HEALTH-SEEKING BEHAVIOR OF WOMEN SUBJECTED TO INTIMATE PARTNER VIOLENCE IN ETHIOPIA

Literature review

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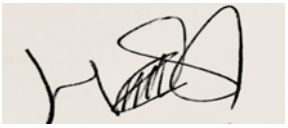
A thesis submitted in partial fulfillment of the requirement for the degree of
Master of Science in Public Health
by
Helena Hailu Fantaye
Ethiopia
Declaration:
Where other people's work has been used (from either a printed source, internet or any other source), this has been carefully acknowledged and referenced in accordance with departmental requirements.
The thesis, Health-seeking behavior of women subjected to intimate partner violence in Ethiopia, is my own work.

Signature: 

56th Master of Public Health/International Course in Health Development (MPH/ICHD)
16 September 2019 – 4 September 2020
KIT (Royal Tropical Institute)/Vrije Universiteit Amsterdam
Amsterdam, The Netherlands
September 2020

Organized by:
KIT (Royal Tropical Institute)
Amsterdam, The Netherlands

In co-operation with:
Vrije Universiteit Amsterdam (VU)
Amsterdam, The Netherlands

DEDICATION

I dedicate this thesis for my legendary Grand Father, Sany Nasser, who passed away while I was in the Netherlands, taking the one year master program.

ACKNOWLEDGEMENT

First and most I would like to thank the almighty God.

Second, I would like to acknowledge the Royal Tropical Institute, Amsterdam, The Netherlands for their technical and academic support. The enthusiasm of their staff strengthened me to complete this thesis.

My deepest and special appreciation goes to my beloved husband, Amanuel Abera and son, Nathan Amanuel, who's encouragement, guidance and support has brought me this far.

My sincere gratitude also goes to my Mother, Etaferahu Sany and Father, Hailu Fantaye, for your support and love throughout the program.

To all my families and friends, I say, "አመሰግናለው" for the encouraging messages and support.

God bless you all.

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ABBREVIATIONS

AIDS= Acquired Immune Deficiency Syndrome

ANC=Antenatal care

CAR= Contraceptive Acceptance Rate

CHE= Current Health Expenditure

DALY=Disability Adjusted Life Year

DHS= Demographic Health Survey

EDHS= Ethiopian Demographic Health Survey

EFY=Ethiopian Fiscal Year

FP=Family Planning

GC= Gregorian calendar

GDP=Gross Domestic Products

HC=Health Centers

HDT=Health Development Team

HIV= Human Immunodeficiency Virus

HEP=Health Extension Program

HEW=Health Extension Workers

IPV=Intimate Partner Violence

KM= Kilo Meter

LMIC=Low and Middle Income Countries

MOE=Ministry of Education

MoFED= Ministry of Finance and Economic Development

MWA=Ministry of Women Affairs

MOH=Ministry of Health

NGO=Non-Governmental Organization

OOP= Out of Pocket Payment

OPD= Outpatient Department

PHC=Primary Health Care

PHCU=Primary Health Care Unit

PNC=Post Natal Care

SNNPR= Southern Nations, Nationalities, and Peoples Region

SRH=Sexual and Reproductive Health

STI= Sexually Transmitted Infection

UNICEF= United Nations Children's Fund

UHC=Universal Health Coverage

WHO=World Health Organization

GLOSSARY

- **Access to health care services**: is defined as "the opportunity to identify healthcare needs, to seek healthcare services, to reach, to obtain or use health care services and to actually have the need for services fulfilled"(1)

- **Champion**s in the context of intimate partner violence in this paper refer to "social worker or someone set aside by the Department of Health, with the recommended attributes and motivation, who would work in collaboration with primary care services. The Intimate Partner Violence champion provide comprehensive assessment and assistance by taking a history of abuse and attending to social, psycho- logical and legal issues. They also facilitate the five-week personal empowerment group process following the initial assessment."(2)

- **First line support for victim of violence**: means immediate support provided by health-care providers to women experiencing violence. It includes: "being non-judgmental and supportive, providing practical care and support that responds to her concerns, listening carefully, but not pressuring her to talk, helping her access information about resources, including legal and other services that she might think helpful, assisting her to increase safety for herself and her children, where needed and provides or mobilize social support. Providers should ensure that the consultation is conducted in private confidentiality, while informing women of the limits of confidentiality (e.g. when there is mandatory reporting)."(3)

- **Health seeking behavior**: is "any action undertaken by individuals who perceive them-selves to have a health problem or to be ill for the purpose of finding an appropriate remedy."(4)

- **Primary Health Care Unit(PHCU)**:"PHCU is the smallest division in the Ethiopian health tier system, and is the unit most accessible to the general population." (5)

- **Intimate partner**: "a partner in current marriage / cohabitation, relationships with ex-partners, and dating relationships." (6)

- **Intimate partner Violence**: Intimate partner violence (IPV) is the intimidation and/or actual act of "physical aggression, sexual coercion, verbal/emotional abuse and controlling behaviors by a former or present spouse in marriage or cohabitation and in non-marital dating relationship"(7).

- **Emotional violence**: "say or do something to humiliate a person in front of others; threaten to hurt or harm a person or someone close to a person; insult or make a person feel bad about him or herself." (7)

- **Physical violence**: "push, shake, or throw something at a person; slap ; twist arm; punch with his/her fist or with something that could hurt a person; kick, drag, or beat up; try to choke or burn a person on purpose; or threaten or attack with a knife, gun, or any other weapon." (7)

- **Sexual violence**: "physically force a victim to have sexual intercourse with perpetrator even when a person did not want to; physically force a victim to perform any other sexual acts a person did not want to; force with threats or in any other way to perform sexual acts a partner did not want to." (7)

- **Sexual and reproductive health service**: includes care for "improvement of antenatal, perinatal, postpartum, and newborn care; provision of high quality services for family planning, including infertility services: elimination of unsafe abortions and provision of comprehensive abortion care; prevention and treatment of sexually transmitted infections, including HIV, reproductive tract infections cervical cancer, and other gynecological morbidities; addressing violence against women and girls and promotion of healthy sexuality." (6)

- **Violence against women**: "any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life. It includes intimate partner violence, non-partner sexual violence, trafficking, and harmful practices such as female genital mutilation." (6)

ABSTRACT

Background

In Ethiopia, violence against women is a very common societal as well as a public health problem. Hence, intimate partner violence (IPV) found to be the major form. IPV resulted ranges of health consequence on the victims as well as their children. However, in Ethiopia, only 2-3% of IPV victim women seek help from health care. This study explored factors influencing the health-seeking behavior of women subjected to IPV and identified effective interventions to improve health care utilization among them.

Methodology

The study is a literature review. Levesque et al. (2013) model for access to health care was used to analyze findings.

Results

The factors that influenced health seeking behavior of women subjected to IPV in Ethiopia were individual and social factors; perceived IPV as normal and acceptable, permissive culture towards IPV and submissive gender norms as well as low women autonomy. Health system factors: lack of screening and transparency, stigma and judgmental behavior among health care providers and distance from health facility were equally important to influence health seeking behavior of women subjected to IPV. "Three tier model" for early case detection and continuum of care in clinical, social, psychological and legal support found to be effective intervention to increase health care utilization of women subjected to IPV. In addition, gender transformative actions to empower women and raise awareness about IPV using social groups, various campaigns and local Medias were also identified as effective approaches to increase women's uptake in health system.

Conclusion and recommendations

Access to health care for victims of violence is low and interventions that have proven to be effective in addressing access must be expanded. Community mobilization and women empowerment to address gender inequality and poor perception towards IPV is very crucial. In addition, strengthening health care operation through expanding selective screening and reviewing staff training curriculum to incorporate issue of IPV should be considered.

Key words: Violence against women, intimate partner violence, access, health seeking behavior

INTRODUCTION

Violence against women is a human rights violation(6). However, in most countries, governments give less attention to tackle the problem, especially if it happens between intimate partners(6)(8). There are three forms of Intimate Partner Violence (IPV); physical, sexual and psychological. Each form of violence can happen separately or in any combination during the life time of women. The concept IPV is interchangeably used with domestic violence.

"IPV is mostly perpetrated by men against women and globally 1 in 3 women have experienced IPV in their life time"(6). These women's experiences of IPV are primarily rooted in gender inequalities (9)(10) (11)(12). Generally IPV results in physical, psychological and sexual harm to the victim as well as affecting women's sexual and reproductive health and rights (6)(7)(13). Homicide is also a common consequence of IPV where "38% of murders of women are committed by their intimate partners"(6).

Health seeking behavior and use of health care is a fundamental in management of IPV(11). It is complex platform where individual or a population's interact with the health system.(4). Factors that determine health seeking behaviors are embedded in the individual, socio-economic and demographic factors, access to service and perceived quality of care in more dynamic and collective, way. It is complex and determined by patterns of factors which synergistically interact to develop patterns(14).

The selection of this thesis topic is due to my personal interest in the well-being of women subjected to IPV and related to my involvement as a clinician in treating victims of violence. In addition, my personal violence experience has put me to explore the challenges women face with regards to IPV and their health seeking behavior in terms of receiving appropriate information and access to services.

The thesis is organized in six chapters. The first chapter gives a brief description of the relevant background information about Ethiopia. The second chapter presents the problem statement, justification, objectives of the study and methodology. Chapter three describes the findings of the literature review regarding the factors influencing health seeking behavior of women subjected to IPV. Chapter four presents the findings on evidence-informed effective interventions. Chapter five discusses the findings of the study. Finally, chapter six offers conclusion and recommendations.

CHAPTER ONE: BACKGROUND INFORMATION ON ETHIOPIA

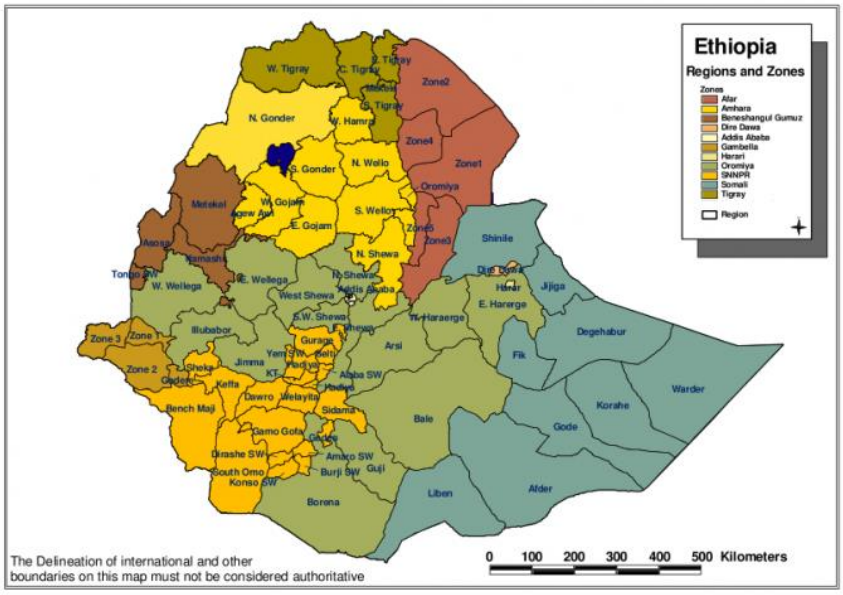
1.1. Geography

Ethiopia, one of the ancient countries, is found in eastern horn of Africa. It is surrounded by Eritrea to the North and North East, Djibouti and Somalia to the East, Sudan and South Sudan to the West, and Kenya to the south. The country covers an area of 1.1 million square kilometers. The country is administratively sub-divided into nine regional states and two Administrative councils. Regional states are Oromia , Southern Nations, Nationalities, and Peoples, Amhara,Tigray, Afar, Gambela ,Somali, Harari and Benishangul- Gumuz; whereas administrative councils are Addis Ababa and Dire Dawa.

