



**Intimate partner violence against women living with and without HIV:
Contexts and associated factors in Wolaita Zone, Ethiopia**

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08 April 2021

DECLARATIONS PLAGIARISM

I, Mengistu Meskele Koyira, declare as follows:

1. That the work described in this thesis has not been submitted to the University of KwaZulu-Natal or another tertiary institution for purposes of obtaining an academic qualification, whether by myself or any other party. The research reported in this dissertation, except where otherwise indicated, is my original work.
2. That my contribution to the project was as follows:
I am the principal investigator of this project, and I conceived and designed the study. I collected qualitative data. I trained the data collectors and supervised the quantitative data collection. I analysed both the qualitative and quantitative data, interpreted the findings and wrote the manuscripts. I am also the primary and the corresponding author for five publications at different journals. I structured and wrote this thesis.
3. The contributions of others to the project were as follows:
Nelisiwe Khuzwayo (PhD) and Professor Myra Taylor are the project supervisors and intellectual contributors. They advised during the conception and design of the research project. They supervised and assisted with the data analysis and interpretation of the findings. Both of them reviewed the draft manuscripts and approved them for submission to journals. They are co-authors of the manuscripts presented in the thesis.
4. This thesis does not contain any other persons' writing or data unless specifically acknowledged as being sourced from other persons. Where written sources have been quoted, their words have been re-phrased, and the reference has been cited. Where their exact words have been used, their writing has been placed in italics and inside quotation marks, and referenced.

Mengistu Meskele Koyira

Signed:



Date: 17 October 2020

Nelisiwe Khuzwayo (PhD, supervisor)

Signed:



Date: 17 October 2020

Professor Myra Taylor (Co-supervisor)



Signed:

Date: 17 October 2020

DEDICATION

I dedicate this work to my wife Meskerm Asrat, who has supported me throughout the process of this work and took care of our children. My son, Nathan Mengistu, and my daughters, Abigail and Eliana Mengistu, have been and will continue to be my motivations and heroes. I also dedicate this thesis to my loving and caring mother, Mamite Maja, and my hero father, Meskele Koyira.

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DEFINITION OF TERMS / OPERATIONAL DEFINITIONS

Intimate partner violence (IPV) (also known as domestic violence) is defined as: "Self-reported experience of one or more acts of physical, sexual, and emotional violence by a current or former male partner, whether cohabiting or not, since the age of 15 years" World Health Organization [WHO],2013; Semahegn and Mengistie, 2015; Breiding et al., 2015; Central Statistical Agency [CSA], 2016). We measured IPV when women had experienced at least one form of abuse of physical, sexual, and emotional violence by their male partner/husband. This study used the term intimate partner violence, abbreviated as IPV, throughout this document.

Physical violence is defined as when a current or former partner of a woman "has ever slapped, or thrown something at her that could hurt her, pushed or shoved her, hit her with a fist or something else that could hurt, kicked, dragged or beaten her up, choked or burnt her on purpose, threatened her with, or used a gun, knife or another weapon against her" (WHO, 2013; Breiding et al., 2015). I considered that physical violence had occurred when women reported at least one item from the physical violence questions.

Sexual violence is defined as: "being physically forced to have sexual intercourse when you did not want to, having sexual intercourse because you were afraid of what your partner might do, and/or being forced to do something sexual that you found humiliating or degrading" (WHO, 2013). I measured sexual violence as occurring when women reported at least one item from the three sexual violence questions (Breiding et al., 2015).

Psychological/emotional violence is defined as "insults, belittling, constant humiliation, intimidation (e.g. destroying things), threats of harm, threats to take away children" (WHO, 2012). I measured emotional violence as occurring when women reported at least one item from the psychological violence questions.

Violence against women (VAW) is defined as: "Any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life" (United Nations [UN], 1993).

Controlling behaviour by an intimate partner is defined as: "isolating a person from family and friends; monitoring their movements; and restricting access to financial resources, employment, education or medical care" (WHO, 2012). I measured controlling behaviour by an intimate partner as occurring when women reported at least one item from the controlling behaviour questions.

TABLE OF CONTENTS

DECLARATIONS	I
DEDICATION	II
ACKNOWLEDGEMENTS	III
DEFINITION OF TERMS / OPERATIONAL DEFINITIONS	IV
TABLE OF CONTENTS	V
LIST OF TABLES	IX
LIST OF FIGURES	IX
ACRONYMS AND ABBREVIATIONS.....	X
CHAPTER ONE: INTRODUCTION	1
1.1. Background	1
1.2. Statement of the research problem.....	2
1.3. Rationale and significance of the study	3
1.4. Purpose and objectives.....	4
1.4.1. Purpose	4
1.4.2. Objectives.....	4
1.4.3. Research questions	5
1.5. List of manuscripts.....	5
1.6. Thesis structure	6
CHAPTER TWO: LITERATURE REVIEW AND METHODS	8
2.1. Introduction.....	8
2.2. The global prevalence of intimate partner violence (IPV).....	8
2.3. The African prevalence of IPV	8
2.5. Factors associated with IPV	10
2.6. The link between HIV/AIDS and intimate partner violence	10
2.7. Intimate partner violence screening experience of healthcare workers	11
2.8. Conclusion of the literature review	12
2.9. Theoretical background	12
2.9.1. Theoretical and philosophical foundation	12
2.9.2. Social learning theory.....	13
2.10. Conceptual framework	15

2.11. METHODS	17
2.12. Type of research.....	17
2.13. Approach and phase.....	18
2.14.1. Qualitative study design	20
2.14.2. Quantitative study design	20
2.15. Study area and setting	21
2.16. Target population	21
2.17. Study population	22
2.18. Inclusion and exclusion criteria	22
2.18.1. Inclusion criteria for the quantitative study.....	22
2.18.2. Exclusion criteria for quantitative study	22
2.18.3. Inclusion criteria for the qualitative study.....	23
2.18.4. Exclusion criteria for the qualitative study.....	23
2.19. The phenomenon to be investigated	23
2.20. Sampling strategy and size	23
2.20.1. Sampling strategy.....	23
2.20.2. The sample size for the qualitative study	25
2.20.3. Sample size calculation for quantitative study	25
2.21. Variables	25
2.21.1. Dependent variable.....	25
2.21.2. Independent variables	25
2.22. Data collection	26
2.23. Qualitative study data collection.....	26
2.24. Measures to ensure scientific rigour and trustworthiness	27
2.25. Quantitative study data collection techniques and instruments/tools	28
2.26. Validity and reliability	28
2.27. Data management and storage plan	29
2.28. Data analysis: Quantitative study.....	29
2.29. Data analysis: Qualitative study	29
2.30. Ethical considerations	30
2.31. References.....	32
CHAPTER THREE: MAPPING THE EVIDENCE OF INTIMATE PARTNER VIOLENCE AMONG WOMEN LIVING WITH HIV/AIDS IN AFRICA: A SCOPING REVIEW PROTOCOL	40

.....	47
Chapter 3.2. Mapping the evidence of intimate partner violence among women living with HIV/AIDS in Africa: A scoping review	47
CHAPTER FOUR: INTIMATE PARTNER VIOLENCE AGAINST WOMEN LIVING WITH AND WITHOUT HIV, AND THE ASSOCIATED FACTORS IN WOLAITA ZONE, SOUTHERN ETHIOPIA: A COMPARATIVE CROSS-SECTIONAL STUDY	59
CHAPTER FIVE: LIVED EXPERIENCE OF INTIMATE PARTNER VIOLENCE AMONG WOMEN USING ANTIRETROVIRAL THERAPY AND OTHER OUTPATIENT SERVICES IN WOLAITA ZONE, ETHIOPIA: A PHENOMENOLOGICAL STUDY	78
CHAPTER SIX: HEALTHCARE WORKER EXPERIENCE AND THE CHALLENGES IN SCREENING FOR INTIMATE PARTNER VIOLENCE AMONG WOMEN WHO USE ANTIRETROVIRAL THERAPY AND OTHER HEALTH SERVICES IN WOLAITA ZONE, ETHIOPIA: A PHENOMENOLOGICAL STUDY	90
CHAPTER SEVEN: SYNTHESIS	104
7.1. Main findings	104
7.2. A comprehensive approach to the methods used in this study	105
7.3. Use of mixed methods	106
7.4. Health impacts of IPV	108
7.5. Factors associated with IPV	108
7.7. Male masculinities, gender inequalities, partner’s characteristics.....	110
7.8. Reproductive health-related factors or sexual risk factor	111
7.9. Intimate partner violence prevention approaches from the perspective of participant women.....	111
7.9.1. Legal route.....	111
7.9.2. Social support.....	111
7.9.3. Income-generating initiatives	112
7.9.4. Role of healthcare workers	112
7.9.5. Health system.....	112
7.10. Intimate partner violence prevention strategy in the education and health system	112
7.11. New knowledge	114
7.12. Contributions of this study to what is known in order to provide recommendations to reduce IPV	115
7.12.1. Prevalence	115

7.12.2. Association between HIV and IPV	115
7.12.3 The problem of male controlling behaviour.....	116
7.12.4. Alcohol and other drug abuse.....	117
7.12.5. Health system challenges	117
7.13. Strengths and limitations	118
7.13.1. Strengths of the study	118
7.13.2. Limitations of the study.....	119
7.14. Recommendations based on the study's results.....	119
7.15. Conclusion	121
7.16. References.....	123
Appendix 1: Sample size calculation	128
Appendix 2: Research approval by the Research Ethics and Higher Degrees Committee	129
Appendix 3: Ethical clearance from the University of KwaZulu-Natal (UKZN)	130
Appendix 4: IRB from Wolaita Sodo University, Ethiopia.....	131
Appendix 5: Zonal Department of Health permission (Gatekeeper permission)	132
Appendix 6: Site permission (Sample 1).....	133
Appendix 7: Site permission (Sample 2: Obtained from nine facilities).....	134
Appendix 8: Information sheet, consent form and questionnaire (In-depth-interview with women).....	135
Appendix 9: Information sheet, consent form and focus group discussion guide for women living with and without HIV	139
Appendix 10: Information sheet, consent form and questionnaire (In-depth-interview for the service provider)	144
Appendix 11. Quantitative study information sheet, consent form and questionnaire for women	148
Appendix 12: Local language (Wolaia Donna) questionnaires.....	167
Appendix 13: Amharic questionnaire.....	201

LIST OF TABLES

Table 1. Presentation of research papers by using various methods	19
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LIST OF FIGURES

Figure 1: Conceptual framework showing the relationship between various factors and IPV experienced by women	16
Figure 2. Diagrammatic presentation of exploratory sequential design	18
Figure 3: Map of Wolaita Zone, Ethiopia	21
Figure 4. Schematic presentation of sampling techniques for quantitative study	24
Figure 5. Various factors associated with IPV against women living with and without HIV in Wolaita Zone, Ethiopia (Paper 3)	109
Figure 6. The pathway framework of IPV prevention	113

ACRONYMS AND ABBREVIATIONS

AIDS: acquired immunodeficiency syndrome

ART: antiretroviral therapy

BREC: Biomedical Research Ethics Committee

EDHS: Ethiopian demographic and health survey

FDRE: The Federal Democratic Republic of Ethiopia

FGD: focus group discussion

GBV: gender-based violence

GP: general practitioner

HCWs: healthcare workers

HIV: human immunodeficiency virus

IPD: interpretive phenomenological design

IPV: intimate partner violence

IRB: Institutional Review Board

MCH: mother and child health

MMAT: mixed methods appraisal tool

OPD: outpatient department

PMTCT: prevention of mother to child transmission

PRISMA: preferred reporting items for systematic review and meta-analysis

PRISMA-SCR: PRISMA extension for scoping reviews

PROSPERO: international prospective register of systematic reviews

RA: research assistant

SDG: sustainable development goal

SNNPR: Southern Nations, Nationalities and Peoples' Region

UKZN: University of KwaZulu-Natal

UN: United Nations

VAW: violence against women

VIF: variance inflation factor

WHO: World Health Organization

ABSTRACT

Background: Intimate partner violence (IPV) and Human Immunodeficiency Virus (HIV) are overlapping or intersecting public health challenges. Intimate partner violence is considered to be strongly related to HIV infection among women in Africa. However, the evidence is not conclusive. Women who are abused physically by their partners seek medical treatment in public institutions, yet, in Ethiopia, the experience of healthcare workers (HCWs) in screening IPV among HIV-positive and HIV-negative clients is not fully understood

Purpose: This study aimed to map the evidence of IPV in Sub-Saharan Africa, to measure the factors associated with IPV, to explore the experience of IPV against women living with and without HIV, and the health care workers' IPV screening experience in Wolaita Zone, southern Ethiopia.

Objectives

1. To conduct a scoping review of IPV among women living with HIV/AIDS in Sub-Saharan Africa.
2. To explore the lived experience of IPV against women using antiretroviral therapy (ART) and other outpatient services in Wolaita Zone.
3. To explore the experiences and challenges in screening for IPV among women who use ART and other health services in Wolaita Zone.
4. To measure the prevalence and associated factors of IPV among women living with and without HIV in Wolaita Zone.

Methods: This is a mixed-methods study. I conducted both qualitative and quantitative studies.. Initially, I mapped the evidence of IPV among HIV-positive women in Sub-Saharan Africa using a scoping review. Then, I conducted an exploratory sequential design of mixed-methods research. An interpretative (hermeneutic) phenomenological design was used to explore the lived experiences of women who were living with and without HIV. Additionally, I used a descriptive phenomenological study design to explore the IPV screening experiences of 16 HCWs. I also used a comparative cross-sectional study comprising 816 women between 18-49 years who were living with and without HIV for the quantitative study. I used the standard questionnaire of the World Health Organization (WHO) multi-country study on women's health and domestic violence against women (translated). The scientific rigour, dependability, and credibility relating to this sensitive subject were maintained. I used STATA software, version 15 for the quantitative data analysis; NVIVO 12 assisted us in developing a framework, and

Colaizzi's analysis for the qualitative data. I used the binary and multivariable logistic regression model for the quantitative analysis.

Results: The scoping review provided a summary of the evidence of IPV experiences among women with HIV/AIDS. As this review has shown, the HIV-positive women were at considerable risk of IPV after disclosure of their serostatus to a male partner. Psychological and emotional abuse was the most common form of violence reported by the review. Subsequently, in the quantitative study, we found a high lifetime prevalence of IPV among all women in Wolaita Zone, 487 (59.68%, [95% CI:56.31%-63.05%]). It was slightly higher among women living with HIV, 250 (61.3%), than among those who were HIV negative, 238 (58.09%). Factors associated with IPV were the controlling behaviour of husband/partner [AOR=8.13; 95% CI: 4.93-13.42], poor wealth index [AOR=3.97; 95% CI:1.81-8.72], bride price payment to bride's family [AOR=3.46; 95% CI:1.74-6.87], women's decision to refuse sex [AOR=2.99; 95% CI:1.39-6.41], age group of women [AOR=2.86; 95% CI:1.67-4.90], partner's family choosing a wife [AOR=2.83; 95% CI:1.70-4.69], alcohol consumption by partner [AOR=2.36; 95% CI:1.36-4.10], number of sexual partners [AOR=2.35; 95% CI:1.36-4.09], and if a partner ever physically fought with another man [AOR=1.83; 95% CI: 1.05-3.19]. Inappropriate legal punishment of the perpetrator and the lack of a supportive women's network to avert IPV were perceived as limitations by the women. There were HCW and health system-related challenges in screening for IPV. These challenges comprised a gap in the medico-legal report provision, absence of separate record-keeping for IPV cases, lack of client follow-up, and lack of coordination with an external organisation.

