in government's multisectoral strategy to address VAW.

While factors that perpetuate IPV are well established in the literature, this paper draws on the stages of help seeking of a woman following IPV and different factors influencing the pathway to the uptake of services. The quantitative findings from the study are also put into perspective by the qualitative findings. Some questions remain unanswered due to lack of data, variation in results and limited scope of the study. Nonetheless, the literature review allows an in-depth understanding of help seeking process and generates valuable information on the influencing factors of formal help seeking; which are integral to address intimate partner violence in Bangladesh.

6.2 Recommendation:

Below are some recommendations based on findings to improve knowledge, response, and service utilization for IPV victims aimed at researchers, government, and non-government organizations.

Research:

- Researchers should analyze factors related to services including demand and supply side for a better understanding of gaps in the services.
- Policy and institutional analysis should be carried out by researchers to address IPV.
- Operational research should be carried out to evaluate the impact of individual and group counselling on IPV victims.

Intervention:

- NGOs working to address IPV should undertake community-based intervention that includes community education on IPV as well as advocacy for community support to encourage IPV victims to seek formal help.
- Information and education regarding "intimate partner violence" and support services should be circulated through text messages and digital media as a part of "MSPVAW programme" of the government of Bangladesh. Information about "IPV" should be made explicit in the education material of VAW used by the programme.
- Minister of health and family welfare (MOHFW), home minister, and responsible departments should arrange to train service providers (health and legal) to respond to victims in an appropriate way guided by best practice.
- MOHFW should consider entry points like primary health care or antenatal care to integrate IPV services in existing health system to improve access by rural women; which needs to be followed up by a functional referral system.

Policy:

- Loopholes in the legal framework that allow child marriage and intimate partner violence (especially sexual violence) should be addressed and laws should be strongly implemented.
- Minister of education and minister of public administration should formulate policies to improve retention of female students in upper secondary education and expand public service roles for women.
- Engaging men should be included in the national multisectoral strategy to address violence against women.

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8 ANNEXES:

8.1 Original model of help attainment process:

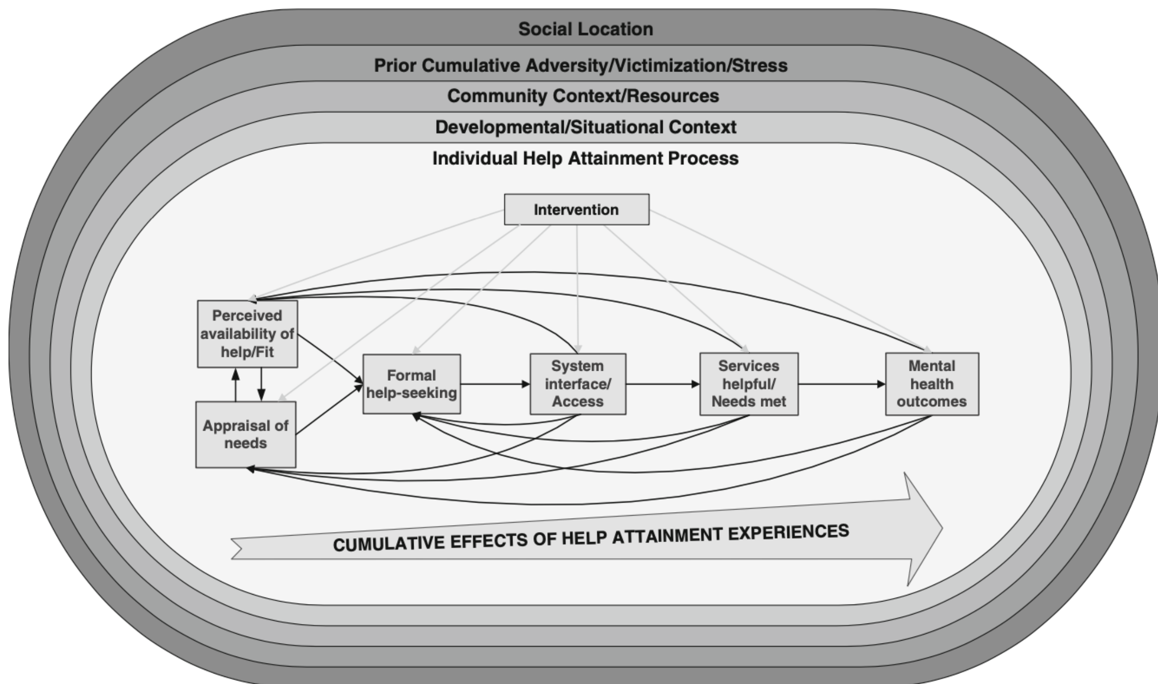

Figure 11 Conceptual model of help attainment process of physically and sexually victimized women by Kennedy (10)

8.2 Acts and laws to address Violence against women in Bangladesh:

- Constitution
- Convention on the Elimination of all forms of Discrimination against Women (1979)
- The Dowry Prohibition Act (1980)
- The Family Courts Ordinance (1985)
- Convention on the Rights of the Child (1989)
- Suppression of Violence against Women and Children Act, 2000 (the *Nari O Shishu Nirjatan Daman Ain*, 2000 (NSA))
- Domestic Violence (Prevention and Protection) Act (2010)
- National Children Policy (2011)
- National Women Development Policy (2011)
- Domestic Violence (Prevention and Protection) Rules (2013)

Figure 12 Acts and laws to address violence against women in Bangladesh(113)