1.2. Demography

The total population of the country estimated to be 109 million (2018) where women account for about half of the population. The median age in Ethiopia is 19.5 years. Life expectancy for female is 69.8 years and for men 65.9 years. 20.9 % of the population lives in urban area. The capital and largest city of the country is Addis Ababa(15). Women of reproductive age(15-49 years) constitute 23.4% of the population and 73% of women in Ethiopia ever had a partner in their lifetime(16).

Figure 1: Map of Ethiopia showing regions and zones, Ethiopia, 2003(17).



Source: https://reliefweb.int/map/ethiopia/ethiopia-regions-and-zones

1.3. Economy

Ethiopia's economy has registered rapid growth with a 10.9% annual average growth rate of Gross Domestic Product (GDP) in 2016.However, GDP per capita income of $790 makes Ethiopia one of the poorest countries in the world. Industry, mainly construction, and services based economic growth on top of agriculture and manufacturing contribute to reduction of poverty line.24% of the population lived below poverty line in 2016 compared to 30% in 2011(15). The Ethiopian constitution recognizes the principle of equality of access to economic opportunities, employment and property ownership for women. In line with this, Ministry of Women's Affair is established to sets up mechanisms for the improvement of women's conditions on equality(18).

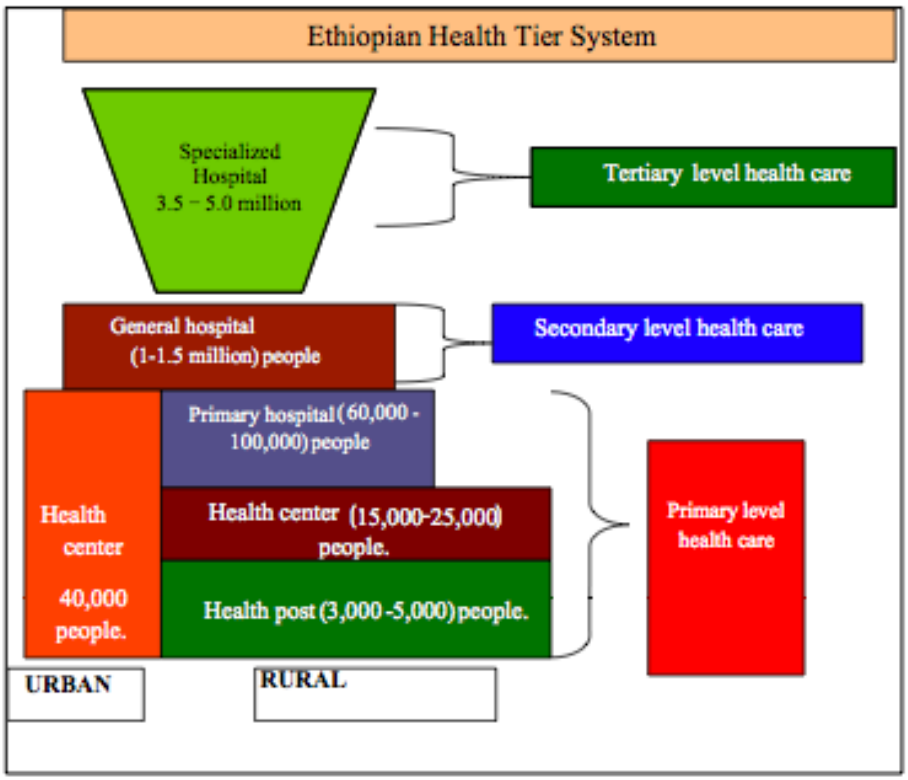
1.4. Education

Ethiopia has given due attention for expansion of primary (Grade 1-6), secondary (Grade 6-8) and tertiary level (Grade 9-12) teaching institutions to change the education status of its citizens. The net primary school enrollment is 95% in 2016/2017 and this is a fivefold increase from the year 1990 rate of 19%. Proportion of girls enrolled in primary and secondary education has exceeded 45% in 2014 as a result of the government's policy to empower women through enhancing girls' education. However, only 25% of girls completed secondary school, and an estimated 10% enroll in college (2018)(19).

1.5. Health system organizations

In Ethiopia health care delivery is provided in 3 tier system: primary health care(PHC) unit, secondary-general hospital and tertiary-specialized hospital(Figure 1)(20). Primary health care unit (PHCU) is the most accessible component that is comprised of five health centers (HC), each having five satellite health posts, and a primary hospital. Each health post covers an estimated 3000- 5,000 people of rural residents. A health center covers up to 25,000 rural residents and 40,000 people in urban residents. Primary hospital provides inpatient and ambulatory services to an average population of 60,000 - 100,000 where it serves as a referral center for HC. According to national referral guideline, Primary hospital is level of care and the first point of contact for clinical management of violence and assault(21). Secondary level health care comprises a general hospital, which provides in-patient and ambulatory services to an average of 1 million-1.5 million people. Tertiary level health care is provided by a specialized hospital for an average of 3.5 million - 5 million people(22).

Figure 2: Ethiopian Health Tier system, Ethiopia,2015(20).



1.6. Health Care Utilization

Generally, in Ethiopia, health service coverage has reached 86.7%(23).However, health care utilization rate was as low as 45.6%, ranging from 35.5% utilization rate in the government facility to 18.5% in private facility(24)(25)(20)(26). This could be because of gender inequality in health care utilization, income below poverty line, cost of health care poor perception of health status and uneven distribution of health facility(27)(26). In the year 2015, there were 3586 health centers in Ethiopia with national average functional health center to population ratio of 1:25,395. National outpatient department (OPD) attendance per capita is 0.48. The most common cause of hospital admission for female is child delivery (39.5%)(28). The ratio of health professionals per 10,000 populations is 0.88 for midwifery and 4.93 for all nurses respectively(28). According to National Health Account, Ethiopian Health Expenditure (CHE) was 4% of GDP(2017) where government expenditure accounts for 11.1% (2015) (28)(29). The total expenditure on reproductive health and PHC expenditure accounted for 13% and 14.69% of CHE respectively(18).

Nearly 98% of public health facility provides basic emergency care and maternal health service as well as essential reproductive health services (5).However, the national Universal Health coverage(UHC) service capacity and access coverage for the year 2015 was only 20%, with large variations across regions, ranging from 3.7% in the Somali region to 41.1% in the Harari region (23). This could be due to inadequacy and inequality in health service coverage as well as catastrophic out- of- pocket (OOP) spending for health care.

Maternal health and family planning services are important indicators to determine the health service coverage for women of reproductive age group(28). As illustrated on figure 3 here below, antenatal care (ANC) and deliveries attended by skilled birth attendant show increment(Figure 3) (30). Similar trend was also observed in contraceptive acceptance rate (CAR) (Figure 4)(28).The improvement in essential health service such as ANC and institutional delivery are attributable to large economic growth and introduction of innovative health policy strategies such as the Health Extension Program (HEP)(31). Therefore, it is in the government's interest to further improve the stock, distribution and performance of relevant health workers especially health extension workers in Ethiopia, particularly to bring about improvement in access to maternal health services for the poor(32)(Annex 1).

Figure 3: Trends in antenatal and delivery care coverage, Ethiopia,(2005-2019 GC.)(30).

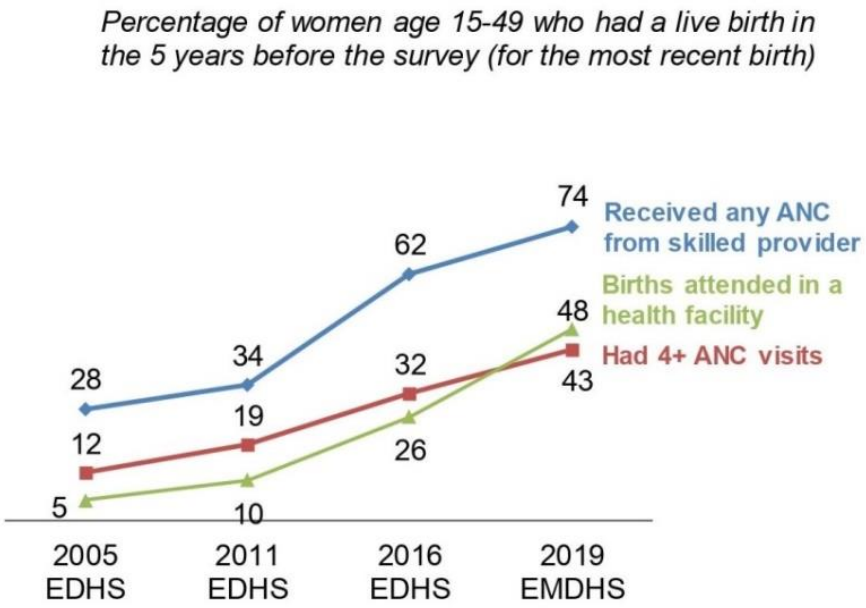
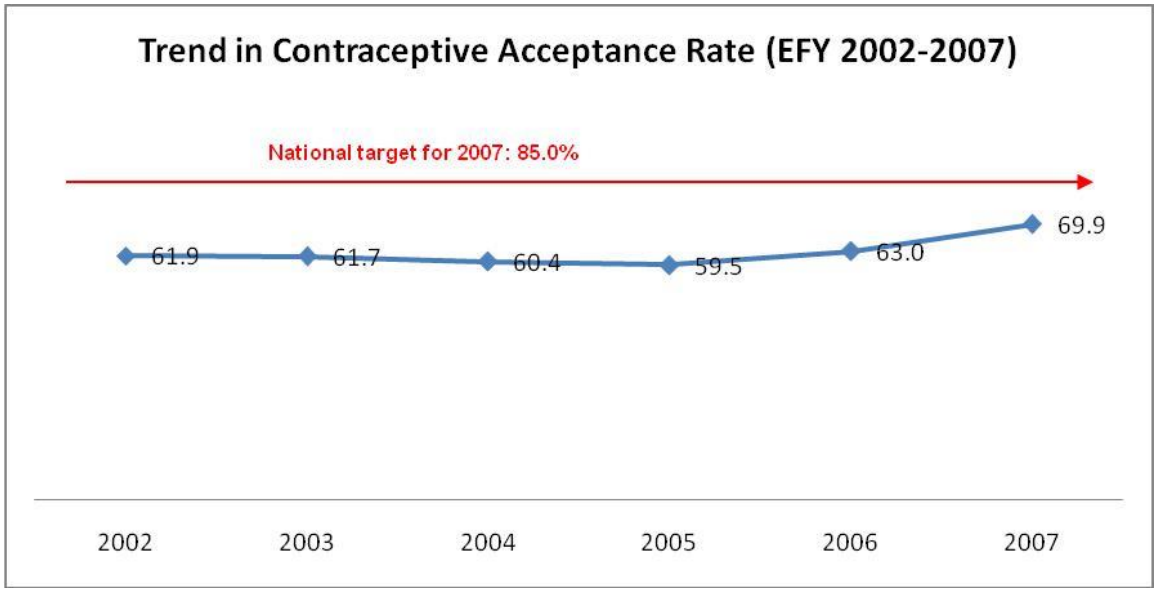


Figure 4: Trend in contraceptive Acceptance Rate, Ethiopia, (2002-2007 EFY)/(2010-2015 GC.) (28).