Conclusions and recommendations: There was a high prevalence of IPV among women, both living with and without HIV. The extent of IPV and its presentation in the different forms (physical, sexual and psychological), which frequently overlapped, highlights the urgency of intervention measures. Women reported terrifying experiences of violence, which affected their health physically, mentally, and psychologically. There are also challenges concerning HCWs, health systems, and the clients, relating to screening for IPV. Scoping review revealed evidence of IPV experience among women with HIV/AIDS, evidence of how HIV status disclosure influences IPV, and proof of the association of socio-demographic characteristics with IPV. It was concluded that marriage arrangements should be by mutual consent of the marriage partners rather than being made by parents; it is advisable to involve males in all programmes of gender-based violence prevention to change their violent behaviours; there is a need for the arrangement of separate record-keeping of IPV cases at the health facilities and for

standardising the medico-legal reporting system. Finally, this study emphasises the importance of executing more gender-equitable policies.

Keywords: Intimate partner violence, HIV, Women, Wolaita, Ethiopia

CHAPTER ONE: INTRODUCTION

This chapter presents background information on intimate partner violence (IPV). It provides a statement of the research problem, the rationale for the study, its purpose and objectives, the research questions, a list of manuscripts and the thesis structure.

1.1. Background

Intimate partner violence among women living with Human Immune Deficiency Virus (HIV) is progressively recognised as a severe, global public health concern (Karim and Baxter, 2016; Breiding et al., 2015). According to the National Centre for Victims of Crime (NCVR) which was conducted in the United States (U.S), IPV affects millions of individuals, irrespective of sexual orientation, marital status, race, national origin, ethnicity, age, education, religion, or economic status (NCVR, 2018).

Globally, more than 35% of women have experienced one form of physical and/or sexual IPV or non-partner sexual violence (World Health Organization [WHO], 2013). Intimate partner violence and HIV are intersecting, or overlapping, challenges, with considerably high occurrence among women and girls who are living with HIV/ acquired immunodeficiency syndrome[AIDS] (The White House Washington Working Group, 2013). Therefore, it is a priority to address both the domestic HIV/AIDS epidemic and violence against women. For instance, a study in Zimbabwe showed that the total prevalence of HIV among pregnant women was 32.8%, whereas the IPV prevalence among pregnant women living with HIV was 40.5% (Shamu et al., 2014). According to the Demographic and Health Survey (DHS) studies of ten sub-Saharan Africa countries, IPV, as a substantial public health problem, is associated with both infections of HIV among African women and various types of abuse such as physical and emotional violence and male controlling behaviour (Durevall and Lindskog, 2015). Moreover, IPV is statistically associated with the HIV-positive status of women (Patrikar et al., 2017).

Most of the time, it is difficult to talk about HIV independently from IPV. Biological, socio-cultural and economic factors explain the link between the two health problems. The intersection of IPV and HIV, however, is complex to understand. Moreover, HIV status disclosure can lead to serious physical violence (Durevall and Lindskog, 2015; Ashaba et al., 2017; Orza et al., 2015). It was shown in the body of literature that about one in three women had experienced partner violence following HIV serostatus disclosure (Colombini, 2016). Women also experienced emotional abuse, controlling behaviour, blame, with denial of communication, abandonment, sexual coercion (a denial to use safer sex methods), taking away of marital support, stigma and violence from their husband/partner (Colombini, 2016). Although

there are negative consequences of HIV status disclosure, it has its positive benefits in HIV care such as support from the partner, families and others. However, it is notable that HIV-positive women in serodiscordant couples are severely susceptible to the negative consequences of HIV-test disclosure to a partner (Maeri et al., 2016).

Previous studies have shown that Ethiopia is one of the nations with a magnitude of IPV, which is also widespread in different regions in Ethiopia (Semahegn and Mengistie, 2015). A community-based study in western Ethiopia showed that 44.5% of women had experienced IPV and that a substantial proportion of women (55.5%) had experienced all three types of IPV (physical, sexual, and emotional violence) (Abebe Abate et al., 2016). Intimate partner violence is thus a tremendous community health concern in Ethiopia. Despite the Ethiopian government revising various documents to assure the rights of women, there is a need of further reliable information to protect women's rights (Ethiopian demographic and health survey [EDHS], 2016). The EDHS 2016 showed that more than 35% of ever-married women had experienced emotional, physical, or sexual violence from their husband or partner. Similarly, in the southern region of Ethiopia, 30.4% of ever-married women have suffered sexual, physical, or psychological violence from a partner (EDHS, 2016). Therefore, based on the evidence of IPV from the existing studies, this study aimed to explore the context of IPV through the perspectives of women and healthcare workers (HCWs), and to identify the various factors linked with IPV among women living with and without HIV in Wolaita Zone in southern Ethiopia.

1.2. Statement of the research problem

Regarding the global picture, above one in three women (35.6%) had experienced physical and /or sexual violence by a partner or by a non-partner (WHO, 2013). There is a high degree of variation in regional estimates of IPV and non-partner sexual violence among the different regions in the world (27.2%-45.6%). Among the various forms of violence, IPV is the most common. Its prevalence was reported by the WHO to be highest in African, South-East Asian and Eastern Mediterranean regions, where 37% of women describe experiences of sexual and or physical IPV at some point in their lives. The prevalence decreased in developed countries to 23.2% (WHO, 2013). The global lifetime prevalence of non-partner sexual violence was 7.2% (WHO, 2013). Furthermore, IPV can result in femicide and, globally, 38% of all murders of women are perpetrated by their intimate partner, with 42% of women who have been sexually abused by a partner or husband having experienced injuries (WHO, 2013). The magnitude of lifetime IPV reported in this global study was 35.3%.

The scope of the IPV problem elsewhere in the world is equally large, revealed by a study in India, that one in three women (35.3%) experienced lifetime IPV (Patrikar et al., 2017), and a study in Zimbabwe

showing that IPV prevalence increased with women found to be HIV-positive (HIV-positive prevalence was 40.5%, compared to 31.5% IPV prevalence in HIV-negative women). Therefore, being HIV positive is associated with IPV. Moreover, gender inequalities, living with relatives and past IPV are also statistically associated with IPV (Shamu et al., 2014).

It is evident that IPV has a harmful impact on mental health and on reproductive and sexual health. Women who are exposed to IPV are twice as likely to develop depression, 16% more likely to have a low birth weight baby, twice as likely to have alcohol use disorder, 1.5 times more likely to acquire HIV and 1.5 times more likely to acquire an STI (WHO, 2013). Along with the growing attention to IPV is an increasing concern of its presence among serodiscordant couples. A study in Kenya revealed that some husbands of serodiscordant women refuse to use safe sexual practices such as the use of condoms. Women in serodiscordant relationships also experience negative consequences from serostatus disclosure to their partner (Maeri et al., 2016).

Femicide, at the far end of the scale of violence is defined as "intentional murder of women because they are women, but broader definitions include any killings of women or girls". It was committed by partners or ex-partners and involved ongoing violence in the home, sexual violence, where women have low income or fewer resources and less power than their male partner (WHO, 2012).

A study conducted in Tigray women in Ethiopia also revealed that HIV transmission is a form of IPV in its own right. Poverty and lack of gender equality often did not afford women to protect themselves from IPV and HIV (Ní Raghallaigh, 2015). The Northern Ethiopia qualitative study revealed that study participant women reported that transmission of HIV from their sexual partners, including husbands, was a form of abuse. Women also were aware of men who intentionally didn't disclose their HIV-positive status from their partner (Ní Raghallaigh, 2015).

At this time, according to the EDHS 2016 report, IPV or domestic violence is considered to be of significant concern from economic, health and human rights perspectives (EDHS, 2016). Along with the emphasis on IPV, there is an increasing concern over its presence among women living with HIV after their serostatus disclosure. Therefore, the aim of this study was to measure IPV among women who were both living with and without HIV, to explore HCW experience of screening for IPV and to identify the factors associated with IPV in Ethiopia.

1.3. Rationale and significance of the study

Recent studies of IPV have intensified the need to emphasise the eradication of all forms of violence against all girls and women in public and private organisations. Such attention targeting violence elimination is noted in the Sustainable Development Goals (SDGs), which includes trafficking and sexual and other types of exploitation (United Nations, 2015). Furthermore, the concern with IPV against women who are living with HIV has received considerable critical attention (The White House Washington Working Group, 2013). Thus, there is a need for assessing the factors that contribute to the increased risk of violence against women and girls living with HIV. Moreover, it is essential to know the extent of the association between HIV/AIDS and violence against women (VAW) and girls. These are the core objectives to obtain due attention to develop effective action (The White House Washington Working Group, 2013).

Thus, the importance of this study is to find answers to questions concerning IPV against women and to find the hidden truths behind this research question. All research should have a purpose (Pandey et al., 2015), and after exploring the experience of IPV against women and measuring the factors associated with it, this research shows the relationships and interaction among the various factors linked to IPV among women living with and without HIV in Ethiopia. Moreover, the knowledge generated in this study can be used by researchers in other parts of the country, by policymakers and programme developers to develop appropriate policy frameworks and programmes. Understanding risk factors will assist the Ethiopian government to develop context based interventions including primary prevention of violence and management and treatment of gender based victims.

1.4. Purpose and objectives

1.4.1. Purpose

This study aimed to map the evidence of IPV in Sub-Saharan Africa, to measure the factors associated with IPV, to explore the experience of IPV against women living with and without HIV, and the health care workers' IPV screening experience in Wolaita Zone , southern Ethiopia in order to contribute to solutions to the problem of IPV.

1.4.2. Objectives

The study objectives were

1. To conduct a scoping review of IPV among women living with HIV and AIDS in sub-Saharan Africa.

2. To explore the lived experience of IPV against women using ART and other outpatient services in Wolaita Zone in Ethiopia.
3. To explore the health care workers experiences and challenges in screening for IPV among women who use ART and other health services in Wolaita Zone in Ethiopia.
4. To measure the prevalence and associated factors of IPV among women living with and without HIV in Wolaita Zone in southern Ethiopia.

1.4.3. Research questions

What is the existing evidence of IPV among women living with HIV? What is the experience, context, and meaning and what are the factors associated with IPV against women living with and without HIV in Wolaita Zone in southern Ethiopia? What are the screening practices of HCWs for IPV in this region?

1.5. List of manuscripts

The study consists of five manuscripts, including the protocol of the scoping review, all the manuscripts o have been published. Two papers have been published in BMJ Open, one in PLoS One, one in Reproductive Health, and the rest one in Journal of Multidisciplinary Healthcare, respectively. These papers are detailed below.

Papers 1 and 2 (Protocol and the result of the scoping review)

Meskele M, Khuzwayo N, Taylor M. Mapping the evidence of intimate partner violence among women living with HIV/AIDS in Africa: A scoping review protocol. *BMJ Open* 2019;9: e029284. doi:10.1136/bmjopen-2019-029284

Meskele M, Khuzwayo N, Taylor M. Mapping the evidence of intimate partner violence among women living with HIV/ AIDS in sub- Saharan Africa: a scoping review.*BMJ Open* 2021;11:e041326. doi:10.1136/ bmjopen-2020-041326

Paper 3

Meskele M, Khuzwayo N, Taylor M (2019) Intimate partner violence against women living with and without HIV, and the associated factors in Wolaita Zone, southern Ethiopia: A comparative cross-sectional study. *PLoS ONE* 14(8): e0220919. <https://doi.org/10.1371/journal.pone.0220919>.

Paper 4

Meskele, M., Khuzwayo, N. & Taylor, M. 2021. Lived experience of intimate partner violence among women using antiretroviral therapy and other outpatient services in Wolaita Zone, Ethiopia: a phenomenological study. *Reproductive Health*, 18, 25. <https://doi.org/10.1186/s12978-020-01044-0>.

Paper 5

Meskele M, Khuzwayo N, Taylor M. Healthcare Worker Experience and the Challenges in Screening for Intimate Partner Violence Among Women Who Use Antiretroviral Therapy and Other Health Services in Wolaita Zone, Ethiopia: A Phenomenological Study. *J Multidiscip Healthc.* 2020;13:1047-1059 <https://doi.org/10.2147/JMDH.S269940>.

1.6. Thesis structure

The thesis is presented in seven chapters; the summary of each is as follows:

Chapter 1: Introduction

This chapter provides the background information about the experience and prevalence of IPV, the problem statement, and the significance of the study. It explains the purpose and objectives of the study, and lists the research questions and the manuscripts resulting from the study.

Chapter 2: Literature review and Methodology

This chapter encompasses current literature on IPV, the conceptual framework and the theoretical and philosophical foundations of the study. Moreover, the chapter describes the type of research, the phase, design, study setting, population, sample size, sampling procedure, variables, inclusion and exclusion criteria, definitions/operational definitions, data collection, management, analysis, data storage and quality control, and ethical considerations.

Chapters 3 to 6: Publications

These chapters contain five published papers. These comprise one scoping review protocol and one review of the first objective (Chapter 3) and the paper reporting on the quantitative results, objective four, (Chapter 4). The paper reporting on the women's lived experience, objective two (Chapter 5), and the paper on health workers' experiences in screening for IPV (Chapter 6) was published.

Chapter 8: Synthesis

This chapter discusses the main findings reported in the manuscripts, indicating how they are related to each other. The chapter ends with recommendations for further studies and initiatives that can contribute to reducing the risk of IPV.

Appendices

This section contains copies of the information and consent forms, the letters of permission, the questionnaire, interview guides, and ethical approval.

CHAPTER TWO: LITERATURE REVIEW AND METHODS

2.1. Introduction

This chapter presents the relevant reviewed literature on the epidemiology of IPV against women and its relationship to HIV. It discusses not only the global but also the African and Ethiopian contexts and the experience of IPV against women in these locations, particularly women living with HIV. Additionally, the literature on HCWs' experience of screening IPV cases in Ethiopia and regarding the related associations of IPV among HIV-negative and HIV-positive women is reviewed. At the end of this chapter, concluding the literature review, the research gap is identified, and the conceptual framework and the theoretical and philosophical foundations used for the study, and the methods are presented.

2.2. The global prevalence of intimate partner violence (IPV)

Globally, IPV is a substantial public health problem (Freire-Vargas L., 2018; National Network to End Domestic Violence [NNEDV], 2017). Data from the global and regional estimates, conducted in 79 countries and two territories by the WHO in 2013, have revealed that the worldwide prevalence of sexual and/or physical IPV among ever-partnered women was 30% (WHO, 2013). The prevalence was highest, at 37%, among African, South-East Asian and Eastern Mediterranean regions. However, a relatively lower occurrence has been detected in developed countries (23%). Among European and the Western Pacific regions, 25% of ever-partnered women stated lifetime IPV experience (WHO, 2013). A survey conducted in Brazil in 2016 showed that there was a high prevalence of three forms of IPV, physical (46.1%), emotional (52.7%), and sexual (13.6%), among women aged 15 to 49 (De Barros et al., 2016), while a study conducted in Iran among 2091 women also showed different types of IPV prevalence, reporting that about 57.1% of women had suffered psychological aggression, 26.6% suffered sexual abuse, 27.6% suffered physical abuse, and 6.9% suffered an injury (Ahmadi et al., 2017).

2.3. The African prevalence of IPV

A study in the same country revealed that 132 (21%) of women had experienced IPV in 2016, including physical, emotional, and or sexual violence (15%, 15%, and 2% respectively). Out of the 21% in this study, 48% had experienced two or more types of IPV, and among women aged 18-24, emotional and physical violence were the most prevalent forms (Bernstein et al., 2016).

In Tanzania, a survey showed that 61% of women had at some time experienced IPV and they experienced a 27% prevalence of IPV in the year preceding the study. Moreover, the survey showed that 82% of the women had experienced partner controlling behaviour in their lifetime and 63% during the 12

months prior to the study (Kapiga et al., 2017). A survey conducted among 894 HIV-positive Cameroonian women showed an IPV prevalence of 29% for emotional violence, 22% for physical abuse, and 18% for sexual violence (Fiorentino et al., 2019). In Togo, a survey conducted by Burgos-Soto et al. (2014) revealed that the prevalence of lifetime physical violence among women infected with HIV (63.1%) was considerably higher than among HIV-uninfected women (39.3%). Togo study also revealed that any form of sexual violence among HIV infected women was 69.7%; while it was 35.3% among HIV-uninfected. Moreover, 42% of these women revealed having had physical injuries due to IPV. Among the injured women, only one-third had ever revealed the real cause of the injuries to medical staff, and none of them had been referred to local institutions to obtain proper psychological care (Burgos-Soto et al., 2014).

In 2016, Colombini et al. published a paper from a Kenyan study in which they reported that approximately one-third of the participants admitted experiencing emotional and or physical violence perpetrated by their husband or partner as a result of sero status disclosure (Colombini et al., 2016).

2.4. The magnitude of IPV in Ethiopia

Currently, according to the 2016 EDHS report, IPV or domestic violence is considered a significant concern from the perspectives of economics, health, and human rights. It is significant that questions about IPV or domestic violence were included in such a survey for the first time (EDHS, 2016). Regarding the magnitude of the problem, in excess of one in three of ever-married women (35%) testified that they had experienced either physical, emotional, or sexual violence from their husband or partner at some point in their relationship (EDHS, 2016). Of these women, 24% experienced emotional violence, 25% experienced physical abuse, and 11% experienced sexual violence. Thirty-eight percent of women overall had experienced physical, emotional, or sexual abuse from a husband or partner with a higher prevalence among older women (40-49) (EDHS, 2016). More than one in four pregnant women in Ethiopia experience IPV (Alebel et al., 2018). A review conducted among pregnant women showed that the overall lifetime prevalence of IPV was 26.1% (95% CI: 20.0, 32.3) (Alebel et al., 2018). Moreover, a systematic review of ten studies revealed that the lifetime prevalence of IPV by a husband or intimate partner ranged from 20% to 78% (Semahegn and Mengistie, 2015). Furthermore, the lifetime domestic physical violence perpetrated by a husband, the IPV, ranged from 31% to 76.5%; the lifetime domestic sexual violence against women by the intimate partner or husband ranged from 19.2% to 59%; and the mean lifetime prevalence of emotional violence was 51.7% (Semahegn and Mengistie, 2015).

The evidence presented concerning the global prevalence, evidence from Africa and the Ethiopian studies in this section, suggest that IPV is a major public health concern prevalent in many parts of the world.

Given all that has been mentioned so far, one may suppose that the IPV prevalence differs from place to place, but this has not been studied among Ethiopians living with HIV and after HIV status disclosure to their intimate partner.

2.5. Factors associated with IPV

Although factors associated with IPV vary in different countries and regions, some of the recurring ones are substance abuse, type of residence, and education. Several studies, thus far, have identified various factors that are associated with IPV. A study conducted in Brazil showed that a partner's drug use and a depressive-anxious mood were associated with IPV (De Barros et al., 2016). In Iran, a study presented that among women less than 40 years of age, low education, being unemployed, a husband's addiction to substances and being rented-householders were associated with IPV (Ahmadi et al., 2017). However, physical violence and education were not associated with IPV in a Ugandan study, but the use of ARTs was associated with all types of violence (Osinde et al., 2011). Research in Zimbabwe in 2014 amongst pregnant women revealed that past IPV, lack of gender equality, risky sexual behaviour and living with a relative were statistically associated with IPV (Shamu et al., 2014). A community-based study in Ethiopian women showed that alcohol consumption by husbands, pregnancy status of women, having decision-making powers, yearly income, family history of violence, occupation, and residence were statistically associated with IPV (Semahegn et al., 2013; Semahegn and Mengistie, 2015). Moreover, another study in Ethiopia revealed that mothers' educational status, intimate partners' alcohol use, and partners' educational status were associated with IPV (Alebel et al., 2018).

2.6. The link between HIV/AIDS and intimate partner violence

Intimate partner violence against women is a public health problem which overlaps with HIV/AIDS (WHO, 2004). Intimate partner violence is a public health concern among HIV-infected women in many countries. The existence of the link between these two public health problems is suggested in a national survey conducted in India showing a dramatically higher incidence of HIV reported among women who experienced IPV (Patrikar et al., 2017; Maimela., 2019). Studies thus far have linked HIV with violence against women in South Africa, Togo (Burgos-Soto et al., 2014; Karim and Baxter, 2016) and Kenya. For instance, a 2016 study conducted in health facilities in Kenya revealed that one-third of the study participants experienced emotional and/or physical violence imposed by their partner after their HIV status disclosure (Colombini et al., 2016). In 2016, the qualitative research conducted in Kenya by Colombini et al. revealed that some women were reporting experience of partner violence, physical

violence, controlling behaviour, emotional abuse, sexual abuse, and denial of material support after their HIV status disclosure (Colombini et al., 2016). Moreover, the study in Togo showed that the factors associated with higher numbers of HIV-infected women than uninfected are: experience of sexual abuse before the age of 15, a history of non-partner violence, concurrent relationships, and being involved in fighting with other men (Burgos-Soto et al., 2014). IPV perpetrators are more likely to be HIV positive themselves (Jewkes et al., 2010).

A study also indicated that IPV perpetrators men were more likely to have HIV-risky behaviours that let them acquire HIV. They were at increased risk of transmitting HIV to their partner (Fiorentino et al., 2021).

In Ethiopia in the South Wollo Zone, IPV, experiencing a lifetime of violence by any perpetrator of violence, and sexual violence, were all associated with HIV (Hassen and Deyassa, 2013).

The bi-directional nature of the two health problems (HIV and IPV) is also a challenge. Intimate partner violence is a prevalent health problem in Africa, as shown in the following studies. A South Africa study identified that the increased prevalence of infection of HIV might be exacerbated by gender-based violence (Karim and Baxter, 2016). HIV status disclosure is a risk for stigma, abuse, and financial withdrawal (Colombini et al., 2016). On the other hand, IPV also leads to HIV infection (Patrikar et al., 2017; Maimela., 2019).

However, the evidence for the relationship between HIV and IPV is inconclusive. Though some studies mentioned have linked HIV with IPV, in 2010, studies that were conducted in low-income countries revealed that the two were not found to be consistently associated, at least among ever-married women (Harling et al., 2010). Because of the need to understand the phenomenon, this study aimed to investigate whether the association does exist. Few types of research have discovered this relationship, and little is known about the experience of emotional, psychological and other types of violence among HIV-positive women. Among a few studies, Northern Ethiopia revealed a transmission of HIV from their sexual partners, including husband, was a form of abuse in itself (Ní Raghallaigh, 2015). In addition, little is known about the experience of health HCWs screening for IPV among women, whether they are HIV-infected or not.

[2.7.Intimate partner violence screening experience of healthcare workers](#)

A study showed that HCWs reported various challenges concerning IPV screening which included time constraints, declining corporate support and services for IPV, and organisational expectations for

increased productivity (D'Avolio, 2011). The study also showed that there is a need to have a supportive environment and resources for IPV screening. The WHO expresses the need to build capacity for the prevention of IPV through, for example, including these issues in the curricula for HCWs and providing in-service training (WHO, 2010). Some studies have revealed a low rate of IPV screening by HCWs, ranging from 1.5% to 12% in primary care settings (Agency for Healthcare Research and Quality[AHCRQ], 2015). The identified challenges for IPV screening by HCWs are the providers' discomfort with the topic, the shortage of time to screen for IPV, fear of offending the client, and the need for privacy (AHCRQ, 2015). Currently, no program are existing in Wolaita Zone to identify the risk of violence and safety planning into ART services. However, studies stated that IPV prevention program has to be integrated with other health care programs (WHO, 2013). Women experiencing IPV and sexual assault should be integrated into the existing health care services like ART, antenatal care (ANC), family planning and outpatient services rather than as a stand-alone service (WHO, 2013). It is also a good strategy of preventing the identification of risk of violence and safety planning into ART services. Therefore, this study aimed to discover the nature of HCWs' practice of screening for IPV among women living with HIV and using ART and women accessing other health services in Wolaita Zone in Ethiopia.

2.8. Conclusion of the literature review

Some studies thus far have identified various factors associated with IPV. However, the topic has not been well studied comparatively among HIV-positive and HIV-negative women. Furthermore, IPV has not been well studied and documented among HIV-positive women after their HIV-status disclosure. Moreover, the service providers' point of view on IPV screening has not been addressed in detail among these categories of client. Therefore, this research aimed to fill these gaps.

2.9. Theoretical background

The theoretical framework is a guide that builds and helps the study. It provides the structure of how the researcher epistemologically, methodologically, philosophically, and analytically worked on the thesis. There are different types of theories for various research problems, and one should select an approach which fits the research problem (Osanloo, 2016). This study was based on social learning theory and feminist theory.

2.9.1. Theoretical and philosophical foundation

In this mixed-methods study design, the philosophical assumption, or the world view (the basic set of beliefs and assumptions of this research), was constructivism for the first and then post-positivism in the second phase. This pragmatic worldview helped us explore the women's lived experience of IPV, HCWs IPV screening experience, and measure the factors associated with IPV. The philosophical assumption of the research is important because it underlines the use of a qualitative design in addition to the quantitative aspects. Moreover, it helped me formulate the problem, apply the research question to the study and answer the queries in a proper manner (Creswell, 2013). The nature of reality or ontology follows singular and multiple truth as to how we gain knowledge of what we know, or the epistemology. It follows practically that the collection of the data is decided by determining what works, in order to address the study question. The data collection entailed getting close to the participants in order to gather the subjective evidence based on their individual reports, since knowledge is gained through peoples' personal experiences (Creswell, 2013). The axiology includes both biased and unbiased perspectives and the positionality of the researcher in the study (Creswell, 2013). This study focuses on an emancipatory theory of social learning, with a theoretical stance which explores marginalised groups and uses feminist theory calling for change (Creswell, 2011).

2.9.2. Social learning theory

Social learning theory, as it was established by Bandura, describes two ideas; the first one is the mediating process which occurs between stimuli and the response. The second socially learned idea, which relates to IPV, is a behaviour learned from the environment through the process of observation learning (Bandura, 1971). An individual, who has in the past observed a partner who abuses women, such as past adult abuse, childhood abuse, or who has witnessed partner abuse, may be influenced to hurt or violate his own partner (Shamu et al., 2014). For instance, this theory explains that boys who have witnessed their father abusing their mother are more likely to become abusers. However, the reverse may be true, that children who have observed their father violating their mother during their childhood may perceive this as bad behaviour and may not abuse women in adulthood. Social learning theory thus suggests that a person's past abuse experience may have a negative influence on their development regarding IPV, and this may occur against both women who are infected with HIV and those who are not.

A study also revealed that more than half of women and men experienced neglect in childhood, while about 25% of all the women and men witnessed the abuse of their mother and sexual abuse. The study shows that individual childhood IPV experiences and interpersonal experiences impact someone's behaviour and attitudes in adulthood. This concept also supports the ecological model of IPV (Machisa et al., 2011). Moreover, a study showed that childhood exposure to hardship influences women and men's

health (Jewkes et al., 2010). Similarly, childhood trauma leads to IPV and further child abuse, which increases the risk of experiencing violence during adulthood(Fulu et al., 2017).

A study of South Africa reported that women and men should be treated equally. However, 53.9% of men believed that men should be the final decision maker in the family. The study also mentioned that women need their husbands' permission to do paid work (Machisa et al., 2011). Therefore, it is essential to base social learning theory to develop the conceptual framework and base our research questions.

2.9.3. Feminist theory perspectives on IPV

Feminism is characterised by the belief that women should be equal politically, economically, and socially. The theory is also defined as the equality of both sexes regarding political, economic, and social aspects. It is also explained as "organised activity on behalf of women's rights and interests" (Merriam-Webster,2020). Feminist theory emphasises the underlying cause of women's subordination. The approach also develops strategies to liberate or free women from any oppression. It explains the power difference between men and women, the so-called lack of gender equality, to understand how this affects women (Crossman, 2017). Therefore, this study investigated male-controlled behaviours influencing IPV among women living with and without HIV, and how the inequality of decision-making affects women in various ways in the context of IPV. As Hooks emphasised, feminist theory aims to end the ideology of male dominance that operates over women, concerning economic and material benefits for men (Hooks, 1984). Feminist theory, in relation to IPV, relates to men's controlling behaviours because of the inequalities between men and women. For instance, we can say that sexual violence against women can happen because of male dominance and male refusal to engage in protective sexual practices, instead of engaging in the practice of multiple sexual partners (WHO, 2010).

A study categorised feminist theory into three approaches(Anderson et al., 2005). These are individualist, interactionist, and structuralist approaches to the study of gender. The first, individualist approaches to the study of gender highlights to the study of gender propose that individual persons are gendered beings. It shows that masculinity and femininity are traits that women and men incorporate into themselves, either through a biologically determined predisposition to these traits or socialisation processes. However, researchers who conceptualise gender from an individualist framework have used studies of partner assault among homosexual couples to buttress their claims that partner violence is not a problem of gender and power(Anderson et al., 2005).

The second approach, the interactionist approach, which emerged in the 1980s, criticised individualist approaches. It states gender as a characteristic of social interaction rather than of individual persons. The

position of interactionist, gender is viewed as an outcome of social practices rather than as a personal characteristic that predicts behaviour. The third approach, structuralist, states a gender is a form of social structure. It focuses that gender organises social institutions as well as identities, attitudes, and interactions. It positions gender as a stratification system that places women and men into unequal categories, roles, and occupation (Anderson et al., 2005).

A resource theory on IPV also suggests that male violence against an intimate partner is to be used as the ultimate resource to gain power and control in case if there is an imbalance in resources (e.g., educational attainment, income, occupation) favouring the other partner (Basile et al., 2013; Gelles, 2007). For instance, a male partner who does not have high education, occupation or income may use abuse to maintain a dominant household position (Gelles, 2007; Gelles, 2007). It shows that social resource theory related to social stress will exacerbate IPV risk (Basile et al., 2013).

2.10. Conceptual framework

After reviewing different kinds of literature and feminist and social learning theory perspectives on IPV, the following conceptual framework was developed (Figure 1) as influencing women's experience of IPV. The table categories are as follows: 1) Socio-demographic factors: income (employment), age of partner, level of education of partner, residence, number of children, if the marriage was arranged/spouse chosen by parents, and whether bride price was paid, 2) Individual characteristics of the woman and her partner : witnessed violence as a child, experienced past adult abuse, childhood abuse 3) Community norms , expectations, gender equalities & sexual risk factors: partner's controlling behaviour, and having multiple sexual partners, and STI treatment; 4) The partner's characteristics: employment, education, whether there was an age discrepancy between the partners, heavy drinking of alcohol, partner previously violent (e.g. men who had engaged in physical violence with other men) and consumption of alcohol and/or drugs by partner or women.5) Women's attitude towards violence: acceptance of physical violence or wife-beating, acceptance of sexual violence, decision making power of women. 6)HIV status: HIV positive/negative status, disclosure of test result, and serodiscordant status, and 7. Broader social and economic context (Specific laws to prevent IPV, women's economic empowerment). The influences that I have shown in this framework interact and are the basis for whether women experienced IPV or not.