CHAPTER TWO: PROBLEM STATEMENT, JUSTIFICATION AND METHODOLOGY.

2.1. Problem statement

Eastern and Southern Africa have high prevalence of IPV (5) (6). According to a WHO multi country study, life time IPV on ever-partnered women ranged from 15% to 71%, where Ethiopia recorded the highest rate of IPV. Hence, sexual assault or rape by an intimate partner was considered as a major concern in the country (2).

In Ethiopia, violence against women is a very common societal as well as a public health problem, IPV being the main form. Systematic reviews done in Ethiopia showed a lifetime prevalence of all types of IPV against women ranging from 20% to 78 %; physical violence, sexual violence and emotional violence being the most common causes(Table 1)(12)(33). These occurrences of IPV varied from region to region. The highest was seen in East Wollega, Oromia region(76.5%)(34), whereas the least occurrence was recorded in Somali region(9%)(9). The variation could be explained by interregional; socioeconomic and cultural disparities as well as difference in societal openness to claim the problem (35).

Table 1: Prevalence of various forms of IPV, Ethiopia,2015,2018 (12)(33)

Forms of IPV	Prevalence of IPV in ranges (%)
Physical	31-76.5%
Sexual	19.2-59%
Emotional	51.7%
All forms of IPV	20-78%

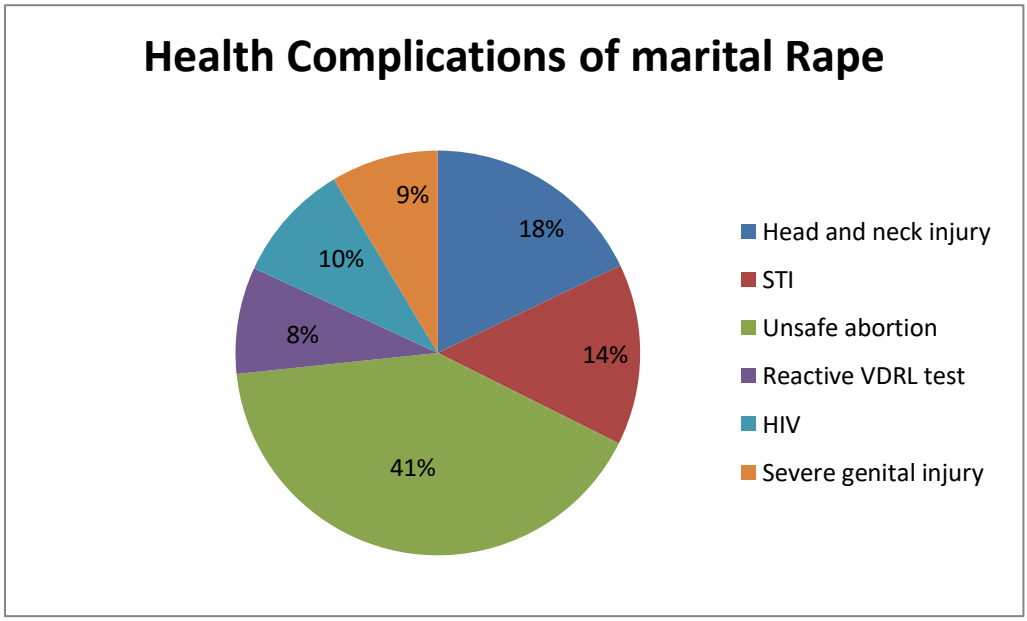
A significant number of women also experience IPV during their pregnancy period that can cause serious problem to the mother, fetus and the child afterwards. A meta-analysis done in Ethiopia on IPV among pregnant women showed overall prevalence of IPV in pregnancy reported as 26.1% with region specific variation(Table 2) (10). Although it is not as common as violence against women, men are also violated by their spouse/intimate partner (4%)(36). A study done at national level identified 2% of boys have been forced into having sex(16).Emergency settings in the country such as war zones, crisis and internal displacements are situations where men and boys are prone to sexual violence and abuse. However, due to social stigma and low awareness among male victims of violence, there is underreporting to formal institutions irrespective of their relationship with the perpetrator (37).

Table 2:Prevalence of IPV in pregnancy, Ethiopia,2018 (10)

Regions	Prevalence of IPV in pregnancy (%)
Oromia	35
Amhara	29
Tigray	20.6
SNNPR	16
Addis Ababa	29.3
National	26.1

In Ethiopia, IPV is found to be associated with a range of health consequences on the victims. Some of the consequences include superficial to deep body and genital injury, burns, fractures, chronic pain syndromes and mental instability, problems with hearing and sight, arthritis, seizures, headaches, sexually transmitted infections (STIs), HIV, and pelvic inflammatory disease as well as unwanted pregnancies. In the worst cases, IPV can be fatal resulting in murder, suicide, maternal mortality, antepartum hemorrhage, unsafe abortion, stillbirth and STI/AIDS(10)(35)(38)(39)(40). It also causes low birth weight and premature labor that can result in increased neonatal and under five child mortality(2). The result of care provided to women in Adigrat zonal hospital showed women who sustained sexual assault by intimate partner presented to the hospital with various SRH complication (Figure-4)(41).In addition the study result also showed the social impact of violence was huge where 32.6% of women got divorced or separated from their partner after the incidence of sexual violence.

Figure 4: Health complication of intimate partner sexual assault, Adigrat Zonal Hospital, Tigray region, Ethiopia,2004(41)



Despite the health consequences of IPV, women neither disclose the presence of violence nor seek health care for their health problem. Various studies also confirmed violence against women was usually underreported(41)(42) and the health system has been responding inadequately(12). According to the National Health Survey done in 2016, only 23% of women who experienced IPV had reported or talked to anyone and only 2%-3% actually sought help from the health sector(36). Compared to physical violence, sexual violence is the least reported act of IPV and victims living in rural settings, housewives and women without paid job were less likely to seek help from formal sector like health facility(36)(12)(43). Women's attitude towards tolerating IPV, lack of societal openness to discuss reproductive health issues, fear of stigma, lack of women's autonomy and poor access to health care have a significant role to play in the health-seeking behavior of women subjected to IPV(34)(35)(38). Commonly, health- seeking behavior starts with recognition of the problem and ability to decide to seek health care which links to the ability to access health service delivery(44).

Health sectors play an important role to improve the health outcome of survivors of IPV (3). This includes health care delivery to IPV victims which usually incorporates but not limited to emergency services, sexual and reproductive health services, HIV testing, mental health, and referral services for other support as needed(45)(44). Likewise health sectors play a great role in prevention and reduction of IPV through providing health promotion and education to the community(46).

2.2. Justification

The occurrence of IPV is causing a huge burden to the country. The morbidity and mortality ratio due to violence against women exceeds a collective burden of cancer, malaria and road traffic accidents(47). In various WHO multi-country studies, 16% of women who have been abused by their partners were more likely to have a low-birth-weight baby, over twice as likely to have induced unsafe abortions, almost twice as likely to experience depression, three times likely to attempt suicide and 1.5 times likely to acquire HIV, as compared to women who have not experienced intimate partner violence(8)(38)(47). Sexual violence including rape by intimate partner was also associated with unwanted pregnancy, HIV and other STIs (34)(35). Women who sustained IPV in Ethiopia were usually under male controlling behaviors to determine their sexual and reproductive life(39). Hence, they were less likely to be tested for HIV, use contraceptives, practice safe sex including use of condoms, go for ANC and attend skill birth delivery in health facility (40) (43). Thus, due to

poor health-seeking behavior, women suffer from IPV complications, and even death(7)(48). These affect the society and economy of the country as a whole(35). Therefore, establishing legislations that aid IPV prevention and improving health seeking behavior of women are the two core intervention areas that can be implemented to reduce the consequence of IPV (11)(49).

Even though there are adequate numbers of research towards identifying the incidence and prevalence of IPV, the perspective of women and their response towards the act of violence is not well studied(35)(50). Various studies have been done on health system response to violence against women(46)(51)(52).However, it is equally required to analyze factors influencing the health seeking behavior of women from the individual and societal contexts in order to improve service utilization and establishing resilient health systems towards violence (53)(9)(35). In addition, I have also witnessed from my clinical professional experience that integrated care of secondary prevention and treatment for IPV victims was only provided once victims actively claimed they had experienced repetitive IPV. Otherwise neither routine screening for IPV nor dedicated organized services are available to provide support and information for the victims. (Personal observation)

Hence, this study tried to identify and analyze the contributing factors that influence the health-seeking behavior of women subjected to IPV. In addition, effective interventions that improved health seeking behavior of women subjected to IPV in similar settings were explored. The paper only focused on IPV, committed against women, because of the high prevalence of IPV against women in Ethiopia. Recommendations were provided to policy makers, governmental bodies, non- government organizations (NGO), and civil societies based on the research findings that could enhance the utilization of health services among women subjected to IPV.

2.3. Research objectives

2.3.1. General Objective:

To explore factors influencing the health-seeking behavior of women subjected to IPV in Ethiopia and similar other settings in order to provide recommendations mainly to the ministry of women affairs and ministry of health to improve health care utilization of women subjected to IPV.

2.3.2. Specific objectives:

1. To explore personal, cultural and socio-economic factors that influence the health seeking behavior of women subjected to IPV
2. To determine health system factors that influence health-seeking behavior of women subjected to IPV
3. To analyze effective interventions that address health-seeking behavior of women subjected to IPV, in Ethiopia and relevant other settings
4. To provide recommendations to the ministry of women affairs and ministry of health ~~for~~ to improve health care utilization of women subjected to IPV

2.4. Methodology

2.4.1. Study design

The study design used for the current paper was literature review that investigates the factors determining the health-seeking behavior of women subjected to IPV

2.4.2. Search strategy

A comprehensive literature review which included peer reviewed academic literatures, grey literature search and desk review were conducted for articles published between 1st January, 2004 until 31st December, 2019. Online databases including Google scholars, Cochrane Library and Web of Sciences, PUBMED, MEDLINE, and the VU library databases and grey literatures like World Health Organization, Ministry of Health, Ministry of women affairs, Ethiopian journal website were used. Snowballing technique was also used for literature search. Some of the keywords used were: health care needs, perception of needs and desire

of care, health care seeking, health care reaching, and intimate partner violence (for detail see annex-2 Search Table).

2.4.3. Inclusion/Exclusion criteria

Inclusion criteria: Studies addressing any form of life time IPV against women; physical, sexual, and psychological violence or a combination of any of the three, committed by intimate partners regardless of the legal status of their relationship, were included.

Exclusion criteria: year of publication from 2004 backwards were excluded. The cutoff year was used to include important frameworks and international and national policy documents relevant for this subject. Non-English language articles were also excluded. Articles, whose violence measures were not in line with the IPV definition used in this paper, were also excluded.