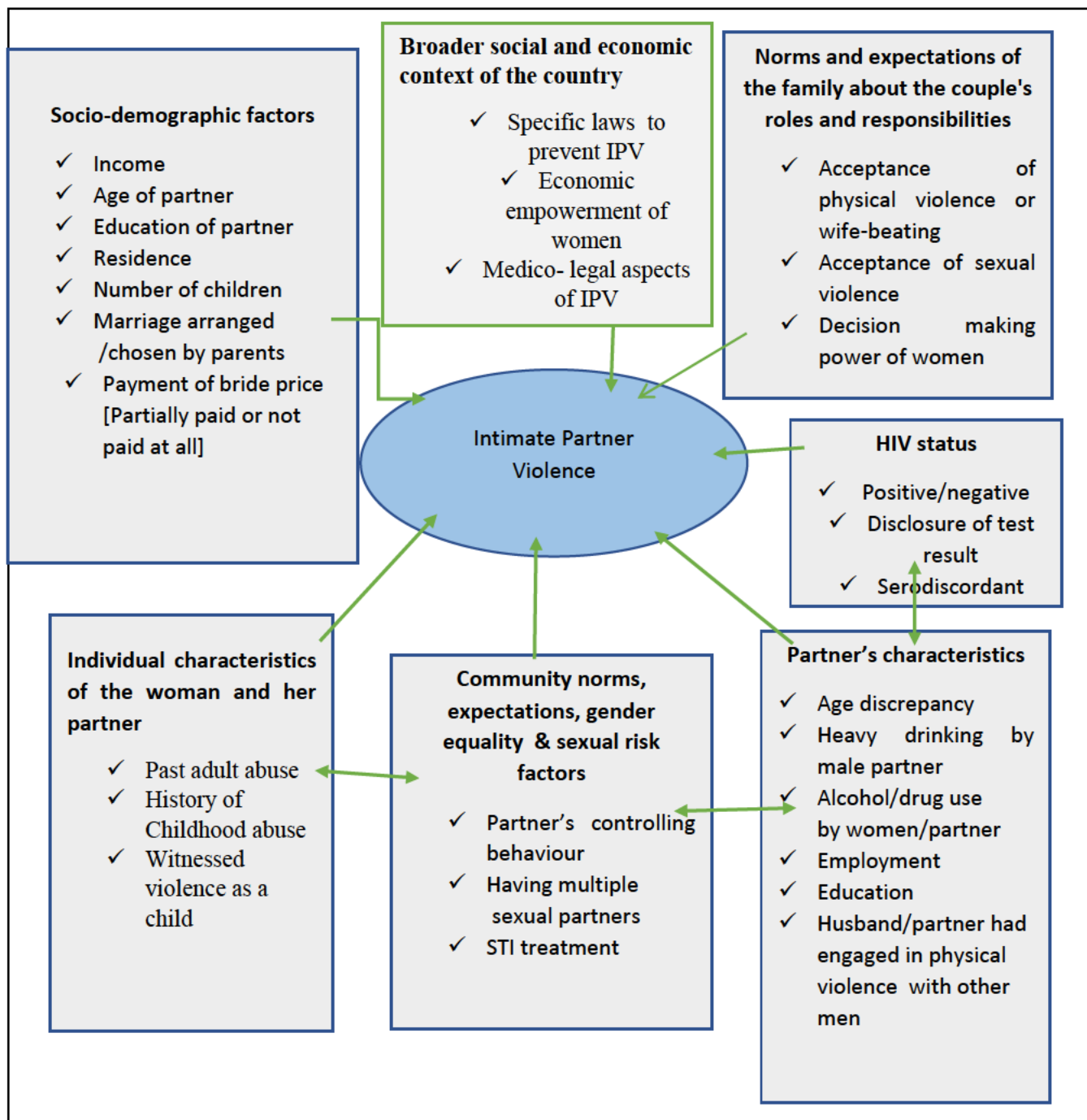


Figure 1: Conceptual framework showing the relationship between various factors and IPV experienced by women

2.11. METHODS

This section describes the methods and materials, such as type of research, the approach and the phases. The design of the study, the study setting and population, the definition of terms, and the perspectives are presented. It then describes the sampling strategy and sample size calculation, variables, data collection, instruments, data management, and data analysis. Moreover, this topic describes data storage and ethical considerations. Finally, it provides references.

2.12. Type of research

In this mixed-method research, we used different approaches for collecting and analysing data. I used a pragmatic worldview perspective, applying the different methods available to understand the research problem, and a pluralistic approach to derive knowledge about the issue (Creswell, 2014). I also used a scoping review with the mixed-methods study design, which included both quantitative (observational, comparative cross-sectional) and qualitative methods, integrating the two data forms, philosophical assumptions, and theoretical or conceptual frameworks (Creswell, 2014). The mixed-methods combined both quantitative and qualitative research methods. The use of the quantitative and qualitative methods, for data collection and analysis provided inference techniques that increased the breadth and depth of understanding and the corroboration of the data (Schoonenboom and Johnson, 2017).

The first phase (qualitative) followed constructivist principles to assess multiple perspectives. This was immediately followed by a post-positivist approach to identify and measure variables and statistics (Creswell, 2011). In this exploratory follow-up design, the plan was to explore IPV phenomena among women in Wolaita Zone in Ethiopia. This strategy was used to check for the truthfulness and validity of both the qualitative and quantitative data (Creswell, 2014).

The primary purpose of this mixed design was to generalise the research findings, to explore the phenomena in-depth, to measure the prevalence of the problem and to assess and to analyse the quantitative results. Using both qualitative and quantitative methods helped to gain complementary views of the same phenomena. Moreover, it helped to achieve completeness (to ensure the study obtained a complete and accurate picture), development (to test a hypothesis for future research), expansiveness (to expand the idea of a previous method), corroboration/confirmation (to assess credibility) and diversity (to determine a different picture of the same phenomena) (Bergman, 2008).

2.13. Approach and phase

This study was conducted in phases, and I followed an exploratory sequential mixed methods design. The first step was the scoping review. The study of this sensitive problem was more qualitatively oriented in order to understand the participants' experiences better. In the first phase of this study, I collected and analysed the qualitative data, and then the quantitative data collection followed. Thus, data collection began with and prioritised the qualitative data collection and analysis, then, to test and generalise the results, I conducted the quantitative second phase after developing the study instruments from the exploratory results.

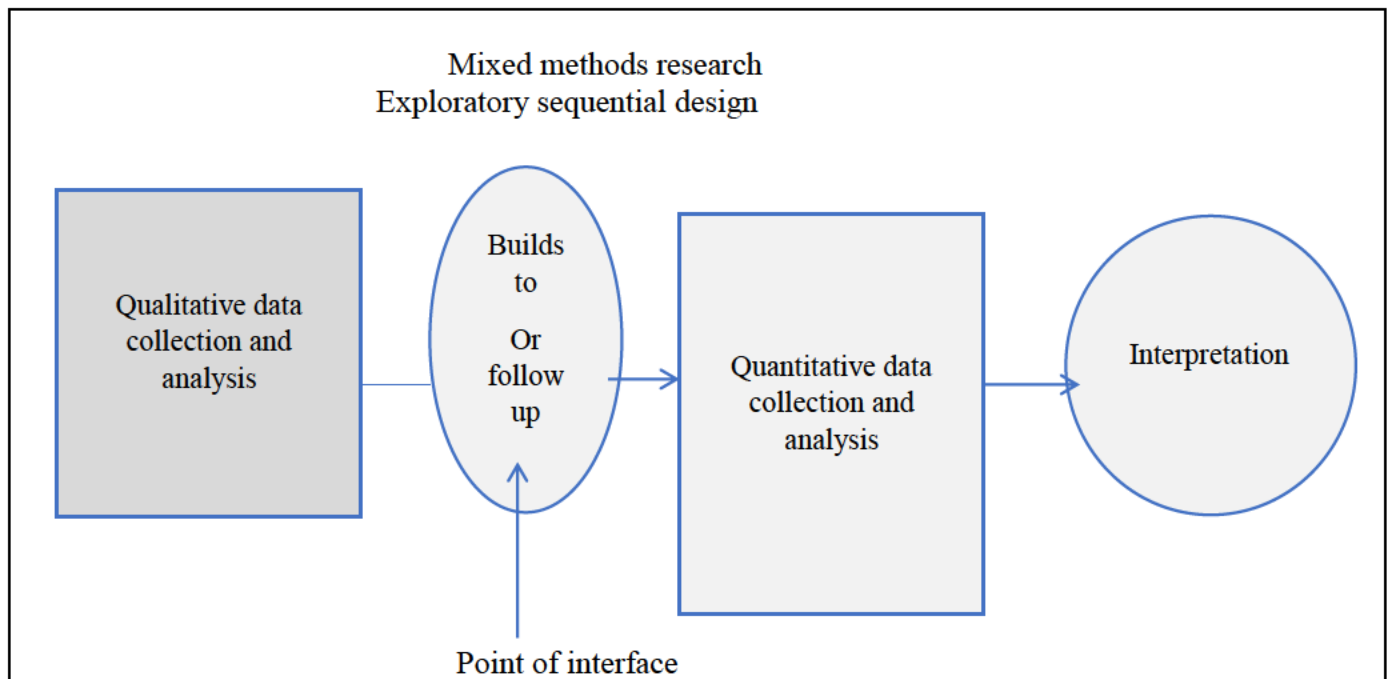


Figure 2. Diagrammatic presentation of exploratory sequential design

Table 1. Presentation of research papers by using various methods

S.N	Research Topic	Research design	Setting	Study population	Sampling and sample size,	Data collection and management/rigors	Outcome Variable/phenomenon/analysis	Independent measures/constructs
1.	Mapping the evidence of intimate partner violence among women living with HIV/AIDS in Africa: A scoping review	Scoping Review	Sub-Saharan Africa	Women aged 15 and above living with HIV/AIDS or receiving ART	20 articles from SSA countries, PRISMA diagram was used	Charting and use of PRISMA 2009 flow diagram used to extract articles	IPV Thematic analysis	NA
2.	Intimate partner violence against women living with and without HIV, and the associated factors in Wolaita Zone, southern Ethiopia: A comparative cross-sectional study	Comparative cross-sectional	Wolaita Zone, Ethiopia	Women 18-49 years of age (408 HIV-positive, 408 HIV-negative)	Multistage sampling; 816	Pre-tested WHO multicounty study on women's health and GBV study tool was used	IPV Logistic regression	Socio-demographic, individual, community norms and social and economic context variable
3.	Lived experience of intimate partner violence among women using antiretroviral therapy and other outpatient services in Wolaita Zone, Ethiopia: A phenomenological study	Phenomenology	Wolaita Zone, Ethiopia	Women 18-49 years of age	43 women	In-depth interview and FGDs was used/rigors used	IPV framework analysis	NA
4.	Healthcare Worker Experience and the Challenges in Screening for Intimate Partner Violence Among Women Who Use Antiretroviral Therapy and Other Health Services in Wolaita Zone, Ethiopia: A Phenomenological Study	Phenomenology	Wolaita Zone, Ethiopia	Health care workers(nurses, midwives, health officers, medical doctors)	16 HCWs	In-depth – interview/rigors considered	Screening of IPV Colaizzi's analysis	NA

2.14. Research design

2.14.1. Qualitative study design

We used a hermeneutic and a descriptive phenomenology study design for objectives 2 and 3, respectively, for the qualitative aspects of the study. This design helped us to explore the lived experience of women experiencing IPV and assisted in interpreting their life text (Creswell, 2014). In-depth interviews and focus group discussions (FGDs) were held with the women and HCWs until data saturation was achieved. This assisted our understanding of the individuals' collective experiences. These interactions focused on what members of the study populations have in common regarding their IPV experience, the explanation of their IPV experience and how it upset their lives. They also related to the interpretation that mediates between the diverse meanings that participants attach to their experiences. These experiences entailed what the HIV-positive women experienced in respect of IPV after their HIV status disclosure and the IPV experiences of HIV-negative women. Additionally, the contexts that influenced the women's experience of IPV were explored (Creswell, 2007). Reflexivity is very important in IPV study. Therefore, I identified with the women who were researched and must, therefore, constantly aware of my own experience that can potentially affect the result. Thus, the current study was not influenced by my own experience. I followed the three phases of bracketing. These are bracketing pre-action, bracketing in-action, and bracketing on-action. The first type of reflexivity was aimed at sustaining objectivity. It also reflects a strong positivist influence. The benefit of bracketing is the suspension of all kinds of biases and beliefs related to the phenomenon being researched before collecting data. The second was conducting a specific interview, and methodological development was undertaken. Third, I have implemented the new IPV experience from women can be utilised during subsequent interviews (Dowling, 2006).

2.14.2. Quantitative study design

I used a cross-sectional comparative survey for objective 4. This comprised a single examination of a random cross-section of a population at a single point in time. It aimed to study the attitude and behaviour, the prevalence, and estimate community needs. The cross-sectional aspect of the study was undertaken to assist in identifying the associations between different factors or diseases. However, this type of design cannot determine temporality; that is, which element might have occurred first. However, the results of this aspect of our study may be of valuable assistance in planning services or proper health education and screening programmes (Daly and Bourke, 2000; Laake et al., 2007).

2.15. Study area and setting

I conducted the current study in Wolaita Zone, one of 14 zones (states) in southern Ethiopia. In this part of Ethiopia, Wolaita inhabitants are categorised as one of the Omotic language-speaking population groups, the native language of this zone being Wolaita, while the Amharic language is an official language in this zone. Wolaita Sodo, the capital town of the zone is 330 km southwest of Addis Ababa, the capital city of the country. It is also 160 km from the southern regional capital, Hawasa. In the northeast, Wolaita is bounded by Kambata Hadiya and Tambaro zones and the Oromiya state. In the year 2016, according to the world population data sheet, the population of Ethiopia was 101.6 million. Wolaita, with a total area of 438 370 hectares or 4 471.3 square kilometres, has the highest population density of 385 persons per square kilometre (PPKM2). The population of the zone contributes around 2.3% (United Nations Population Fund [UNFPA], 2008) to the projected national population of 114.9 million people in 2020 (Worldometer, 2020). Based on the projection, the zone will have more than 2.6 million people in 2020. Of this number, 24.3%, or 631800, are estimated to be women of reproductive age.



Figure 2. Map of Ethiopia
Source: <https://www.google.com/searchq=map+of+Ethiopia&uid>

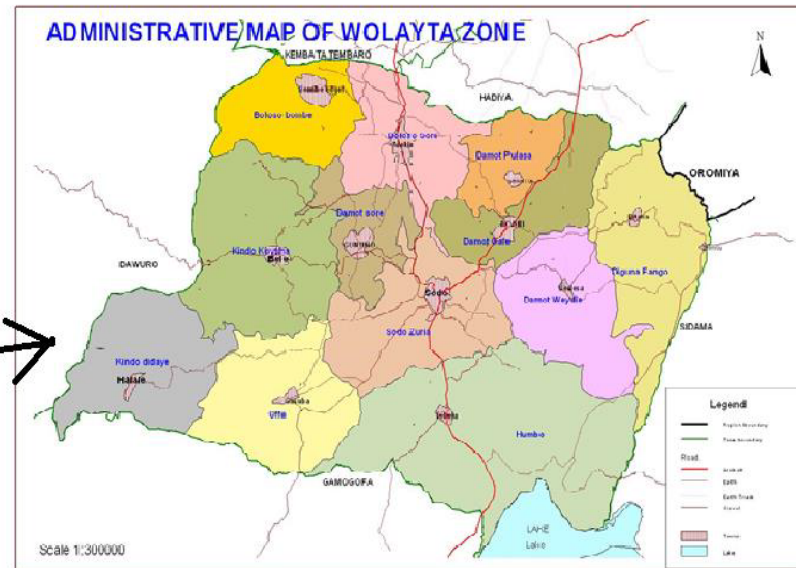


Figure 3. Study area map of Wolaita Zone. Source: <http://www.wolaitaonline.org/map-of-wolaitta-zone/>

Figure 3: Map of Wolaita Zone, Ethiopia

2.16. Target population

The source population were all women, aged 18 to 49, who were living with HIV and using ART and those who were without HIV who were attending health institutions for antenatal (ANC) care, postnatal care (PNC) and family planning care services. There was no testing for HIV conducted for the current study. I used already available HIV test documentation and reports of women using ART, ANC, PNC and family planning from health facility registrations with permission. Those women whose HIV test results were negative among ANC, PNC, and family planning users were included and categorised as HIV-negative. Women on ART were randomly selected and included in the study as HIV-positive. The women, plus the HCW who were providing services for these clients, which included women who were peer counsellors or educators, were the study population for qualitative research. The study population for the quantitative research was women who were HIV-positive and HIV-negative, who were attending the identified health facilities.

2.17. Study population

For the quantitative study, I randomly selected adult women aged 18 to 49, who were infected with HIV and using ART drugs, and HIV-negative women who were using ANC, PNC and family planning services. Besides this, purposely selected women living with HIV, women living without HIV, and HCWs (nurses, midwives, medical doctors or health officers) who were involved in the provision of care for women comprised the study sample for the two aspects of the qualitative study.

2.18. Inclusion and exclusion criteria

2.18.1. Inclusion criteria for the quantitative study

1. Adult women, aged 18 to 49, living with HIV and using ART
2. Adult women living without HIV (already tested for HIV for other purposes) who were using health services of ANC, PNC and family planning

2.18.2. Exclusion criteria for quantitative study

I excluded women aged under 18 and over 49 years, those mentally ill, or those with critical health concerns which would prevent the client from participating in the study. However, the excluded individuals have the right to benefit from these research findings in the same way as participants.

2.18.3. Inclusion criteria for the qualitative study

1. Purposely selected health professionals who were involved in the provision of care for women living with HIV, ANC, PNC and family planning.
2. Purposely selected adult women, who were living with HIV, aged 18 to 49, and using ART.
3. Purposely selected adult women who were living without HIV (already tested for HIV for other purposes) who were using health services for ANC, PNC and family planning.

2.18.4. Exclusion criteria for the qualitative study

I excluded women who had any illness which prevented them from being involved in the interview. However, the individuals who were excluded from this study are entitled to receive the benefits of the research findings in the same way as the participants.

2.19. The phenomenon to be investigated

The investigated phenomenon was IPV against women.

2.20. Sampling strategy and size

2.20.1. Sampling strategy

I used a multistage sampling technique for the second phase, which was the quantitative study. A total of 12 districts (woredas) and three recognised towns were included, in which 68 health centres and seven hospitals are providing health services. Among these health facilities, two health centres and two hospitals are non-governmental. Since this study focused on women who are using ART, a total of 19 health institutions serving ART in the zone were included in the study (12 health centres and seven hospitals). I stratified health facilities by health centres and hospitals; I stratified hospitals into governmental and non-governmental. Therefore, I randomly selected a total of nine health facilities, thus including in the study six health centres and three hospitals.

I allocated the sample size for each health institution based on the probability proportional to the size (PPS) of their preceding six months of client flow. I used the Kth($k=N/n$), where n = the sample size calculated ($n=817$), and N =number of women in the nine health institutions ($N=5\ 301$). I interviewed every sixth woman until the required sample size was obtained at each institution (Figure 3).

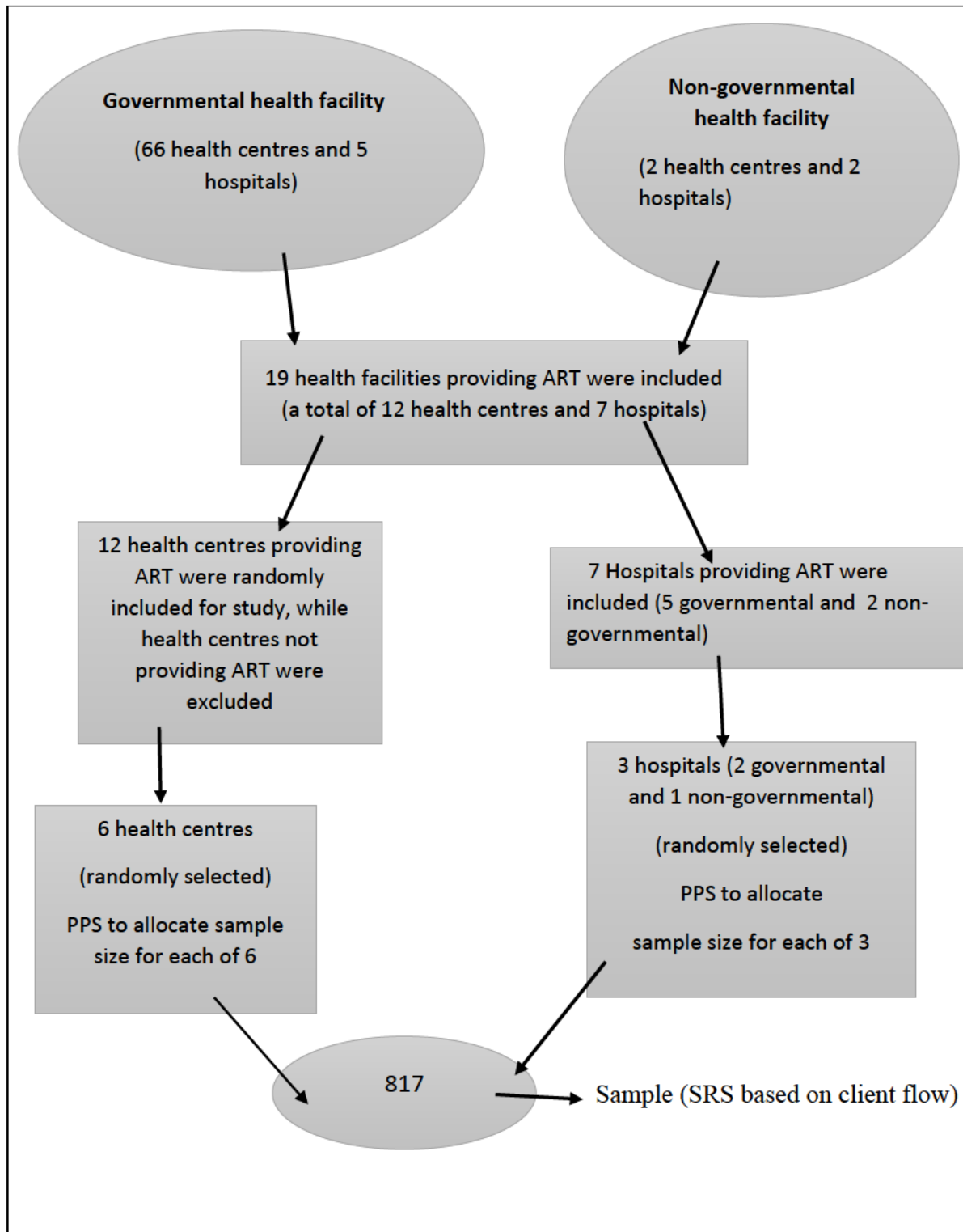


Figure 4. Schematic presentation of sampling techniques for quantitative study

2.20.2. The sample size for the qualitative study

I used purposive sampling methods of a maximum variation sampling type. This method is known to produce a well-matched group for a study. Another benefit of the process is its utilisation of the best available knowledge regarding the study participants in order to obtain a wide range of perspectives relating to the topic that I am interested in studying (in this case the views of both HIV-positive and HIV-negative women) and to have better control of significant variables. A disadvantage is that it will be difficult to generalise the findings from this qualitative study. The participants were selected purposely from the nine health facilities from urban and rural districts until information saturation was achieved (Alvi, 2016). For both the in-depth interview and FGDs for the study, the participants were women living with and without HIV and HCWs.

2.20.3. Sample size calculation for quantitative study

I calculated the sample size by using the calculator designed for clinical research (Kohn et al., 2020). Therefore, I used: total cluster=19, the number of health institutions which were serving ART, the margin of error=0.05, the prevalence of women exposed to abuse in south-west Ethiopia=0.415 (Deribe et al., 2012), power=80%, the prevalence of women unexposed to abuse=0.585 (Deribe et al., 2012), confidence interval=95%, and within-cluster correlation coefficient=0.29. Thus, the sample size calculated by using the formula to calculate sample size with adjustment for clustering (fixed cluster) was 817. The online calculator indicated automatically included design effect and non-response rate in the sample. Finally, 408 women who were living without HIV, and 408 women who were living with HIV and using ART services were interviewed (**Appendix 1**).

2.21. Variables

2.21.1. Dependent variable

Intimate partner violence against women was the dependent variable.

2.21.2. Independent variables

I listed all the independent variables as follows:

Socio-demographic variables: income, the age of partner, education of partner, residence, number of children, and arranged marriage

Partner's characteristics: age discrepancy, heavy drinking by a male partner, alcohol or drug use, employment, education (low), partner prior involvement in a physical fight with other men.

Past violence: a history of past adult abuse, childhood abuse, witnessed violence as a child.

Gender inequalities and sexual risk factors: partner controlling behaviour, multiple sexual partners.

2.22. Data collection

This study followed an exploratory sequential design, and women who participated in the first qualitative stage of data collection did not participate in the next quantitative study. The purpose of the quantitative research was to be able to generalise the results to a population; in this study, women living in the Wolaita Zone of Ethiopia (Creswell, 2006).

2.23. Qualitative study data collection

The investigator developed the semi-structured questionnaire, the open-ended, in-depth interview questions and the FGD guides. I adapted these tools from the WHO's multi-country study on IPV (Ellsberg, 2005). As well as the semi-structured tool guide, further information was sought, and probes were used. Data collection was done by the principal investigator (PI), who was assisted by experienced female research assistants (RAs) who spoke the local languages Wolaita and Amharic fluently. Each RA had a bachelor's degree in health science with a rich experience of qualitative data collection. Each participating RA had been asked to provide certificates of qualitative data collection experience. I provided two days of training for the RAs on the tool for them to familiarise themselves with the study. Therefore, they were involved in preparing for the note-taking, in-depth interview and the FGDs.

I used FGDs, gathering 8 to 12 women from similar backgrounds or experiences together to discuss the participants' experiences of IPV. The FGDs were used to ask specific questions to explore participants' perceptions, beliefs, attitudes, opinions and ideas. In the discussions, women were free to talk with other group members. The FGD method suited this study because it obtained different perspectives of the women about IPV. It also provided insights into women's shared understanding of their day to day lives and how others can influence individuals in a group situation (Baral et al., 2016). Focus group discussions were conducted at the meeting rooms of the health facilities in order to maintain the women's privacy and comfort. Eight to 12 women were purposively selected for each FGD. I also arranged the FGD schedules at the women's preferred times. In order to minimise the limitations of the FGD, the facilitator provided equal chances for all FGD participants to talk. Moreover, I selected a private room preferred by participants and respected every participant's opinion during the FGD session.

Regarding confidentiality issues, I didn't include male in the interview and aware of all women to keep matters discussed in secret. The number of FGDs was determined by data saturation. I provided refreshments for FGD participants. I obtained the written informed consent from all the participants. The PI and one female research assistant undertook the probes and took notes to ensure the data quality, as indicated in the scientific research guides (Pandey et al., 2015).

In addition to the FGDs, I used in-depth interviews. These helped us to obtain a more detailed, rich understanding of our phenomenon, IPV. The in-depth interview method was used to understand the participant's experience, feelings, behaviour, and attitudes and allowed deep probing to identify the underlying concepts of IPV (Morgan et al. 2016). The HCWs and ART adherence counsellor assisted the recruitment of the study participants. I conducted all the in-depth interviews at the offices or their preferred settings to maintain confidentiality and privacy. Conversations were recorded by digital recorder after obtaining consent from the participants. In a few cases, where the participating women or HCWs refused to consent to the recording, I took notes instead, and the results were incorporated into the other data.

Some of the questions included in the interview were: When did your problems with your husband start? How long has this problem continued? Can you tell me the times in which this problem has got worse or improved? What was its effect on your physical well-being? How has it violated your feelings about yourself? In what ways? How did it affect your children? How has it affected your capacity to deliver for the family or to go to a job? How it affected your meeting relatives or friends? Explain to me whether you ever discussed your problems with others? How did they respond?

Finally, notes by the researcher, logbooks, interview notes, recordings of the digital voice recorder, and transcribing data for computer input were carefully entered and confidentially stored (Pandey et al., 2015). As per the developed in-depth interview and FGD guides, further probing questions were used to obtain more information on IPV against women. The RAs assisted with some of the data transcriptions. The PI (student) did the transcriptions, translation, and the complete analysis of the qualitative data.

2.24. Measures to ensure scientific rigour and trustworthiness

The following criteria for scientific integrity and rigour were used (Billups, 2014):

Credibility: I ensured that the data shown in the research reflects the opinion of the participants. At the period of data collection, I had peer debriefing, and, subsequently, the principal investigator and the co-authors did the data analysis and presented the verbatim quotes in the results section. I also provided transcripts to some participants to approve the comments.

Transferability: The thick explanations of the participants were provided in the results section to permit other scholars to decide on the transferability of the findings to their context.

Dependability: I conducted an audit trail with the co-supervisors and supervisor to ensure the analysis is based on the data.

Confirmability: I triangulated the data collection methods, the FGDS and in-depth interviews and analysis methods, in this research.

2.25. Quantitative study data collection techniques and instruments/tools

I adapted and adopted the questionnaire for quantitative study from the WHO's multi-country research study on domestic abuse against women (Ellsberg, 2005). I prepared the tool in English first and then translated it to Wolaita Donna and Amharic, the local languages. In order to check consistency, the tool was translated back to English. I made the wording of the questionnaires unambiguous and clear. I administered the interviews in either Amharic or Wolaita Dona. The interviewer-administered questionnaire was then used to collect data. Eight female HCWs were recruited to collect the data. The recruited data collectors were not employed at the selected health institutions, to minimise interviewer bias. I then assigned four supervisors with various backgrounds (BSC or MPH) to supervise the data collectors. I provided two days of training to the supervisors and data collectors to ensure their familiarity with the aim and objectives of the study. This training was also intended to standardise the interviewing skills of data collectors and supervisors and ensure the interviews were completed consistently.

Prior to data collection, a pre-test was done in a comparable setting, but outside the actual study area. I conducted Cronbach's Alpha to maintain the internal consistency of the questionnaire and to decide the reliability of the test; its result was ≥ 0.80 . The PI and the supervisors managed the work of the data collectors (interviewer, face to face), the quality of the fieldwork and the post fieldwork. The supervisors checked the completed tools daily.

2.26. Validity and reliability

Validity: Before the actual data collection, I conducted a pre-test among 5% of the total sample size to ensure that what was being asked made sense (face validity). I supervised the data collectors to assess whether they had collected real information from the participants. The supervisors checked the questionnaire to ascertain whether it measured what it intended to measure.

Reliability: I made random checks of the data collection process in the field. Amid the data collection period, after the interview completion, supervisors of the data collectors administered the instrument to the same subjects under the same conditions to check reliability. I enrolled a sizeable random sample (816) for the survey. We included 9 out of 19 districts, enough to increase the representativeness of the findings (external validity or generalisability). The questionnaire also was constructed using simple language. The survey was undertaken either in Amharic or Wolaita.

2.27. Data management and storage plan

For both quantitative and qualitative data storage, any information from the participants, including audio or taped records and raw data, was stored securely and kept confidentially. Moreover, the EPI data and STATA version 15 files were stored in the investigator's password-protected computer. Back-up files were copied to CDs, marked and filed in the locked file cabinet along with paper files. All data have been stored securely for five years and will finally be discarded appropriately. The publications that arose from this study and the other submitted manuscripts exclude any information that would make it possible to identify the participants' names or identities.

2.28. Data analysis: Quantitative study

Double entry of the quantitative data was done in EPI data. Then the data were transferred to STATA version 15 for cleaning and analysis. The identified errors were corrected after reviewing the stored raw questionnaires. I computed frequencies, mean values and presented the tables and graphs.