During reviewing of each article, initially, the title and the abstract were critically reviewed for exclusion and later on full document was thoroughly read to include the paper for analysis. Hence, in total, 374 potentially relevant articles were retrieved, from which 204 articles were removed with further screening of full title and abstract. 170 full text articles were further assessed for eligibility and from these 67 articles did not meet the eligibility criteria. Finally, 103 articles that fulfilled the eligibility criteria were included in this literature review.

2.4.4. Conceptual frame work

A conceptual framework developed by Levesque et al. 2013 was used for analysis (54)(figure.4). This model conceptualized access in terms of "the fit between characteristics of providers and health services, and characteristics and expectations of clients."(55) The Levesque conceptual framework was selected for the current paper because it helped to identify, analyze and interpret findings in different dimensions in stepwise manner. The dimensions in the framework were in continuing levels and incorporated determinants from demand and supply side, indicated ways to identify factors influencing health care utilization.

Compared to "Three delay models" and "Ecological model", Lévesque access framework gives a broader and extensive range of determinant factors; incorporating individual, social and environment factors as well as health system factors. Other models, such as social determinant model, are mainly based on bio-medical and quantitative approach. Instead of

focusing on the steps, social determinant model gives focus on highlighting a set of determinants which are associated with the choice of different kinds of health service. Meanwhile, in the "three delay model", the role of the health system is particularly defined through the issue of accessibility and quality of care, and plays a major role in mediating the differential consequences of delays in people's health care utilization. The socioeconomic and cultural factors were also limited in "three delay model" to effect the decision for seeking health care and there is no linkage between factors determining the health care utilization(56).

The conceptual framework by Levesque model determines access from the perspective of health care needs, perception of needs and desire of care, health care seeking, health care reaching and health care utilization. Health care consequences were not incorporated for this study. This was because of the fact that the aim of the current study was to give in depth analysis of the problem from user and supply side that determine health seeking behavior of women subjected to IPV to improve health care utilization. In addition, due to very low uptake of services, there were insufficient studies available on factors influencing health care consequences such as economic impact and patient satisfaction of those who utilize care. Hence, the current study targets to use the framework to explore factors linked to health seeking behavior of women subjected to IPV that lead to health care utilization.

Therefore, in usage of the framework, the upper dimensions referred to supply-side factors, whereas, the lower dimension belonged to demand-side factors. The socio-demographic factors such as age, marital status, education, occupation, ethnicity and religion were intertwined in personal and social values found on demand side accordingly.

Based on the framework, the demand-side factors include ability to perceive, ability to seek, ability to reach, and ability to pay for health care. The ability to perceive is determined by health literacy, education level, expectation or beliefs about IPV and perceived severity of the disease whereas the ability to seek is the woman's autonomy to seek health care based on personal and social values, such as gender and culture. Afterwards, their ability to reach health facility depends on people's personal mobility, severity of injury, social support, living environment and residency area such as urban and rural as well as availability of transportation. Their willingness to pay after reaching the health services is influenced by factors like personal income, assets, social capital, and health insurance.

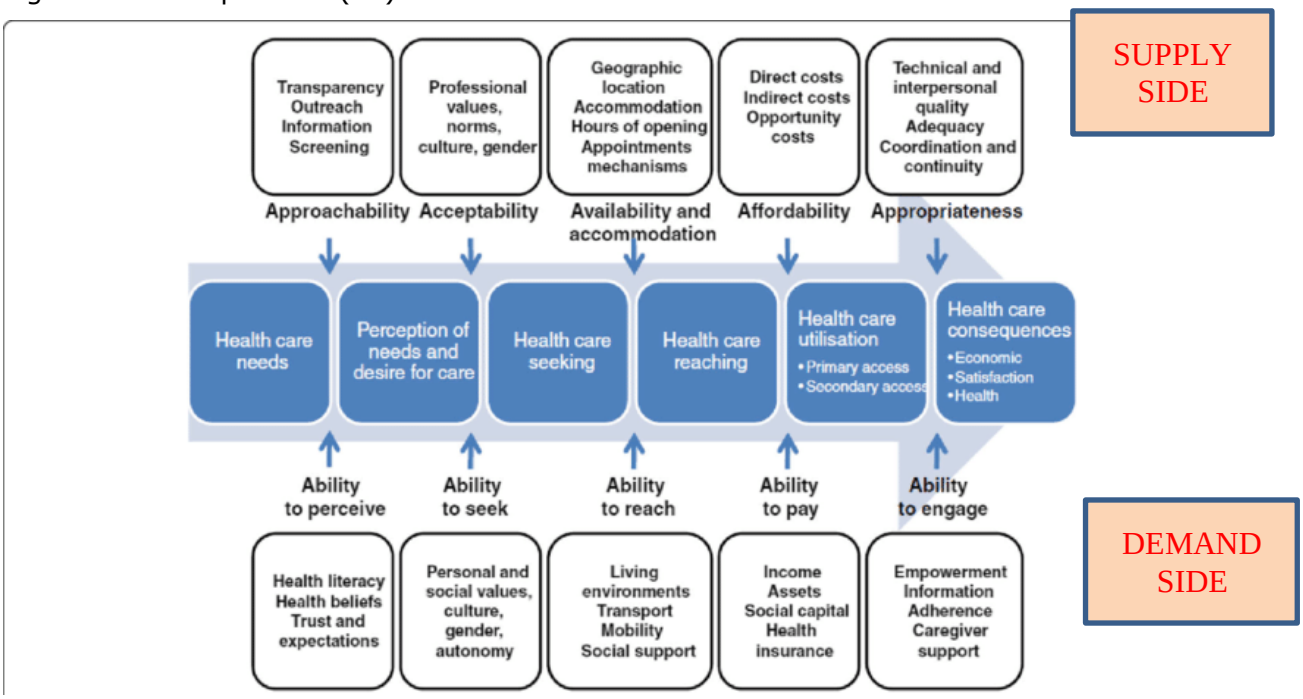
The supply-side factors of the frame work include approachability, acceptability, accommodation, affordability and appropriateness of health services. Approachability

includes transparency, outreach, information, and screening. Acceptability is explained as professional values of health care providers, norms, culture, and gender. Availability and accommodation of health facilities are also dimensions on the supply side which include geographic location, hours of opening, and appointment mechanism. Finally, affordability of the health service incorporates the cost of health care including the direct, indirect and opportunity costs. (1).

The current paper will also discuss effective interventions that address health-seeking behavior of women subjected to IPV using criteria of applicability and feasibility to address the major issues identified to influence health seeking behavior of women subjected to IPV.

This literature review was conducted from May 2020 to August 2020 reviewing studies conducted in Ethiopia and similar other settings. Literatures from similar settings were used to strengthen the evidence and explore good practices that address health-seeking behavior of women subjected to IPV.

Figure 4: Levesque et al.(54) Model of access to health care.



2.4.5. Study Limitations

The methodology for this thesis is a review of literature because it was not possible to collect primary data due unavailability of funds and country's lockdown due to COVID-19. This may limit its reflection on the real and current situation of the problem in the country. Only English written articles were selected for review. There might have been relevant literature in other languages in similar settings within the region which were not included in this study. The literature review was done by single reviewer. The review only focused on women although men are also victims. It was also difficult to find literature on the cost of care specific to IPV; rather the general cost of health delivery was used for analysis. The research did not focus on the causes of IPV and how these can be reduced or prevented.

CHAPTER THREE: RESEARCH FINDINGS ON FACTORS INFLUENCING HEALTH-SEEKING BEHAVIOR OF WOMEN SUBJECTED TO INTIMATE PARTNER VIOLENCE IN ETHIOPIA

This section represents the findings regarding factors influencing health-seeking behavior of women subjected to intimate partner violence in Ethiopia from a demand and supply side perspective. It is structured in accordance with Levesque et al.'s (2013) (54) conceptual framework of access to health care. Factors identified according to the conceptual frameworks are as follows:

3.1. Perception of needs and desire for care

Perception of health care needs and desire of care is formulated by the ability to perceive and approachability of healthcare facilities. Ability to perceive is determined by factors such as health literacy, health beliefs, trust and expectations on health care made by women subjected to IPV. Approachability factors include transparency, outreach, information and screening made by health care providers(54).

3.1.1. Ability to perceive

A. Health literacy

Health literacy is the ability to obtain, read, understand, and use healthcare information in order to make appropriate health decisions and follow instructions for treatment. It is a product of health education and communication activities(57). It is affected by individual's educational level, decision making ability and access to information. Lack of knowledge and information about health is an important barrier to accessing services. Some of the victims reported that they did not know the availability of help or how to receive medical assistance(44). On the other hand, illiteracy and the lack of education in women were associated with lack confidence and low decision making ability to seek healthcare(58).

Schools and working places are important means to access health information that ultimately determines desire for care(57).A study done in Butajiera zone presented that, women with no formal education and who have limited access to meetings, mass media and printable messages had less understanding about health and IPV(48). Similarly, a meta-analysis study by Musa et al. (59) showed women and their husbands who received high level of education or those women with an educated head of household were more likely to realize health care needs and utilize adequate maternal health services after sustaining IPV.

A study done by UNICEF in Ethiopia also indicated that, women with no education were more likely to accept violence and less likely to desire for health care from modern health care providers than women with above secondary level education (16).

In addition, a study done in southwest Ethiopia showed that, unemployed housewives were less likely to report sexual violence than working women (60).This is because of their lack of awareness and poor access to information about their right, and the non-existence of protective laws for women against IPV (59). These findings were also seen in multi-country systematic study done in low income countries(Bangladesh, Cambodia, Colombia, Egypt, Ukraine and Zambia) including Ethiopia(61).The results described high maternal and partner education level, urban residency, richer household wealth level, and working/ employed women were more likely to access information through mass media, printable, and via peer discussions about health and modern medicine which increased maternal health services utilization after experiencing IPV (62).

B. Health Beliefs

Belief on health status and severity of a disease were also found to be significantly associated with health care seeking behavior of women subjected to IPV(27)(26). From a qualitative study done in South-West Ethiopia, the odds of health care seeking behavior were three times higher among those who perceived their illness was serious than those who didn't(62). Women who perceived their health status as poor and very poor after sustaining IPV were 11.7 and 13.1 times more likely to visit the health facilities, respectively, than those who perceived their health status as very good (26). Women subjected to IPV usually believe about their health as disrupted and desire for care only if their situation got worse or "severe enough" to be life threating (44). Similarly, a study in northern part of Ethiopia reported that, among women who sustained IPV injury in the last 12 months prior to the study, those who believed their illness were life threatening and severe visited health facility more likely than those perceived mild illness(27).

C. Lack of trust

Lack of trust on health care providers and non-youth friendly environment in health facility to talk about IPV by young women are another factors influencing perception towards health care(44). In Ethiopia, an inclusive multi-country systematic review study described younger pregnant women who sustained IPV had lower likelihood of utilizing adequate ANC and skilled delivery care. Women subjected to IPV aged 15–24 were less likely to receive skilled

delivery compared to those above 24 years of age(59).This could possibly be related to lack of trust on health system because of poor professionalism as well as low decision making ability among youngsters. Victims of IPV usually trust spiritual personnel more than health care workers, expecting them to better respect confidentiality(63). In addition, in Ethiopia self-medication was practiced in 43% of cases; those victims of IPV who want to report their condition went to traditional healing places like 'Tsebel' (Holy Water),'Wegesha' (traditional physiotherapy) and 'Kalicha' (Traditional Psychotherapy). The reasons found was perceived knowledge of treatment, trust for the traditional healing places and expectation of lower cost (62).