I used binary, and multivariable logistic regression analysis with 95% confidence interval and odds ratio to find the statistical associations. I did the post-estimation test of Hosmer-Lemeshow goodness-of-fit, and it was confirmed that the model fitted when the null hypothesis was true ($p\text{-value} > 0.05$). Moreover, we did the Receiver Operating Characteristics (ROC) graph. It indicated discrimination (0.8796) to show whether the model discriminates between the two groups which experienced IPV and the other group which did not. Furthermore, to differentiate the intercorrelation between independent variables, a multicollinearity test was done. Further details are presented in Chapter four.

2.29. Data analysis: Qualitative study

I used the framework and Colaizzi's descriptive phenomenological method for data analysis (The details are presented in in Chapters five and six. The PI and RAs transcribed the data verbatim and translated into English. Then the PI repeatedly read the transcripts in order to recognize the content of the recording.

NVIVO software was used to assist with the data organisation and analysis. In inductive data analysis, the analysis builds the categories and patterns from the bottom up, organising the data to achieve more abstract information. The process involves exploring back and forth between the database and a theme; hence, a complete set of themes was prepared. To get additional information, deductive analysis was done, that is, looking back at the data from the perspective of the theme. The process starts inductively and, also, deductive thinking has an additional role as the analysis goes forward (Creswell, 2014). Moreover, to ensure accuracy and consistency in the application of codes, we considered the credibility, dependability, transferability, and reflexivity components of the scientific rigours.

2.30. Ethical considerations

The Postgraduate and Research and Higher Degree Committee of the School of Nursing and Public Health at the University of KwaZulu-Natal (UKZN) approved this research for a PhD study (**Appendix 2**). I submitted and presented the proposal to the UKZN, School of Nursing and Public Health and received ethical clearance from its Biomedical Research Ethics Committee (BREC) (**Appendix 3**) and the Institutional Review Board (IRB) from the local Wolaita Sodo University in Ethiopia (**Appendix 4**). I also obtained formal permission from the Zonal Health Department of Wolaita Zone, and further permissions from the health facilities that participated in the study (**Appendices 5-7**). I explained the information concerning the informed consent to the participants clearly in their own language, and we obtained their written consent. I maintained respect for the person and the protection of vulnerable participants. I maintained the confidentiality of the participants by not writing their names in any part of the results (anonymity was ensured). Moreover, the interviews were held in private rooms (office of the service provider or a meeting room) in order to ensure the privacy of the participants. All individual interviews and FGDs were held in a safe place, somewhere that did not draw unnecessary attention and did not raise suspicion, and where participants cannot be overheard (WHO, 2007). Moreover, I and all members of the data collection team understood and were sensitive to the political, socio-cultural, security and economic factors that may affect the safety and security of those involved in the data collection process (WHO, 2007). Moreover, I arranged a referral sites like hospitals and counselling center at other health facilities and psychologist to link the client in case encountered emotional problem during interview.

In order to achieve reflexivity criticality, it emphasizes the diverse field of representations. I gave due attention to an examination of the political and social constructions in this IPV research process. I also provided field notes and transcripts of interviews to participant women for feedback. However, it related

with some difficulties like participants inadequate grammatical expression. Moreover, I engaged in a continuous self-critique and self-appraisal and explain how my own experience has not influenced the stages of the study process (Dowling, 2006). In order to achieve reflexivity criticality, it emphasizes the diverse field of representations. I gave due attention to an examination of the political and social constructions in this IPV research process. I also provided field notes and transcripts of interviews to participant women for feedback. However, it related with some difficulties like participants inadequate grammatical expression. Moreover, I engaged in a continuous self-critique and self-appraisal and explain how my own experience has not influenced the stages of the study process (Dowling, 2006). Through reflexivity, the researcher's capacity to recognize forces of socialization and change their place in the social structure, and by bracketing, I was always the protector of my own biases, beliefs, and assumptions that I might bring to the study. I was also aware that complete bracketing is not possible in interpretive phenomenological design (Brigitte, 2017). I implemented a high level of reflexivity to reduce my own biases. A high level of reflexivity would result in shaping me mainly by the study of community norms. Moreover, the PI also knows the norms of society very well.

Though, it is the ethical obligation to maximize the benefit to participants. The interviews used as an intervention; hence it is the opportunity for the participants to discuss their stories of trauma, which can be a transforming experience for both the researcher and the respondents. Most women welcome this opportunity to discuss their story when they are asked in the manner of non-judgmental and sympathetically (Ellsberg, 2005). The PI made reimbursement to the expense that the participant incurred for transportation paid where appropriate (WHO, 2016). I also reimbursed the costs incurred (such as refreshment). Further details are provided in the following chapter.

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CHAPTER THREE: MAPPING THE EVIDENCE OF INTIMATE PARTNER VIOLENCE AMONG WOMEN LIVING WITH HIV/AIDS IN AFRICA: A SCOPING REVIEW PROTOCOL

Status: 1. Protocol published in BMJ Open.

Meskele M, Khuzwayo N, Taylor M. Mapping the evidence of intimate partner violence among women living with HIV/AIDS in Africa: a scoping review protocol. *BMJ Open* 2019;9: e029284. doi:10.1136/bmjopen-2019-029284

2. Result of the Review: Published in BMJ Open.

Meskele M, Khuzwayo N, Taylor M. Mapping the evidence of intimate partner violence among women living with HIV/AIDS in sub-Saharan Africa: a scoping review. *BMJ Open* 2021;11:e041326. doi:10.1136/bmjopen-2020-041326

Introduction: Before beginning this PhD project, we mapped the evidence of IPV experiences among women living with HIV in Africa. It also helped us to map the evidence of how their HIV status disclosure leads to IPV and the evidence of socio-demographic factors associated with IPV in sub-Saharan Africa. This review showed us further of the need to conduct primary research based on the gaps we identified through the review—the protocol was published in BMJ and the results of the review were submitted to BMJ Open where it is under review.

Doctoral student's contribution

1. I conceived and formulated the project.
2. Study design: I designed the study with my supervisors.
3. Study selection and data analysis: I formulated the study question, identified the relevant studies, made the study selection, charted the data, summarized the results
4. Write up: I wrote the manuscript together with my co-authors/supervisors

These papers are presented below.

3.1. Mapping the evidence of intimate partner violence among women living with HIV/AIDS in Africa: A scoping review protocol. Page 41

3.2. Mapping the evidence of intimate partner violence among women living with HIV/AIDS in Africa: A scoping review .Page 47.

BMJ Open Mapping the evidence of intimate partner violence among women living with HIV/AIDS in Africa: a scoping review protocol

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ABSTRACT

Introduction Among women living with HIV, intimate partner violence (IPV) is increasingly recognised worldwide as a serious public health concern. The understanding of the link between IPV and HIV is currently inconclusive and information concerning the IPV experiences of HIV-infected women is insufficient. This protocol aims to map evidence of IPV against women living with HIV/AIDS in Africa.

Methods and analysis We will search and review peer-reviewed and review articles. The comprehensive search will include the electronic databases PubMed, MEDLINE with full text via EBSCO host, Google Scholar, Science Direct and Scopus. The advanced search will use MeSH terms. Grey literature will also be included. The titles of the studies from the database searches will be screened, and duplicates will be removed. The abstract screening will be done independently by two reviewers, followed by the full-text screening which will be based on the eligibility criteria. The six methodological stages in this review will be to: identify the research questions; identify relevant studies; select the studies; chart the data; collate, summarise and report the results; and thereafter undertake consultations. The quality of studies included in the review will be determined by the Mixed Methods Appraisal Tool. NVIVO software V.11 will be used to undertake a thematic analysis of each of the studies and to extract the relevant outcomes.

Dissemination The results of this study will be disseminated through publication, and presented at conferences related to IPV.

Scoping review registration Currently, a scoping review is not eligible for registration on the International Prospective Register of Systematic Reviews.

INTRODUCTION

Women who are living with HIV and who disclose their HIV serostatus are more likely to experience intimate partner violence (IPV) than women who are HIV negative.¹ Among the former IPV and HIV may provide overlapping or perhaps intersecting challenges.² The reason that women experience such violence is that the abusers have been shown to usually want to establish and maintain power and control over another person.

Strengths and limitations of this study

- The links between HIV/AIDS and intimate partner violence (IPV) are complex and not well understood; hence, this review aims to assess in-depth any associations among women living with HIV and the evidence obtained will provide a baseline for future research in gender-based violence.
- One of the limitations of this review will be that it only includes the literature published in the English language. Since the studies published in other languages will be missing, other evidence about IPV in women infected with HIV will be lacking.
- It is possible that our review will not include all articles which have been published in every journal since some may not be accessible.

This is often reflected in the imbalance of power between the women and their abusers.³ IPV is defined as ‘...any behaviour within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship’. This also includes ‘emotional abuse and controlling behaviour by an intimate partner’.⁴

Worldwide, IPV is of public health and social concern. The prevalence of IPV in the WHO’s different regions varies, but is similar in the Eastern Mediterranean and South East Asian regions (where IPV was reported to be 37% and 37.7%, respectively), to that in Sub-Saharan Africa, where the prevalence was 36.6%.⁵ Over a third of women in these regions reported IPV, and this high prevalence of IPV both among women and girls is of concern.^{2,5} The deleterious consequences of IPV among women and young girls are well documented, and this has been shown to affect their mental, sexual and reproductive health.^{5–7} Studies on IPV and depression show that women who are exposed to physical violence, childhood sexual abuse, mild or severe emotional violence, and where there is



high spousal control are more likely to be depressed,⁶⁻⁸ more likely to abuse alcohol,⁵⁻⁷ give birth to babies of low weight.⁵⁻⁷ Since they may not be able to negotiate condom use,⁵⁻⁷ they are also at risk of being infected with sexually transmitted infections (STIs) including HIV.^{5-7,9}

The relationship of IPV and HIV among women and girls is a topic of intense debate within the scientific community.^{9,10} Some researchers consider that IPV increases women's vulnerability to HIV infection,^{1,5-7} while other researchers suggest that HIV positive status among women may influence IPV.^{2,11} A study conducted in Zimbabwe among pregnant women living with HIV revealed an IPV prevalence of 40%.¹² Further, a study in Kenya showed that after post-HIV serostatus disclosure, one in three women experienced partner violence.¹³ Moreover, both the combination of physical and sexual IPV (OR: 2.00; 95% CI: 1.24 to 3.22), but also experiencing any type of IPV were associated with HIV infection in women (OR=1.41; 95% CI: 1.16 to 1.73).¹⁴

IPV and HIV/AIDS are thus two pandemics that require integrated and collaborative interventions. The Joint United Nations Programme established new targets for the scale-up of HIV treatment by 2030, including increasing the number of people who know their HIV status by 90%, increasing the number of people who receive sustained antiretroviral therapy by 90% and aiming to ensure that 90% of all the people who are HIV sero positive receive ART.¹⁵ These new targets are promising but achieving these goals could be compromised by women and young girls experiencing IPV. Therefore, this scoping review aims to map evidence of IPV among women living with HIV in Africa.

The information generated through this scoping review can be used by researchers, policy-makers and programme developers to develop appropriate programmes and policy frameworks.

METHODS

This review is part of a large-scale study on IPV among women living with and without HIV in Ethiopia. The review will use the framework which is proposed by Arksey and O'Malley¹⁶ which has six stages. These are: (1) identifying the research questions and defining the eligibility criteria, (2) conducting an extensive search and identifying relevant studies, (3) making the study selection and appraising the quality of the study (4) synthesising the included studies (charting the data) and presenting the findings by using a Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) chart, (5) collating, summarising and reporting and (6) consultation (box 1).

Stage 1: identifying the research questions

This scoping protocol is based on the following research questions:

1. Is there evidence of IPV experiences among women living with HIV in Africa?

Box 1 The proposed scoping review will follow the below steps

- Stage 1: Formulating the study question.
- Stage 2: Identifying the relevant studies.
- Stage 3: Study selection.
- Stage 4: Charting the data.
- Stage 5: Collating, summarising and reporting.
- Stage 6: Consultation.

2. Is there evidence that shows that HIV status disclosure influences IPV among women in Africa?
3. Is there evidence that socio-demographic characteristics are associated with IPV among women living with HIV in Africa?

Eligibility criteria

Inclusion criteria are:

- ▶ Studies with study participants aged 15 years and above.
- ▶ Studies with evidence of IPV against women.
- ▶ Studies with evidence about HIV positive persons.
- ▶ Year of publication: from 1 January 2009 to 1 April 2019. In order to obtain the maximum amount of updated information, studies on IPV over the past 10 years will be reviewed.
- ▶ Peer-reviewed literature, grey literature, government documents, policy briefs, systematic reviews and meta-analysis.
- ▶ Studies conducted in Sub-Saharan African countries (namely, all the countries in Africa except Algeria, Djibouti, Egypt, Libya, Morocco, Somalia, Sudan and Tunisia).

Exclusion criterion: Articles published in a language other than English.

The elements of the Population, Concept and Context criteria to map studies¹⁷ (table 1).

Stage 2: identification of the relevant studies

To search the literature, a Google form will be created to record the topic of the study, author and date, and a review questionnaire will be created. The Google form will enable screeners to record studies for screening that have been included in the endnote library. The keywords will be inserted into the PubMed advanced search menu and the results that appear will be selected and exported to Endnote. Furthermore, using a comprehensive search strategy, published evidences will be searched and included in this study. A variety of literature, including peer-reviewed articles and grey literature will be retrieved. The PubMed advanced search will use Mesh terms using terms such as IPV, women, HIV, Africa, domestic violence and date of publication after 1 January 2009 will be sought.

In addition to PubMed, MEDLINE with full text via EBSCO host, Google Scholar, Science Direct and Scopus will be used. As a result of the search to date, a total of 697

**Table 1** PCC frame work

PCC	Description
P=Population	Women living with HIV: The population for this study will be all women aged 15 years and above, who are either living with HIV and/or receiving antiretroviral treatment.
C=Concept	IPV (physical and/or sexual and/or emotional/ psychological violence) or domestic violence.
C=Context	Sub-Saharan African countries, where most of the problem of IPV exists among women living with HIV.

IPV, intimate partner violence; PCC, Population, Concept and Context.

articles have been found from the PubMed search. The search was conducted on 8 April 2019 (table 2).

Stage 3: study selection

Screening

The search strategy will be piloted in order to check the appropriateness of the selected electronic database and the keywords we decided to include. The title screening will be conducted by the principal investigator and the abstract screening will be done independently by two reviewers. The purpose of the title screening is to assess the titles for eligibility and to remove duplicates. An Endnote library will be created and all the eligible titles will be exported to the library. Any duplicates which are identified will be removed before the screening of abstract. Relevant articles based on the inclusion criteria of the scoping review will be selected.

In order to minimise reporting bias, the abstract screening will be done independently by two reviewers.¹⁷ Moreover, the full-text article screening will be done independently, based on the eligibility criteria. Authors will be contacted for articles not available electronically. During the full article retrieval, the University of KwaZulu-Natal library will be used. When a disagreement arises among two reviewers, the third reviewer will make the decision. Update of the findings will be presented using a PRISMA chart (figure 1).

Quality assurance of the study

To determine the methodological quality, the Mixed Methods Appraisal Tool (MMAT) 2018 version will be adapted and used. Hence, each study will be evaluated using the MMAT tool.¹⁸ Moreover, the Preferred Reporting Items for Systematic Review and Meta-Analysis-Protocol

2015 and PRISMA extension for Scoping Reviews checklists will be used to check whether the recommended items will be used.^{19 20} Moreover, during analysis, we will review the checklist of the COnsolidated criteria for REporting Qualitative research: a 32-item checklist for interviews and focus groups will be used.²¹

Stage 4: charting the data

Data charting table (table 3) will be used to extract the necessary background information and to extract information from each selected study. Data charting will be done using an Excel spreadsheet. The data charting form will highlight important ideas regarding the variables from the background. The research questions will be answered by the variables and the themes included in the form. We will continuously update data charting form during the duration of the study.

Stage 5: collating, summarising and reporting the result

Qualitative data analyses using thematic and NVIVO software V.11 will be used to collate, summarise and report the results. The researchers will read and reread the articles thoroughly noting down the initial ideas in order to find codes. Coding interesting features of the data in a systematic fashion across the entire articles and collating data relevant to each code will be done. We will develop the codes into potential themes. Finally, defining and naming of the themes and producing the report will be done.²² The description of the coding tree and thematic content analysis will be used to analyse the data. Data related to the IPV experience among HIV positive women will be extracted and coded. Emerging themes will be identified and the data will be coded according to the identified themes. The analysis process will use the following steps (1) Coding data from the selected articles, (2) categorising the codes into themes, (3) displaying the data, (4) identifying key patterns in the data and identifying sub-themes, (5) summarising and synthesising.

Stage 6: consultation

There will be consultation of the stakeholders, such as policy-makers, clinicians, patients and families, and any other appropriate group which has conducted research on IPV, in order to obtain more references and to

Table 2 Results of pilot search in PubMed

Keywords searched	Date of search	Search engine used	Number of publication retrieved
((("intimate partner violence"(MeSH Terms) AND "women"(MeSH Terms)) AND hiv(Title) OR "domestic violence"(MeSH Terms) AND "africa"(MeSH Terms) AND ("2009/01/01"(PDAT): "3000"(PDAT)	8 April 2019	PubMed	697
Intimate partner violence and its associated factors among women living with HIV/AIDS in Sub-Saharan Africa		Google scholar	7430
Intimate partner, HIV, Sub-Saharan, Africa		EBSCO host	48

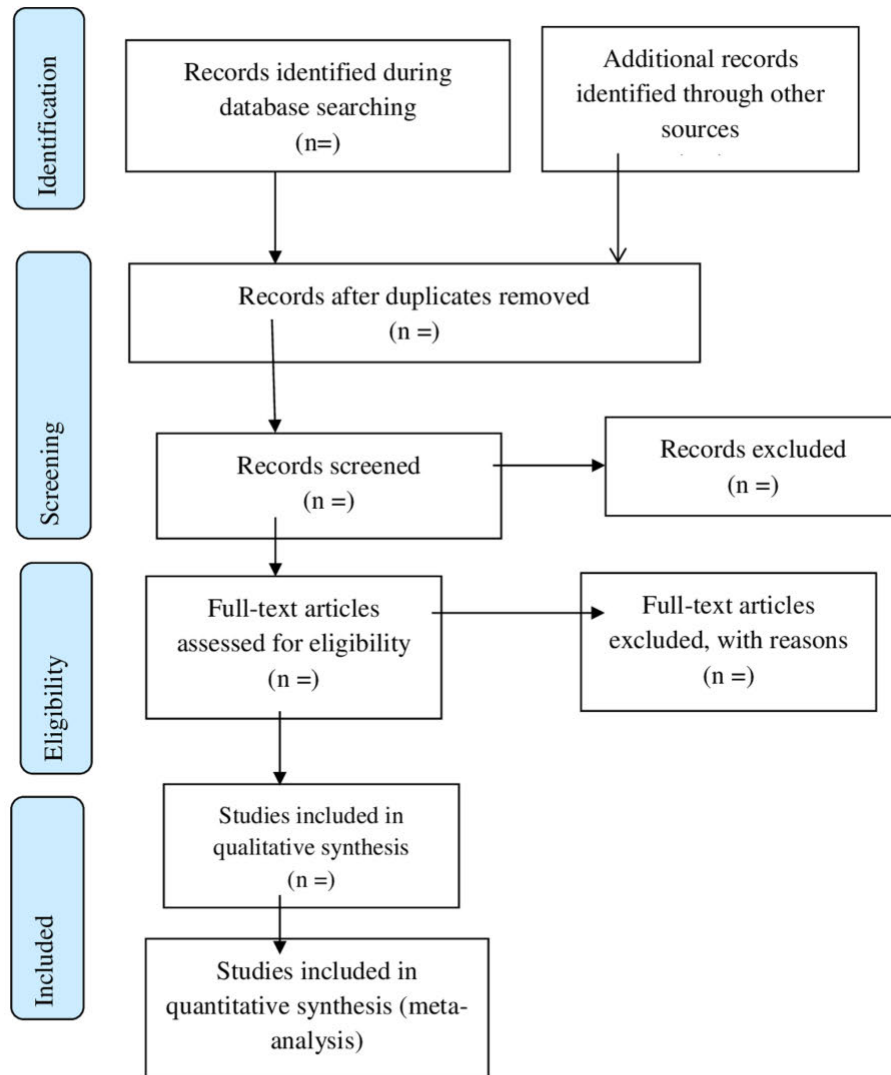


Figure 1 The Preferred Reporting Items for Systematic Reviews and Meta-Analyses 2009 flow diagram to update screening. Source: Moher *et al.*¹⁹

provide insights on what the literature fails to highlight (table 3).²³

DISCUSSION

Understanding evidence of the experience of IPV among women living with HIV in Africa is vital. The evidence from the current review may provide a framework that can improve the health of HIV positive women, develop advocacy strategies and strengthen women's rights. The links between HIV/AIDS and IPV against women are not completely understood. Moreover, IPV poses an indirect risk of HIV infection in different ways. IPV may increase

sexual risk-taking and women with a history of violence may not be able to discuss condom use.^{6,7} Fear of violence may prevent women from seeking HIV test, and this also prevents disclosure of their HIV status. Furthermore, women who experienced violence may delay in accessing to antiretroviral treatment (ART) for fear of further violence.^{6,7} Therefore, it is important to study violence against women who are living with HIV.

As revealed in the Sustainable Development Goals (SDG), gender discrimination is still a social norm in many nations. Achieving gender equality and empowering all women and girls were given due attention and emphasis

Table 3 Sample data extraction table

Authors	Briefly specify
Year of publication	
Country of origin	
Aims of the study	
Sample size	
Methodology	
Intervention	
Outcomes measured	
Duration of the intervention	
Key findings which match the review questions	

by the SDGs.^{7 24} The current scoping review will map and document the existing evidence of IPV among HIV-positive women. The information from the review will help to understand the evidence of IPV among HIV-positive women in Africa. It will also map the evidence that HIV status contributes to IPV in Africa and the evidence as to whether disclosure of HIV-positive status leads to IPV. This review will focus on the studies published between 2009 and 2019. We chose these years because we want to obtain updated information; hence, we used the literature over the past 10 years, particularly focusing on the studies of women who are living with HIV. This is because their health needs have to be prioritised. The results from this scoping review will highlight key evidence of IPV against women who are living with HIV, and the evidence will also highlight the gaps and opportunities for future research. The result of the scoping review will also help to identify the priority areas for primary research on gender-based violence.

Dissemination

This study will be disseminated through publication in an open access peer-reviewed journal, printed and presented in international and national conferences related to IPV.

Definition of terms

IPV can occur among two people in a close relationship. The perpetrators include current and former spouses as well as dating partners. IPV includes four behaviours, namely physical violence, sexual violence, stalking and psychological aggression.²⁵ Similarly, the WHO document on IPV includes physical and sexual violence, emotional abuse and controlling behaviours by partner.²⁶ The definitions are detailed below.

Intimate partner violence

'Any act or omission by a current or former intimate partner which negatively effects the well-being, physical or psychological integrity, freedom, or right to full development of a woman.'²⁷

Physical violence

'The intentional use of physical force with the potential for causing death, injury, or harm.'²⁷

Sexual violence

'Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work.'²⁸

Psychological violence

This 'occurs when someone says or does something to make a person feel stupid or worthless.'²⁹

Controlling behaviours by an intimate partner

'Controlling behaviours, include acts to constrain a woman's mobility or her access to friends and relatives, extreme jealousy, etc.'²⁹

Emotional abuse by an intimate partner

Emotional abuse, or mental abuse (psychological abuse) 'is a form of abuse, characterized by a person subjecting or exposing another person to behaviour that may result in psychological trauma, including anxiety, chronic depression, or post-traumatic stress disorder'.³⁰

CONCLUSION

The evidence of the link between IPV and HIV is currently inconclusive, and information regarding the IPV experience among HIV-infected women is inadequate. This review is part of a large-scale study on IPV among women living with and without HIV in Ethiopia. This study has a particular emphasis on IPV against women living with HIV in Africa. The review will use a framework which has six stages. It aims to assess whether there is evidence of IPV among HIV-positive women, whether HIV status contributes to IPV in Africa, and if the disclosure of HIV-positive status to one's partner leads to IPV in Africa. The result of the scoping review will also help to identify priority areas for primary research in gender-based violence.

Patient and public involvement

This study is a scoping review which was done without patient involvement. Patients were not invited to comment on the study design and were not consulted to develop patient-relevant outcomes or interpret the results. They were also not invited to contribute to the writing or editing of this document for readability or accuracy.

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Contributors MM: conceived and drafted the study as part of his PhD study; NK and MT: supervised the protocol development and revisited the manuscript critically for important intellectual content. The three authors are involved in substantial contributions to conception and design. The three authors read and approved the final manuscript. MM, NK and MT are agreed to be accountable for all aspects of the work.

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The protocol for this review was published in BMJ Open, as was the results of the review. This paper has been published in BMJ Open.

Please see page 47 for further details.

Chapter 3.2. Mapping the evidence of intimate partner violence among women living with HIV/AIDS in Africa: A scoping review

Bridging Statement

Authors: Meskele M., N. Khuzwayo, Taylor M

Status: 1. Submitted to BMJ Open on 05-June-2020. The reviewer's is published in BMJ Open.

Introduction: I mapped the evidence of IPV experiences among women living with HIV in Africa. I conducted the abstract screening with two independent reviewers. The review revealed that following the serostatus disclosure, there is evidence of heightened risk for IPV. The review results were submitted to BMJ Open, where it is published now.

Doctoral student's contribution

1. I conceived and formulated the project.
2. Study design: I designed the study with my supervisors.
3. Study selection and data analysis: I formulated the study question, identified the relevant studies, made the study selection, charted the data, summarized the results
4. Write up: I wrote the manuscript

BMJ Open Mapping the evidence of intimate partner violence among women living with HIV/AIDS in sub-Saharan Africa: a scoping review

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ABSTRACT

Objectives The present study undertakes a scoping review aimed to map the evidence of intimate partner violence (IPV) against women living with HIV/AIDS in Africa.

Design We used the online database to identify papers published from 1 January 2009 to 1 April 2019, from which we selected 21 articles from Uganda, Nigeria, Kenya, South Africa, Zambia, Ethiopia, Cameroon, Tanzania and Swaziland that used IPV as an outcome variable among women living with HIV/AIDS.

Data sources PubMed, MEDLINE, EBSCO host, Google Scholar.

Eligibility criteria We included women who were aged 15 years and above, living with HIV/AIDS in sub-Saharan Africa.

Data extraction and synthesis We conducted the abstract screening with two independent reviewers. We also performed full-text screening. We used the six methodological frameworks proposed by Arksey and O'Malley. The Mixed Method Appraisal Tool was used to determine the quality of the studies. We used NVIVO software V.12 to undertake a thematic analysis.

Results Of the studies, the majority, 57.1%, reported cross-sectional results. In comparison, 23.8% examined qualitative studies, 9.5% were clinical trials, 4.8% were cohort studies and the remaining 4.8% covered grey literature. This review revealed evidence of IPV experience among women with HIV/AIDS, evidence of how HIV status disclosure influences IPV, proof of the association of sociodemographic characteristics with IPV and implications for practice. Moreover, the review revealed that following the serostatus disclosure, there is evidence of heightened risk for IPV.

Conclusions This study found evidence of IPV among women living with HIV/AIDS. The HIV-positive women were at considerable risk of IPV after disclosure of their serostatus to a male partner. Therefore, further research is needed to promote action to reduce IPV among HIV-positive and HIV-negative women and to determine healthcare workers' IPV screening experience.

INTRODUCTION

Women living with HIV/AIDS who disclose their HIV serostatus are more likely to experience intimate partner violence (IPV) than women who are HIV-negative.¹ Among the

Strengths and limitations of this study

- This review aimed to assess in-depth associations among women living with HIV/AIDS, and we obtained baseline evidence for future research in intimate partner violence (IPV).
- One of the limitations of this review is that it only included the literature published in the English language.
- The studies published in other languages were not included and the additional evidence of IPV among women infected with HIV/AIDS was not part of this review's assessment is also a limitation.
- We did not include all the articles in our review because some were published in journals inaccessible to us.

former, IPV and HIV/AIDS may provide overlapping, or perhaps intersecting, challenges.² The reason that women experience this violence is that the abusers have usually been shown to want to establish and maintain power and control over another person. This is often reflected in the imbalance of power between the women and their abusers.³ IPV is defined as any behaviour within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship. This also includes emotional abuse and controlling behaviours by an intimate partner.⁴

Worldwide, IPV is of public health and social concern. The prevalence of IPV in the WHO's different regions varies but was similar in the Eastern Mediterranean and South-East Asian regions, where IPV was reported to be 37% and 37.7%, respectively, to that in sub-Saharan Africa (SSA), where the prevalence was 36.6%.⁵ Over a third of women in SSA reported IPV, and because this high prevalence of IPV was among both women and young girls, it is of concern.^{2,5} The harmful consequences of IPV among women and

**Box 1 The proposed scoping review following the six Arksey and O'Malley steps**

Stage 1: formulating the study question.
 Stage 2: identifying the relevant studies.
 Stage 3: study selection.
 Stage 4: charting the data.
 Stage 5: collating, summarising and reporting.
 Stage 6: consultation.

young girls are well documented and have been shown to affect their mental, sexual and reproductive health.⁵⁻⁷ In response to stress due to abuse, the immune system can be compromised, which later exacerbating the spread of cancer and viral infections.⁵ To the biological stress response, there are behavioural and other risk factors that also influence the link between IPV and adverse health outcomes.⁵

Studies on IPV and depression show that women who are exposed to physical violence, childhood sexual abuse, mild or severe emotional violence and high levels of spousal control are more likely to be depressed,⁶⁻⁸ to abuse alcohol⁵⁻⁷ and give birth to babies of low birth weight.⁵⁻⁷ Since they may not be able to negotiate condom use,⁵⁻⁷ they are also at risk of sexually transmitted infections, including HIV/AIDS.⁵⁻⁹

The relationship between IPV and HIV/AIDS among women and young girls is a topic of intense debate within the scientific community.^{2 10} Some researchers consider that IPV increases women's vulnerability to HIV infection,¹⁵⁻⁷ while other researchers suggest that HIV-positive status among women may influence IPV.^{2 11} A study conducted in Zimbabwe among pregnant women living with HIV/AIDS revealed an IPV prevalence of 40%.¹² Another study in Kenya showed that after HIV-positive serostatus disclosure, one in three women experienced IPV.¹³ Moreover, both the combination of physical and sexual IPV (OR: 2.00; 95% CI 1.24 to 3.22) and the experience of any type of IPV were associated with HIV/AIDS infection in women (OR=1.41; 95% CI 1.16 to 1.73).¹⁴

IPV and HIV/AIDS are thus two pandemics that require integrated and collaborative interventions. The Joint United Nations Programme established new targets for the scaling up of HIV/AIDS treatment by 2030. Among its aims are to increase the number of people who know their HIV/AIDS status by 90%, to increase the number of people who receive sustained antiretroviral therapy (ART) by 90% and to strive to ensure that 90% of all people who are HIV/AIDS seropositive receive ART.¹⁵ These new targets are promising, but achieving them could be compromised by women and young girls experiencing IPV. Therefore, we conducted a scoping review to systematically map the IPV research conducted among women living with HIV/AIDS to identify the existing gaps in knowledge. The information generated through this scoping review can be used by researchers, policymakers

and programme developers to foster appropriate programmes and policy frameworks.