3.1.2. Approachability

Approachability relates to the fact that people facing health needs can actually identify that some form of services exist, can be reached, and have an impact on the health of the individual. (54).Transparency and outreach by health professionals to share information and advice are key elements for health service to be approachable and timely utilized.

Victims of IPV usually lack information about available health services for general health as well as IPV care(44). According to a systemic review done in Ethiopia, the majority of victims did not know where to go and what to do. This led to situations whereby women and girls, survivors of violence, decided not to report and seek help(64). According to Gossaye et al.(48), health care providers usually do not consider screening patients for violence and providing information or support to victims as part of their role". Rather patients only receive medical treatment to their clinical presentation and were sent back home.

Approaching the community regarding the topic of IPV and health advocacy in transparent, non-judgmental, and supportive ways by trained health professionals through outreach are major determinants of access (35). In Ethiopia, outreach in a health extension program is designed to provide health education and information through female health extension workers by visiting families/households(20). Female health extension workers were trained to approach women in households in a transparent and confidential way to address the issue of SRH. In addition, the package also constitutes family health and general health communication by engaging men or the head of households. Women who had frequent household visits by the health extension workers were 1.3 more likely to visit health facilities than women who did not have frequent household visits(65). In addition, a majority (91%) of rural women also claims the source of information for health and health related issues were from health extension workers. Women who received information from

health workers regarding general health and pregnancy danger signs after experiencing IPV were associated with adequate use of maternal health services(59).However, no evidence was found regarding information provided to women and/or men about IPV as part of a health problem which need care at the health facility. A study done in Addis Ababa showed that, women who received advice on the appropriate time of ANC initiation were more likely to book ANC timely compared to others (66) . However, most of the time, health care providers only educate and screen women on signs of physical injury and pregnancy danger signs , and failed to notice and screen health dynamics of IPV (40).

3.2. Health care seeking

Health care seeking is preceded by a decision making process that is further governed by individual and/or household behavior, community norms and expectations as well as provider related characteristics and behavior(4). It includes the ability to seek care and acceptability of health system. Ability to seek care is determined by factors such as personal and social values, culture, gender and autonomy whereas acceptability includes perceived professional values, norms, culture and stigma.

3.2.1. Ability to seek care

A. Personal and social values

The main factors for determining health seeking behavior of women subjected to IPV seem to be related to perceiving IPV as a private matter instead of a social and systemic phenomenon. Women usually do not want to disclose the issue because of stigma, shame, embarrassment or blame from the community(13) (42). Moreover, terrified of further violence, fear of divorce and family humiliation, or being threatened by perpetrator are causes that reinforce the inability to seek health care in case of intimate partner violence(35)(38)(42). The other factor is based on social and individual toleration towards IPV (18). Studies done in Ethiopia demonstrated that, violence against women was perceived as normal, acceptable and justifiable if it happened in marriage between husband and wife (35)(42)(67)(68)(69). In several studies conducted in Ethiopia, majority of women believed that, men have a right to beat their wife when she refuses to have sex with him, or abandon the family or household care (12)(16)(70). Similarly, a report from sub-Saharan African countries also supported the link of acceptance of wife beating with countries having low levels of female literacy such as Mali and Ethiopia(71). The Ethiopian DHS analysis showed that, an opposing attitude towards wife beating at individual and community level

were significantly associated with increased maternal healthcare service utilization(72).After violence, victims of IPV usually experience a loss of self-worth and self-esteem, which also affect women from taking care of their health and it affects their health seeking behavior (35).

B. Culture

The culture of tolerating IPV influenced health seeking behavior of victims of violence(41)(42)(43)(64)(68). In Ethiopia, forced sex in marriage has been accepted as normal and not viewed as a crime(41)(58).The Ethiopian culture mostly values maintaining marriage union than prioritizing the health of victims of IPV. The gender norms dictate women not to go elsewhere to tell the issue of their marriage. The culture rather condemns women, and forces them to keep their marriage issue a secret. It is expected from her to tolerate any violence to keep her partner, especially for the welfare of their children(42)(43)(64). If women accept and tolerate an abusive partner, her high level of endurance is appreciated and respected in the community. Thus, they tend to stay tolerant of every challenge from their abusive partner without reporting(41)(42)(43)(68). If she shared the IPV act to a third party, it resulted in isolation, shame, embarrassment, or blame (64). Culturally most victims, as a first measure, went to the local/village elders, religious leaders, relatives, or close friends for help. These were a safer space for most women to share confidential matters. In fact, these people often advised the couple to tolerate each other rather than visiting health facility(42).

C. Gender

Gender norms or expectations about men's and women's roles, rights, and responsibilities have shown to be associated with IPV and health seeking behavior(73). Women's role in the households and their responsibility to take care of their children limited their health seeking behavior. Multiparous pregnant women entered to ANC late and had decreased odds of using skilled delivery care when reporting any lifetime emotional or physical abuse , or recent sexual IPV (59)(74) . Experiencing IPV on top of pregnancy related physiological stress and fulfilling gender roles (take care of household activity and caring for existing children) may overwhelm women and restrict them from seeking health care(74). Gender norms coupled with limited awareness of women rights made many of the victims to deny the existence of rape by intimate partner. Since, culturally, in marriage the man can demand for sex at any time and woman's role is to satisfy it, most women accept marital

rape and live with it. As the result only 3% of women seek medical assistance after partner rape(16).

D. Autonomy

Women's autonomy and empowerment is a common indicator for seeking care and support from professionals(18). Intimate partner controlling behavior over their wives determines women's ability to seek health care(60)(75). Different studies done on the association of IPV and maternal health care utilization in Ethiopia and similar settings demonstrated the decreased odds of using antenatal care by victims of IPV and lower skilled birth attendant were associated with lack of women's autonomy and decision making in accessing health care services (59)(43). A study done in Adigrat Zonal Hospital also described women's autonomy in terms of economic dependence on their partner where reporting of marital rape to the health institutions were very limited (41). Furthermore, partner controlling behaviors on free movement of women prevented them from working and participate in economic activity. In addition, control women about their money expenditure as well as her dependency on the husband for economic reasons restricted women from sharing power and exercise autonomy. These all had a huge impact on health seeking behavior of women subjected to IPV(35) (38)(42)(43)(60). Partner's suspicious thinking of women as unfaithful also restricted the victims of IPV from going out and seek help(75) (59).In a qualitative study in northern Ethiopia, a woman who was victim of IPV narrated her husband's controlling behavior as "*When I begged him to take me to the health center, he always made excuses. Then the disease got worse as a result of the delay*"(76).This study also demonstrated the significant association of women's decision making power with healthcare service utilization. In 29 % of the women, there were concerns about getting permission from their partner to go for IPV treatment(16).

3.2.2. Acceptability

Women subjected to violence face several challenges from supply side. Acceptability relates to "cultural and social factors determining the possibility for people to accept the aspects of the service(54)." Some challenges of acceptability are poor perception towards IPV, stigma by health care providers, lack of confidentiality and gender discrimination (35)(48)(77).

From a study done in LMICs about services provided to IPV victims, health worker's attitudes and professional values hindered women subjected to IPV from seeking health care(78). Negative attitudes among health workers towards IPV manifest as: being

judgmental and blaming as well as considering IPV as a social problem and not a health problem. Health care staffs from a high income country's hospital, Australia, have also highlighted their struggle on maintaining non-judgmental attitudes and managing their feelings during IPV management—especially if they had personally experienced violence(79). According to a study in Ethiopia and South Africa, most primary care providers enrolled in the interview lack concerns and were reluctant on managing the victims of violence because of: "possible personal experiences with IPV; fear of invading clients' privacy and being targeted by partners; perception of IPV as a social not biomedical problem and their busy and heavy workload." These factors were found to affect the health seeking behavior of women subjected to IPV(80)(2).

Certain health care professionals were also disrespectful of women because of professional, class, ethnic, or gender hierarchy(78). There are a number of cases where women subjected to IPV are not taken serious by health staff because of influence from long-standing traditions of gender role in the community in Ethiopia (42).A study by Gossaye et al.(48) Concluded that stigma by health professionals might contributed to why many women felt reporting violence was unwise. This stigma happened among women who came for abortion, contraceptive or family planning claiming they were raped by partner in marriage or partnerships(41). When health professionals would not keep IPV report confidentially, it also causes potential stigma on the victims and their families. Due to the fact that IPV can lead to long term psychological problems and physical disability, disease associated stigma and discrimination can prevent survivors from seeking health services(76)(81). In addition, women who experienced violence had concerns about dual stigma if they are living with (or presumed to be living with) HIV or AIDS as well as having experienced violence(63). Most IPV survivors avoid going to health facility,especially, when health care workers in the nearby health facility are member of the community or relatives. When those health care workers disclose women's health status to their partner, family and community members, victim women become stigmatized and further violated (10)(35)(40)(63). Especially in rural Ethiopia , the sociocultural acceptance of the devaluation of women and stigmatizing IPV victims by front line workers, could impede women's access to care(35).

3.3. Health care reaching

Access to health care is usually limited because of difficulty in reaching health facility. While underutilization of modern health services is influenced by local beliefs, availability of those services and physical access are equally important(4). According to the Levesque et al.(54) Model, health care reaching is influenced by the availability and accommodation of health service where geographical location, hours of opening and appointment mechanisms play a crucial role. Meanwhile, social support, transport availability, capability to move and living environment of women subjected to IPV are determinants for women to be able to reach to health care.

3.3.1. Ability to Reach

Living environment is one of the crucial determinants for seeking health care in Ethiopia. Generally, health care utilization rate is higher in the urban area(81%) than rural residents(49.1%) (62). When it comes to women, those who resides in urban areas are also more likely to utilize health care than their counterparts ($p<0.05$) (35) (43)(59)(62). A national survey showed 15% of the urban and 7% percent of the rural women who sustained lifetime IPV received medical care(16). The scattered and nomadic-pastoralist way of living, like in Afar, and the harsh climate could also hinder women from accessing healthcare services(82).

Women's mobility also determines the ability to reach to health facility. Physical IPV and combined IPV which cause immobility is associated with reduced odds of reaching to health facility(59). Emotional/psychological violence against women is associated with late initiation of first ANC visit whereas physical IPV and sexual IPV are associated with poor utilization of four or more ANC during pregnancy(43).This is because of the traumatic nature of the sexual, psychological and physical violence. However, a facility based cross-sectional study done in Ethiopia found no statistically significant association between lifetime emotional or physical abuse and ANC utilization, rather women who reported recent sexual abuse were significantly associated with late ANC initiation (74). Existing physical disability is also a risk factor for avoiding health care for those sustaining IPV. A study done in northern Ethiopia on IPV-disability-gender relations among people living with disability showed that, help-seeking behaviors were often limited by characteristic of the disease (76).The study also highlighted the link between bias, discrimination and stigmatization against women living with disability that commonly enacted in the form of denial of societal support and lack access to social resources which had effect on seeking health care.

According to 2011 Ethiopian Demographic Health Survey, constraints in women's access to health care in general was mainly determined by lack of transport to a facility (71%), and being concerned about their workload inside and outside the home (61%). A study by Girma et al. (26)also demonestrated similar finding where absence of transportation was associated with lower chance of service utilization. Female victims of violence who are employed, resides in urban areas, who had their own motorized transport were more likely to utilize health care than their counterparts (43)(59).These also connected with low autonomy and decision making power of women that determine health care utilization of women subjected to IPV(62).

3.3.2. Availability and Accommodation

Availability and accommodation relates to the fact that "health services (either the physical space or those working in health care roles) can be reached both physically and in a timely manner. It constitutes the existence of productive facilities"(54). It constitutes the existence of primary level of care at the nearest geographical location possible to the community with accommodative and accessible working hours that are evenly distributed around the country. Entry points for victims of violence tend to be in ANC at primary level of care. This is because usually violence start or escalate during pregnancy that could be identified during ANC visit(78).

Important factors from supply side of health sector that affects women's decision to seek health care are; unable to reach for health care because of distance to health facility and their uneven distribution, lack of fully functional emergency service and sexual and reproductive health service, lack of trained health professionals, absence of active routine screening for violence by health providers, and poor referral systems in place(22)(35)(48)(77). According to 2011 EDHS, the most common barrier to access was long distances to a health facility (66 %). A study done by Begashaw et al. in southwest Ethiopia also showed households located within 10KM distance from health facility were 3 times more likely to seek healthcare than those located more than10KM (62) (26). Similarly, a study in Ethiopia on policy and practice towards addressing Gender Based Violence(GBV) described the association of farther distance to health facility with decreased access to health care(83).

In addition, accommodation of health facility affects health seeking behavior of victims of IPV. 56% of the women expressed concern about absence of a health provider at the health facility, while 53% specifically pointed out concerns about not getting a female health

provider(16). These determinant factors concerns victims of IPV. A study done in Tigray, Dire-Dawa and Afar region of Ethiopia showed statistically significant uneven distribution of health center between urban versus rural area and inadequate staffing in health centers with median of 6.2, 7.5 and 5.2 skilled health worker per 10,000 inhabitants respectively(82).A sub-Saharan Africa study also demonstrated long waiting time and lack of privacy discouraged women from accessing SRH services(84).

Flexible working hours have the potential to improve health care utilization among victims of IPV. Ethiopian health sector transformation identified inconvenient working hours of health facilities, in general, as one of the barriers to access(22).In addition, reproductive health strategy in Ethiopia demonstrated the importance of enhancing functionality of health facility including working after hours and 7 days a week had impact on increasing access to SRH services(18).

A lack of high-quality referral options, particularly in low-resource or rural areas, emerged as a barrier to access to violence care(78)(83).In emergency department, health care providers routinely referred IPV victim to higher level of health care delivery after providing medical treatment. This was related to lack of competencies in comprehensive management of IPV and described ineffective collaboration across professionals. This inappropriate referral and lack of coordination at primary care level have refrained women from accessing timely care(79).In humanitarian settings of Ethiopia, a psychosocial support team in a refugee camp conducted routine screening and offered referrals by communicating with the nearest health facility and made appointments for identified violence survivors. This increased the uptake of women subjected to violence in health system(80).

The legal restriction which causes unavailability of safe abortion in health facility for unintended pregnancy can prevent access to abortion care and lower health seeking behavior of women who sustained sexual intimate partner violence. Rape by intimate partner in marriage is not considered as criminal act under Ethiopian law and as a result, survivors cannot access safe abortion(85). According to WHO multi-country study, the prevalence of unintended pregnancy attributed to IPV in Ethiopia was 65% where majority of them ended up in unsafe abortion because of restricted law in abortion care in Ethiopia(86). As a result, the choices of IPV victims diverted to seeking unsafe abortion than going to health facility.

3.4. Health care Utilization

Health care utilization is influenced by cost of service and ability to pay in addition to local beliefs and availability of those services(4). Affordability "reflects the economic capacity for people to spend resources and time to use appropriate services"(1). It includes direct medical costs such as medicine, laboratory, medical care costs, and non-medical costs such as transportation, food and accommodation costs. In addition, indirect cost of waiting time lost in health facility and time lost in health care process are also considered to determine affordability. Meanwhile ability of a person to pay defines their health care utilization. Ability to pay is described in way as individual's income, assets, social capital and savings are enough to pay for health care services without catastrophic expenditure of resources required for basic necessities.

3.4.1. Ability to pay and Affordability

Although there is no specific financial method and determined cost of care specific to IPV, in Ethiopia, there are two healthcare financing schemes that are put in the national policy. The one for formal employee, social health insurance/SHI/, and the other one, community based health insurance/CBHI/, for informal section of community(22). However, since a majority (80%) of the population live in rural setting, not formally employed and 10% of population lives below the poverty line, none of the insurance scheme is yet fully in place. The biggest share of current health expenditure(34%) is from out of pocket payment (OOP)(29). According to 2017 National Health Account, Ethiopian Health Expenditure (CHE) was 4% of GDP. The biggest share of CHE is from out of pocket payment (OOP) (29). Eighty one percent of patients reported that the expenses related to the health care services were covered by themselves or their families(87). This hindered population from accessing health facility. According to 2011 EDHS, one of major constraints in women's access to health care was lack of money (68%)(16).This lack of money among women also connected with gender inequalities in accessing and controlling household's income. An institution based survey done in Gondar university hospital also showed nearly half of women who visited the hospital were mainly housewives and had no asset(87).

Rural households in Ethiopia with a monthly income above 54 USD were six times more likely to utilize health care as compared to those who earn less (62). Similarly, household wealth categorized as rich by the Demographic and Health Survey (DHS) wealth index , or who were not living in absolute poverty had also a higher likelihood of using health care service (43)(59)(72). Women from higher income families were 2.9 times more likely to visit the health facility than women from lower income families(65). In addition, those households with extensive social capital were 0.64 times likely to utilize the services when compared to those with minimal social support(26).

A study in rural Ethiopia reported that, households in the lower wealth quintiles are paying 49% of their income for maternal health care OOP expenditure(88). Hailemichael et al. (89) demonstrated, 32.2% of rural households experienced catastrophic OOP payment in health care where they cope with a financial hardship by cutting medical visit on top of reducing family food consumption and stopping children from sending school($p<0.001$)which are usually more likely to occur among women.

Health care costs of IPV in both the immediate aftermath and over the lifespan among those experiencing abuse were higher than the costs for non-abused women(36)(90). Although no study found to show a complete picture of the full cost(direct, indirect and opportunity costs) of victims of IPV in Ethiopia ,a study in USA showed the mean per incident DALYs cost for IPV victims of rape and physical violence were $2,084 and $2,66 5 respectively(90). A study done in northwestern Ethiopia showed that, the mean OOP costs incurred before hospital visit were 10.87 USD that includes self-treatment and informal health care visit. Whereas, the median total cost of 22.25 USD was incurred by patient who visited the hospital with a median direct cost(such as medical and transportation) of 10.76 USD and indirect cost(time lost in the hospital process) of 3.66 USD(87).These OOP payments were catastrophic or significantly high for those living far from the hospital, in lowest wealth index and for those frequent health care visitors(87)(89). A study from jimma, south west Ethiopia, documented that, transport and treatment cost were the main costs associated with utilization of health service. Hence, those who perceived the transport cost to be ‘cheap’ were 2.5 times more likely to utilize the services than those who perceived it as ‘expensive’. Similarly, those respondents with a perceived treatment cost of 'expensive' were 0.18 times less likely to use the services as compared to those who said the cost was 'cheap’(26).Other reasons for limited health service responses to IPV were identified as expecting the woman to pay for the medical card, medication and other direct and indirect costs (35).

CHAPTER FOUR: EFFECTIVE INTERVENTIONS THAT ADDRESS IPV AND HEALTH-SEEKING BEHAVIOR OF WOMEN SUBJECTED TO IPV

Effective interventions were analyzed to address key factors influencing health-seeking behavior of women subjected to IPV. Based on levesque model, the major issues identified to influence health seeking behavior of violence survivors from demand side were social and cultural norms and values which prioritize males over females in multiple ways. This normative framework impacts negatively on the perception towards IPV and women access to health care. Whereas from the supply side there is a lack of screening and poor violence health care delivery found to be the key issue on determining health seeking behavior of women subjected to IPV. Interventions were explored in this literature review based on effectiveness and feasibility to address the two major issues identified from demand and supply side.

4.1. Health Sector Interventions

In general, health care responses play a key role in saving lives and reduce morbidity associated with violence against women. An effective health system intervention to improve health care utilization of women subjected to IPV can contribute to achievement of the Sustainable Development Goals(SDG), in particular those on gender equality and reduction of maternal and child mortality and HIV/AIDS(11)(46).There are different types of health sector intervention identified by WHO study to improve health care utilization of women subjected to IPV(46). The major one is active detection followed by acute and long term management and support of victim of violence at the facility level and/or at system level(46)(77). Facility-level intervention is an intervention where series of services are provided at the same facility by the same or different providers. Systems-level integration means that there is a coordination between multisite facilities with comprehensible referral system(77). Both approaches have their own challenges but found to be effective for health sector to actively respond to IPV which has an impact on uptake of IPV survivors.

Three tier model

A Comprehensive three tier model of care introduced in West Cape, South Africa, found to be effective on improving health seeking behavior of women subjected to IPV ,over a 14 months of piloting period. This three-tier model is mixed facility level and system level intervention which consists of ; case finding/screening and clinical care provision by primary care providers; coordinated with 'IPV champions' in same health facility for

psychological, social and legal assistance with possible referral to relevant organizations; and then ongoing community-based support groups(Figure 2)(2). Like Ethiopia, in most South African social contexts the perception towards IPV is culturally negatively impacted. IPV is regarded as acceptable, and considered to be normal(51). According to South African three tier model of care for IPV, in the first tier, women with cues suggestive of IPV were screened by trained primary health care providers for possible experience of IPV. The approach for screening in the model was selective case finding rather than universal screening via outreach reproductive health clinics or health facility based detection. This approach works with IPV champions on second tier. They are trained social workers who were assigned in health facility to provide and coordinate continuity of psychological care, social support and women empowerment as well as attend legal issue to IPV victims. The victim of IPV receives initial clinical care by nurses and doctors in primary health centers and is referred to IPV champions with the capacity to provide more comprehensive assessment and counseling. IPV champions are social worker or other health workforces in health facility who provide counseling, social support and link the women to empowerment and legal organizations. The third tier of the approach focus on the establishment of community-based support groups that would support women in the longer term. These groups consist of women subjected to IPV with different age group separately and were facilitated by a social worker or health care professionals for the first times but over time become self-sustaining. The support group aid women directly by providing them with information and psychosocial-support as well as help them access community resources such as housing and financial services which helps to improve women's empowerment and autonomy. This three-tier approach appeared to be the best fit in South African primary care. After the model of care was introduced, health care utilization improved in 74% of women by returning into follow-up care after one month(2).

A similar comprehensive violence management model was successfully implemented in other developing countries such as Malaysia, Namibia and Thailand(77)(91)(92).Here, facility-level integration of comprehensive services including screening, health, legal, welfare and counseling services were offered to IPV victims, in one location. Like South African model, some of these centers have dedicated staff or have core staff members and a list of contacts, such as psychologists and medical social workers, who can be called upon to provide specialized services on site when needed. Whereas, in a setting like Kenya and Bangladesh, "Systems-level integration" approach was coordinated in a way to deliver screening and medical care at primary health care level, with external referrals to other facilities for specialized services(93)(94)(77). This model used a coordinated referral

approach to strengthen external NGO links to counseling, legal aid, social support, hot-line services for legal, shelter and economic support for women subjected to IPV.

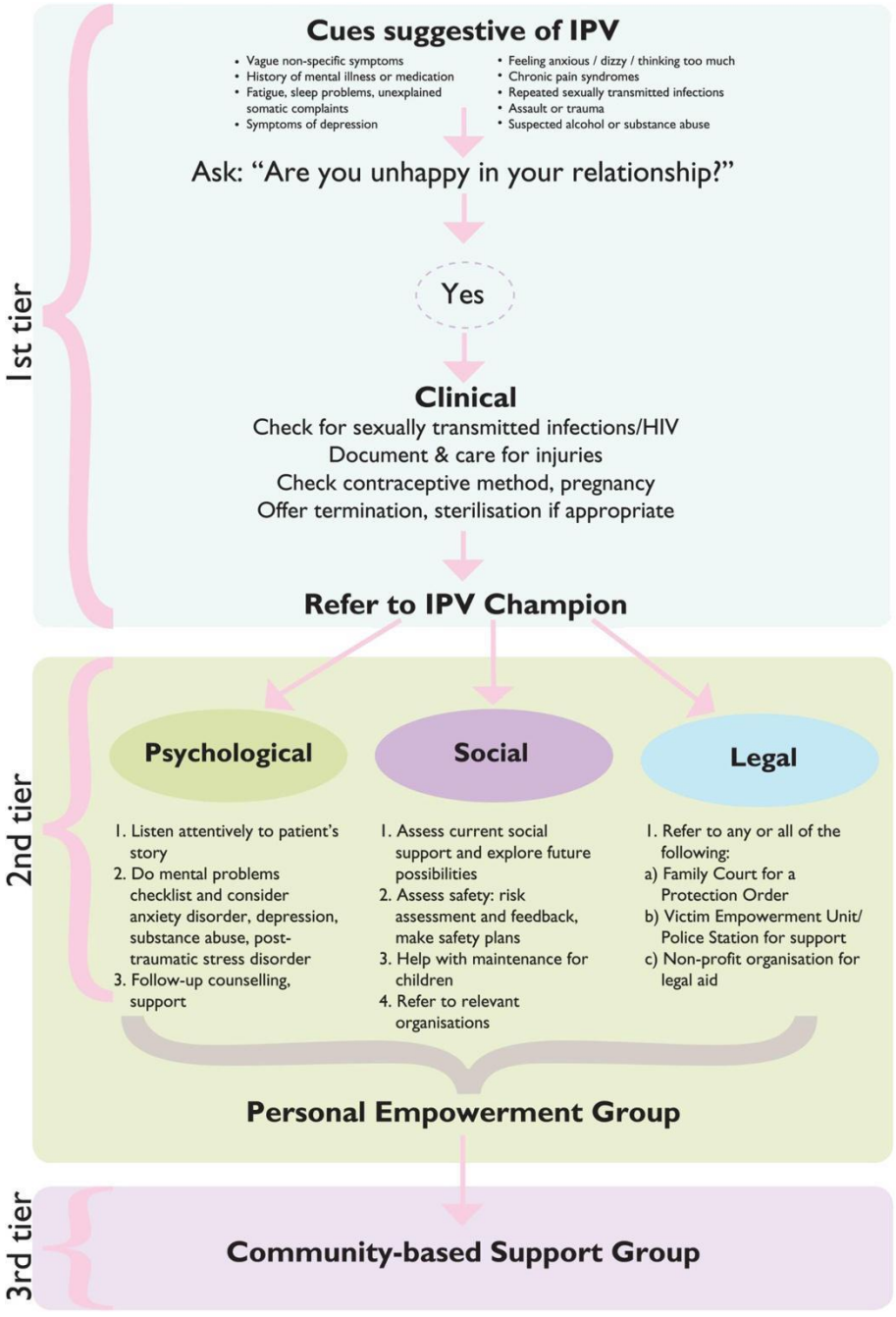
In both facility level and system level health sector interventions, protocols for violence against women were developed and health care providers were trained on the protocol(2) (77) (92)(93). According to a systematic review done in LMIC on comprehensive health sector intervention, in-service trainings which were provided at primary health care level were mainly focusing on screening, implementation of clinical guidelines, referral and coordination as well as raising awareness about IPV(78).As the result of these intervention processes, a change was effected in the perceptions, emotions, attitude, knowledge and skills of providers. These helped to create women friendly facilities where women who experienced IPV were treated appropriately with respect, dignity and equity that contributed for increased utilization of services by women and improved disclosure(2)(77)(78)(93) .However, challenges, such as insufficient staff training, no clear protocols and guideline on IPV management, and lack of coordination among various actors and departments were seen during implementation (77).

4.2. Gender focused interventions

To improve health care utilization of IPV victims, comprehensive and systems-wide approaches have been most effective; however, society-level barriers impede implementation(51). To tackle this societal barrier addressing gender inequities is a key intervention approach. In relation to IPV, an experimental intervention study with men that was conducted to address IPV in Ethiopia showed gender-focused interventions has led to reductions in violence and to other positive outcomes such as increased women health care utilization (e.g. increased contraception or condom use)(73).This community-based project in Ethiopia was the Male Norms Initiative, that worked with young men to promote gender-equitable norms and reductions in IPV through community engagement and interactive group education. As the result of men involvement intervention, among men who were enrolled in the intervention project gender-equitable norms has increased significantly(73)(95). This has a huge impact on health seeking behavior and health outcome of women(39)(71). In addition, to address women and men perception towards IPV, advocacy interventions aimed to help them directly by providing them with information towards IPV were introduced in LMIC(46).The advocacy were given on community based support group, campaigns and local medias; newsletter, TV and radio (2) Similarly, in China, as the result of women advocacy intervention, women facing intimate partner

violence report some reduction in violence and possible improvement in mental health outcomes via increased health care utilization(96).

Figure 3: Joyner's Intimate Partner Violence Model(2).



CHAPTER FIVE: DISCUSSION

In this chapter the major factors influencing health seeking behavior of women subjected to IPV are discussed. In addition, Effective interventions that are relevant and feasible in the Ethiopian health system were also discussed in this chapter. The core findings identified from this literature review were behavioral factors such as perceiving IPV as normal and acceptable; the negative attitude of health professionals towards IPV and gaps in delivery of care.

5.1. Personal, cultural and socio-economic factors

The attitude of women; to regard IPV as a normal phenomenon, and traditional societal gender norms played the major role in determining the health seeking behavior of women subjected to IPV. Consistent with findings from Mali, Rwanda, Uganda, Benin and Zimbabwe(44) (71) , the current literature review found the acceptance of IPV as part of gender roles. Women were forced by the society to tolerate abusive and controlling partner for the sake of her children or to preserve the relationship. Most women also accepted the existence of disagreement and conflict in marriage union as normal phenomenon and perceived IPV as private matter. IPV was also considered justifiable when partner beat his wife and had forced sex. The victim believes that health service was not needed because of the situation "wasn't that serious." or they already talked to someone else. Likewise, women tend to tolerate the issue of IPV for fear of repercussion, isolation, shame, embarrassment, and blame from the society. This non-recognition of violence or the perception of violence as normal or not serious impedes help-seeking.

In Ethiopian culture, husband is considered the head of the household; he has a right to have sex with his wife at any time in any act. Men are acceptable to become controlling and the power dynamics as well as lack of autonomy restricted women from going outside of the house and seek heath care. This finding is consistent with findings from Kenya, Cambodia, Haiti and Dominican Republic which demonstrated lack of autonomy among abused women in decisions regarding reproductive health exhibited a higher fertility rate among IPV survivors(97)(98). This higher fertility rate among victims of violence could be explained by forced sex and lower utilization of family planning services. All these factors negatively affect women from seeking health care. This is consistent with other research finding in Nicaragua where majority of respondents expressed the personal and social value towards IPV, in terms of disclosure, where outsiders including health care providers should not

intervene in marriage issues(99). In addition, published review from Middle East revealed that fears of further violence, loss of support and relationships, cultural expectations and family reputation as reasons why women do not seek services for domestic violence(81).

Ministry of Health of Ethiopia has introduced the concept of women community groups to influence behavioral change on health promotion and disease prevention for communicable and non-communicable diseases as well as to improve the health seeking behavior of women for SRH(65)(100). However, due to possible societal perception of IPV as private matter and lack of support from health professionals, in practice women are restricted from discussing the issue openly in the group. Nonetheless, the government can take this women group as opportunity and involve health professionals to influence culture and perception around IPV and improve the health seeking behavior of women subjected to IPV.

5.2. Health system factors

A health system factor, such as lack of transparency, poor IPV screening and failure of confidentiality among health professionals were some of the barriers for women to seek health care. A dominating theme emerging from this research is the attitude of health care professionals towards IPV. They managed victims of violence in judgmental, non-confidential and stigmatized way. In some cases, health care staffs were even reluctant to manage IPV victims perceiving IPV as social not biomedical matter and for avoiding being targeted by partner. This is probably because of the fact that most health care providers share the same social and cultural environment with their clients, and they may themselves have been involved in IPV either as victims or as perpetrators(8). In addition, trust built on health care providers in their professionalism and confidentiality determines the health seeking behavior of women subjected to IPV. The health care providers' attitude towards IPV and poor competencies in managing IPV can causes IPV to be overlooked and undetected in health facility. While addressing IPV should be an integral part of health care including providers' pre service and continuous professional development(46). On the top of how health professionals are providing care, availability of emergency service, SRH services, rehabilitative and psychosocial service at grass root level with adequate skilled health care providers or with functional referral system in flexible working hours are also major factors for women subjected to IPV from accessing health care. The government of Ethiopia has shown progressive improvement on expansion of primary health care with community outreach program for the past decade. However, the existing structure of health extension workers (HEW) at the primary level of care usually provide information on FP and screen

women on pregnancy danger signs as part of SRH. They usually missed to be transparent about the IPV services and failed to actively identifying victims of violence for proper management and referral. This could be because of lack competencies, unclear protocol and policy on HEW health service package regarding IPV. In line with this review, a study done in Bangladesh also revealed the significant association of professionalism and functionality of hospital maternity care and the likelihood of women's' health care utilization (101). This could link to building trust on health system and women satisfaction on provision of care for victims of violence.

5.3. Effective health interventions

Based on the current literature review, key issues identified to address health seeking behavior of women subjected to IPV were health system factors associated with screening and care for the victims as well as cultural and social norms associated with domestic violence related disclosure. When the health care system becomes involved in IPV, women feel encouraged, supported, and relieved(102). A comprehensive, inter-sectorial and system-wide three tier model was identified as piloted intervention from South Africa which comprises early case detection through selective screening followed by clinical care with continuum of social, psychological and legal support. These continuums of care help to increase health seeking behavior of women as well as lessen violence by lowering gender power dynamics and increase women right protection. This model was replicated in Kenya, Peru, Dominican Republic and Bangladesh where the model found to be effective on increasing uptake of victims of violence(77). Since it was an effective intervention in different similar settings, it can also be adapted in Ethiopia. To ensure sustainability of the intervention the government of Ethiopia can incorporate comprehensive three tier models of care for IPV victims in existing primary health care structure that involve health centers, health post and health extension workers. Moreover, in order to ensure the replicated intervention are implemented properly, protocols and operating procedures should be in place and health care providers should be trained through regular pre-service and in service trainings. As the result, health extension workers can perform selective screening at community level and perform appropriate referral to respective organization inside or outside the health sector in order to improve the uptake of victims of violence in health system(20)(65). Although there is well established health extension worker at primary health care level, the reason why government has not incorporated IPV management in the existing health system until now could possibly be because of lack of policy and regulations on IPV. From the intervention validation review done in LMIC, for resource poor settings

like Ethiopia mixed facility and system-level integration are most important and feasible way for implementing comprehensive IPV care model (77). One site facility-level intervention alone ,where a single provider offers a comprehensive service, is popular mostly in high income settings like USA where large scale highly qualified manpower, and high resources and budget are utilized mainly at secondary or tertiary levels of care(103).

In addition, community based support and advocacy groups can be used to educate and communicate women and men against cultural perception towards IPV and gender equality. This can be implemented in coordination of ministry of health and ministry of women and social affairs through various communication modalities, such as involving community groups, campaigns and broadcast Medias. For men as well, in Ethiopia, community based "male normative imitative" that engage men to adjust and transform gender inequality bring improvement in redetection of IPV and women health care utilization. Since the perpetrators in IPV are usually men, advocacy should engage local exemplary men role models as well as religious and local leaders. In line with this findings, studies that refer to men engagement and gender transformative programs in Rwanda and DRC show men's commitment to transforming gender norms brought greater equity and better health, especially in terms of improving reproductive health and reducing GBV(71)(104). In Ethiopia, there are well- established functional health development teams (HDTs), which comprise up to 30 households residing in the same neighborhood(5). These community networks are part of PHC system where household members meet every 2 weeks to discuss about their health. The community group is supported by PHCU coordinator at 'kebele' level to promote health and follow up each household's performance regarding the implementation of selected community health package. Hence, integrating the gender equality advocacy in the existing community networking group can make the intervention feasible and sustainable. The expected result of behavioral changes; in social and gender norms, values and roles adjustment, which possibly leads to better health as well as prevent IPV. Initially, community advocacy can be piloted in selected woreda which later can be scaled up to other part of the country with proper program evaluation, as it was implemented in South Africa.

5.4. Views on framework

Levesque model is a tool to analyze uptake of services from different perspective; both the individual and the health service perspective. It also describes at each stage the influences of other construction in the model. However, the model fails to acknowledge the policy and governance issues that influence access to health care services in development of its construct. The political structures in most countries determine the allocation of resources and development of laws related. Laws, such as abortion law and women rights, that govern health care delivery were missing from the framework. These have consequences on health care delivery where the health care providers refrained to provide care without protective law. In addition, the concepts in the model are overlapping and this has been duly acknowledged by the developer of the model.

CHAPTER SIX: CONCLUSION AND RECOMMENDATIONS

6.1. Conclusion

Health-seeking behaviors of women subjected to IPV are influenced by individual, social and health system factors. Individual factors include attitudes and beliefs towards IPV, women's core values concerning health and illness, knowledge about violence and health literacy. Social factors including gender roles and norms, power dynamics and variation in decision making ability, social support, socio-cultural and economic aspects are also among the contributing factors for health seeking of women subjected to IPV. On the other hand, health system factors include availability of skilled health professionals, approach of health care providers, active screening and referral system, accessibility of health facility and cost of health care.

Among all those factors, perception towards IPV and traditional gender norms have been the major influencing factors for health-seeking behavior of women subjected to IPV. Most victims tolerate the incident, perceiving IPV as normal and not a serious event in marriage. Women's gender roles in marriage to take care of their children and their relationship hinder their desire to seek help from health care providers when they sustain IPV. Women need to ask permission and they are mostly economically dependent upon their partner to seek health care due to lack of autonomy and low decision making power in their relationship. In addition, feeling of shame, embarrassment, being judged or criticized or fears of retaliation restrict women from disclosing the violence. These factors coupled with the professional stigma and discrimination in health care delivery are found to be the major barriers for low health care utilization of women subjected to IPV. The current gaps in the Ethiopian health system towards functionality of essential health service including emergency services and SRH services in primary health care with proper and well-coordinated referral system were also found to influence the health care utilization of victims of violence. Furthermore, the lack of inter-departmental coordination and absence of integrated care with champions to provide comprehensive care to victims of violence are equally important to influence health seeking behavior of women subjected to IPV.

The suggested effective intervention for increasing uptake of victims of violence in health system focuses on active screening and the provision of comprehensive and coordinated clinical, psychological and SRH management services in addition to social and legal support to the victims. Providing continuous medical education and regular trainings to health care

providers on management of IPV and non-judgmental approach are also part of the intervention. Meanwhile, involvement of policy makers on development of guidelines and protocols for comprehensive three tier model as well as continuous monitoring and evaluation of the program have contributed for success of the intervention in South Africa and all other LMIC. In addition, gender transformative actions to empower women and raise awareness using social groups, various campaigns and local Medias targeting different stakeholders at all levels were also identified as effective approaches to increase women's health care utilization.

6.2. Recommendations

6.2.1. Community level

The following recommendations are made to MOH, MWA, local NGOs, Medias and civil societies who represent the community and can influence them;

I. Strengthen existing community based household networks and use them as core engine for disseminating information women's rights and that IPV is unacceptable.. This helps mainly women to understand gender equality, equity, negotiation skills, decision making, and autonomy and transform their attitudes towards being violated of their rights. In addition, strong community networks can help improve social support which improves women health care utilization.

II. Empower women through income generating activities and other financial incentives such as conditional cash transfer and voucher scheme to overcome the indirect and opportunistic cost barriers for accessing health care.

III. Involving men/husband or partner as change agents in group health education and discussions to promote gender equality, equity and improve shared decision making as well as involving men on reproductive health issues as part of human right.

IV. Community mobilization by continuously engaging with religious, traditional and opinion leaders as well as local Medias and campaigns to address gender inequalities and cultural norms towards IPV.

6.2.2. Health facility level

The following recommendations are made to MOH, professional associations, MOE and NGOs involved in management of IPV;

I. Strengthen primary level health care by equipping it with necessary medical equipment and supplies. Strengthen capacity of health work forces in PHCU, at all departments, for proper inter-departmental coordination and provision of appropriate care for victims of violence with timely referral as required. Each PHCU should, as a minimum, provide first-line support to victims of violence.
II. Implement selective screening and care for victims of IPV: Develop IPV screening checklist and protocol and train health professionals involved in active screening of IPV. Therefore, cases of IPV will be early identified and referred to appropriate care.
III. Strengthen monitoring and evaluation systems in health facility to ensure quality of care and accountability mechanism are created in health facility.

6.2.3. Policy level

The following recommendations are made to MOH, MWA , MOE, legal affair and MoFED, involved directly and indirectly in addressing health issues and well-being of the citizens;

I. Conduct advocacy for politicians to enhance commitment to formulate and implement policy documents and create champions towards IPV and gender equality.
II. Review the National Health Policy, Health Sector Transformation plan, Reproductive Health Policy, Ethiopian Hospital Transformation Plan and Health extension worker health service package to incorporate comprehensive and integrated IPV management and advocacy of gender equality.
III. Review the country's abortion law to allow women to access safe abortion in case of sexual violence including IPV.
IV. Review and design pre-service curriculum, continuous education and in-service trainings to addresses: basic knowledge and skills towards managing violence, knowledge of existing services that may offer support to survivors of IPV including laws that are relevant to victims of IPV, positive attitudes and /or appropriate behavior among health-care providers during managing victims of violence, as well as their own experiences of partner and sexual violence.

V. Integrate care for women subjected to IPV into existing health services rather than as a stand-alone service. For example: - Integrate regular community outreach program with the health extension package to increase identifying IPV cases and disseminate health information. Develop service directory and protocols for integrated health services and inform women about integrated services.

VI. Improve health care financing by increasing government health expenditure for health service and insurance services which help to expand health infrastructure, ensure the availability of medical equipment and supplies and provide regular trainings to increase capacity of health work force.

VII. Establish clear inter-sectorial collaboration and coordination system to implement effective women health seeking behavior enhancing interventions.

6.2.4. Research level

The following recommendations are made to MOH, professional associations, and research institutes involved in research of IPV;

I. Further research on behavioral change towards IPV perception should be conducted. This can help to provide more insights in how to prevent and reduce IPV as well as improve health seeking behavior of women subjected to IPV

II. Studies should be conducted on how to stimulate health seeking behavior of women subjected to IPV that has an impact on increasing health care utilization of women subjected to IPV

III. Research towards IPV against men needs also be conducted since it is also a problem. This may help the government to address IPV in a holistic manner.

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Annexes

Annex 1: Distribution of human resources for health by region, Ethiopia, 2015

Health Workers	Central	Tigray	Afar	Amhara	Oromia	Somali	B/Gumuz	SNNP	Gambela	Harari	Addis Ababa	D/Dawa	Total
Health officer	89	620	76	1,480	1,805	606	99	1,390	71	56	651	79	**7,022**
Pharmacist	74	102	3	277	495	26		155	4	21	195	26	**1,378**
Pharmacy tech.	29	765	116	1,652	1,790	253	113	1,384	13	78	472	78	**6,743**
Nurse BSC	313	470	119	846	1,584	1,024	97	823	88	94	1,227	104	**6,789**
Nurse Diploma	383	3,150	506	7,726	11,820	1,533	729	8,538	235	293	1,907	254	**37,074**
Midwifery (BSC+ Diploma)	45	627	52	1,178	3,324	655	112	1,390	64	51	409	60	**7,967**
All nurses	802	3,797	632	8,718	13,679	2,748	837	9,624	324	408	3,276	375	**45,220**
Medical Lab. Tech.(BSc)	99	194	5	394	698	45	33	382	15	10	221	26	**2,122**
Medical Lab. Tech.(Diploma)	59	410	119	1,231	1,345	249	76	1,139	38	75	271	31	**5,043**
Radiographer	16	69	3	73	91	20	45	47	15	14	84	6	**483**
Environmental and Occupational Health and safety (BSC+ Diploma)	23	252	26	422	871	7	38	546	11	3	171	39	**2,409**
Total Specialist (Non-Medical)	190	146	4	191	231	1	19	232	-	13	57	25	**1,109**
All other Health professionals	128	2,708	684	7,938	18,075	889	6,193	8,937	637	153	1,364	272	**47,978**

Annex 2: Search Table

Objectives	**Issues**
1.To explore individual , cultural and socio-economic factors that influence the health seeking behavior of women subjected to IPV	• Health literacy • Health beliefs • Trust • Personal and social norms and values • Culture • Gender • Stigma/Discrimination • Autonomy, empowerment • Living environments • Transport • Mobility • Social support • Income (Assets, social capital) • Health insurance
2. To determine health system factors that influence health-seeking behavior of women	• Distance to health centers and hospitals • Availability of and cost of transportation • Poor roads and infrastructure • Geographical location • Opening hours • Poor facilities and lack of medical supplies • Inadequately trained and poorly motivated

subjected to IPV	medical staff • Inadequate referral systems • Direct and indirect cost • Quality • Referral system
3. To analyze effective interventions that address health-seeking behavior of women subjected to IPV, in Ethiopia and relevant other settings	• Gender empowerment • Economic empowerment (cash transfer) • Men and boys engagement • Community mobilization • Integrated services (SRHR and violence care, HIV and Violence care) • Multisectoral approaches • Law and policies implementation