METHODS

The protocol¹⁶ of this review was published in the *BMJ Open*. Currently, the International Prospective Register of Systematic Reviews does not register a scoping review. This review is part of a large-scale study on IPV among women in Ethiopia living both with and without HIV/AIDS. We used the six frameworks proposed by Arksey and O'Malley¹⁷: (i) identifying the research questions and defining the eligibility criteria; (ii) identifying relevant studies by conducting an extensive search; (iii) making the study selection and appraising its quality; (iv) synthesising the included studies (charting the data) and presenting the findings by using a Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) chart; (v) collating, summarising and reporting; (vi) consulting (box 1).

Stage 1: identifying the research questions

This scoping protocol is based on the following research questions:

1. Is there evidence of IPV experience among women living with HIV/AIDS in Africa?
2. Is there evidence that shows that HIV/AIDS status disclosure influences IPV among women in Africa?
3. Is there evidence that sociodemographic characteristics are associated with IPV among women living with HIV/AIDS in Africa?

Eligibility criteria**Inclusion criteria**

1. Studies with study participants aged 15 years and above.
2. Studies with evidence of IPV against women.
3. Studies with evidence about HIV-positive persons.
4. Studies on IPV over the past 10 years for the maximum amount of updated information: years of publication from 1 January 2009 to 1 April 2019.
5. Peer-reviewed literature, grey literature, government documents, policy briefs, systematic reviews and meta-analysis.
6. Studies conducted in sub-Saharan African countries (all the countries in Africa except Algeria, Djibouti, Egypt, Libya, Morocco, Somalia, Sudan and Tunisia).

Exclusion criteria

Articles published in a language other than English.

The elements of the population, concept and context criteria to map studies correctly¹⁸ (table 1).

Stage 2: identifying the relevant studies

We created a Google form to search the literature in which we included the topic of the study, author and date and a review questionnaire. The Google form enabled screeners to record studies for screening that have been included in the Endnote library. We inserted the keywords

Table 1 PCC framework

PCC	Description
P=Population	The population for this study were all women aged 15 years and above living with HIV/AIDS or receiving ART
C=Concept	IPV (physical, and/or sexual and/or emotional/psychological violence) or domestic violence
C=Context	Sub-Saharan African countries where the problem of IPV mostly exists among women living with HIV/AIDS

ART, antiretroviral therapy; IPV, intimate partner violence.

into the PubMed advanced search menu, and the results that appeared were selected and exported to Endnote.

In addition, using a comprehensive strategy, we searched for published evidence and included it in this study. A variety of literature, including peer-reviewed articles and grey literature, were retrieved. In the PubMed advanced search, we used MeSH terms such as IPV, women, HIV, Africa, domestic violence, and focused on dates of publication after 1 January 2009.

In addition to PubMed, we used MEDLINE with full text via EBSCO host, Google Scholar, Science Direct and Scopus. We found a total of 750 articles from the PubMed search and identified 128 additional records through other sources. We completed the search on 8 April 2019 (online supplemental file 1).

Stage 3: study selection

Screening

In our search strategy, we piloted to check the appropriateness of the selected electronic databases and the keywords we decided to include. The principal author conducted title screening, and two reviewers conducted the abstract screening independently. The purpose of the title screening was to assess the titles for eligibility and to remove duplicates. We created an Endnote library to which all the eligible titles were exported. We removed any duplicates before the screening of the abstract. Relevant articles based on the inclusion criteria of the scoping review were selected.

The independent reviewer abstract screening was to minimise reporting bias.¹⁸ Moreover, we undertook the full-text article screening independently, based on the eligibility criteria. We contacted the authors for the articles that were not available electronically and requested these be sent to us directly. During the full article retrieval, we used the University of KwaZulu-Natal library. When a disagreement arose between the two reviewers, a third reviewer made the decision. We presented the update of the findings by using a PRISMA chart.

Quality assurance of the study

To determine the methodological quality, we adapted and used the Mixed Methods Appraisal Tool (MMAT) 2018

version to evaluate each review.¹⁹ Additionally, we used the Preferred Reporting Items for Systematic Review and Meta-Analysis Protocols 2015 and PRISMA Extension for Scoping Reviews checklists to check whether the recommended items were included or not.^{20,21} During analysis, we reviewed the checklist of the Consolidated Criteria for Reporting Qualitative Research, a 32-item checklist for interviews and focus group discussions.²²

Stage 4: charting the data

We used the data charting table (table 2) to extract the necessary background information and to extract information from each selected study. We used an Excel spreadsheet for the data charting. This form highlighted essential ideas regarding the variables from the background and included the research questions which were addressed by the variables and the themes. Two reviewers jointly developed the data charting form to decide which variables to extract, which they charted independently. We continuously updated the data charting form during the duration of the study.

Data items

We abstracted data on the article characteristics (eg, year, country of origin), aim of the study, IPV and population (HIV-positive women), sample size, age group, and the study design.

Stage 5: collating, summarising and reporting the result

We undertook qualitative data analyses using NVIVO software V.12 to collate, summarise and report the results. First, the researchers read and reread the articles thoroughly, noting down the initial ideas to find codes. The notable features of the data across the entire article were systematically coded, and data relevant to each code was collated. We then developed the codes into potential themes and finally defined and named the themes and produced the report.²³ We used the description of the coding tree and thematic content analysis to analyse the data. We extracted and coded the data that were related to the IPV experience among HIV-positive women, identified the emerging themes and then coded the data according to these themes. The analysis process used the following steps: (i) coding data from the selected articles; (ii) categorising the codes into themes; (iii) displaying the data; (iv) identifying key patterns in the data and the subthemes; (v) summarising and synthesising.

Stage 6: consultation

We held consultations with the stakeholders, such as policymakers (two), clinicians (three), patients (five) and families (two), in addition to other appropriate groups who researched IPV, in order to obtain more references and to provide insights on what the literature failed to highlight.²⁴ Moreover, these consultations helped in mapping the evidence of the existence of physical, emotional and sexual violence among HIV infected women. The talks helped to gain further insight into IPV.



Table 2 Data charting table

Author	Country	Study aim	Population	Sample Size	Age group (years)	Study design
Ashaba <i>et al</i> ²⁵	Uganda	To explore psychosocial challenges experienced by women living with HIV	Women	20	22–40	Qualitative
Bernstein <i>et al</i> ²⁶	South Africa	To assess the prevalence and correlates of IPV among HIV-infected pregnant women	Women	623	18–44	Cross-sectional
Lauren and Van Zyl ²⁷	South Africa	To measure how IPV impacts women's safety following mobile HCT diagnosis	Women	255	18+	Clinical trial
Colombini <i>et al</i> ¹³	Kenya	To explore women's experiences of IPV risks following disclosure to their partner	Women	30	15–49	Qualitative
Conroy <i>et al</i> ²⁸	Uganda	To examine the association between relationship power and sexual violence	Women	307	19–75	Cross-sectional
Emusu <i>et al</i> ²⁹	Uganda	To explore the experiences of sexual violence among women in HIV-discordant unions	Women	26	Not mentioned	Qualitative
Ezeanochie <i>et al</i> ³⁰	Nigeria	To evaluate the prevalence and correlates of IPV among HIV-positive women	Women	305	21–43	Cross-sectional
Ezechi <i>et al</i> ³¹	Nigeria	To determine the prevalence, types and correlates of IPV	Women	652	<20–≥40	Cross-sectional
Florentino <i>et al</i> ³²	Cameroon	To assess the prevalence and factors of IPV against HIV-positive women and its relationship with ART interruption ≥1 month	Women	894	≥21	Cross-sectional
Hampanda <i>et al</i> ³³	Zambia	To determine how IPV against HIV-positive women affects safe infant feeding practices	Women	320	18+	Cross-sectional
Hampanda and Rael ³⁴	Zambia	To advance the current understanding of the relationship between IPV against women and their HIV status disclosure behaviours	Women	320	18+	Cross-sectional
Ilyasu <i>et al</i> ³⁵	Northern Nigeria	To assess prevalence and risk factors of domestic violence among HIV-positive women	Women	300	18–70	Descriptive and cross-sectional
Malaju and Alene ³⁶	Ethiopia	To assess women's expectations of their partner's violence on the disclosure of the HIV test	Women	400	15–49	Cross-sectional
Mulrenan <i>et al</i> ³⁷	Swaziland	To explore the risks of experiencing IPV after HIV infection among women with HIV	Women	19	18–44	Qualitative

Continued

Table 2 Continued

Author	Country	Study aim	Population	Sample Size	Age group (years)	Study design
Olowookere <i>et al</i> ³⁸	Nigeria	To assess the prevalence and correlates of IPV among women living with HIV/AIDS in an antiretroviral clinic in Nigeria	Women	360	18+	Cross-sectional
Onu <i>et al</i> ³⁹	Kenya	To examine SV against HIV-positive women enrolled in HIV care in Kenya	Women	25	18+	Qualitative
Osinde <i>et al</i> ⁴⁰	Uganda	To measure the prevalence and factors associated with IPV among HIV-infected women	Women	317	15+	Cross-sectional
Wilson <i>et al</i> ⁴¹	Kenya	To assess the prevalence and correlates of IPV in the past year by a regular male partner in HIV-positive female sex workers in Mombasa, Kenya	Women	357	18+	Cross-sectional
Young <i>et al</i> ⁴²	Uganda	To examine physical and sexual IPV prevalence and correlates among WLWH in Uganda	Women	455	18+	Cohort
United Nations Educational, Scientific and Cultural Organization ⁴⁴	Tanzania	To discuss the links between gender-based violence and HIV and AIDS in conflict and post-conflict situations in the Great Lakes Region	Women	N/A	N/A	Workshop report
Matseke <i>et al</i> ⁴³	South Africa	Intimate partner violence among HIV positive pregnant women in South Africa	Women	673	18+	A clinic-randomised, controlled trial

ART, antiretroviral therapy; HCT, HIV Counseling and Testing; IPV, intimate partner violence; SV, Sexual Violence; WLWH, Women Living With HIV.

RESULTS

Screening results

We found 750 articles in the original data search. A total of 159 publications remained after we removed duplicates and other unrelated topics. A 136 articles were excluded, which did not meet our inclusion criteria, and 23 items were included for full-text screening. After the full-article screening, we excluded two studies, providing reasons for this, and a final 21 articles remained from which to extract data (figure 1).

Characteristics of the included studies

Out of the 21 included studies, 20 were published in peer-reviewed journals,^{13 25–43} while the remaining one was categorised as grey literature.⁴⁴ From the included studies, 12 were quantitative and cross-sectional in nature,^{26 28 30–36 38 40 41} 5 were qualitative,^{13 26 29 37} 2 was a clinical trial,^{27 43} 1 was a cohort design⁴² and the remaining one was grey literature (a conference discussion report)⁴⁴ (figure 2).

Out of the 21 studies, 5 were conducted in Uganda,^{25 28 29 40 42} 4 in Nigeria,^{30 31 35 36} 3 in Kenya,^{13 39 41} 2 in South Africa,^{26 27} 2 in Zambia,^{33 34} 1 in Ethiopia,³⁶ 1 in Cameroon,³² 1 in Tanzania⁴⁴ and the remaining 1 in Swaziland³⁷ (figure 3).

Study findings

Four themes emerged from the identified studies: evidence of IPV experience among women with HIV/AIDS, evidence of HIV/AIDS status disclosure influencing IPV, evidence of the association of sociodemographic characteristics with IPV and implications for future practice.

Evidence of IPV experience among women with HIV/AIDS

We found evidence of IPV experience from almost all of the 21 included studies in the 11 countries in the Sub-Saharan African region.^{13 25–44} The prevalence of IPV varied among countries; we identified the highest prevalence of IPV in South Africa (67.3%)²⁷ and the lowest

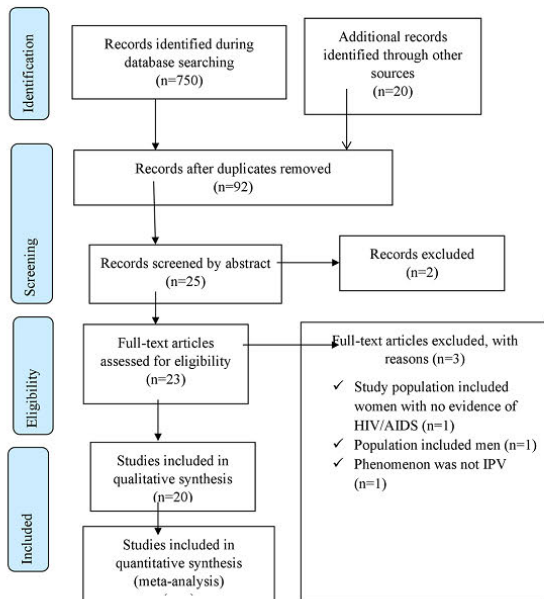


Figure 1 The Preferred Reporting Items for Systematic Reviews and Meta-Analyses 2009 flow diagram. Source: PRISMA Group: doi: 10.1371/journal.pmed.1000097.²⁰

prevalence in Kenya (14.6%).⁴¹ IPV was also identified in Nigeria (65.8%),³¹ in South Africa, overall, 56.3% reported having experienced either psychological or physical IPV,⁴³ Uganda (29%),⁴² another study in South Africa, (21%),²⁶ Nigeria, (23.6%),³⁸ Kenya, nearly one-third of women in the study,¹³ Cameroon (23%),³² Nigeria (22.1%)³⁵ and Uganda (29.3%).⁴⁰ On average, one-third (30.2%) of HIV-positive women experienced IPV among the included studies. Psychological, emotional or verbal abuse was the most common form of violence reported

among HIV-positive women and ranged from 12.1% to 51.7%.^{30-32 38 40} One study showed that physical violence had a more pronounced effect on status disclosure than sexual or emotional violence.³⁴ Sexual violence was found to be the least common type of abuse among HIV-positive women, ranging from 2% to 44.8%.^{26 31 32 38}

Three studies showed evidence of further abuse following IPV, such as the difficulty of engaging in HIV/AIDS care, interruption of ART adherence, partner stigma and abuse, and financial withdrawal.^{13 25 32} There was also evidence showing that physical weakness, economic and social dependence on a partner and alcohol abuse by a male partner were the leading causes of IPV.^{29 44}

Evidence of HIV/AIDS status disclosure influencing IPV

Evidence of IPV after HIV/AIDS status disclosure was reported from six studies.^{31 34-38} Following the sero-disclosure, there was evidence of heightened risk for IPV, stigma, abuse, marriage disruption and financial withdrawal.^{13 25 31 32 35 36} Evidence from one study showed about 74% of abuse coming after HIV/AIDS status disclosure.³¹ However, some studies found that sero-concordance is protective of emotional or verbal abuse.¹³ Women who had their own income, those who did not have a stigmatising attitude towards people living with HIV/AIDS, those who had attained secondary level education and above, those with a positive attitude towards counsellors, and those able to access health facilities were all associated with positive partner reaction.³⁶ On the other hand, having an HIV-negative spouse and disclosure of HIV/AIDS status was associated with abuse.³¹

Studies also explored the expectation of adverse reactions related to HIV/AIDS in the community, including gossip and discrimination.^{25 36} Evidence even existed that some women did not disclose their HIV/AIDS status because of expected fear of rejection, abuse and anticipated loss of trust from their partner.^{25 31 44} For instance,

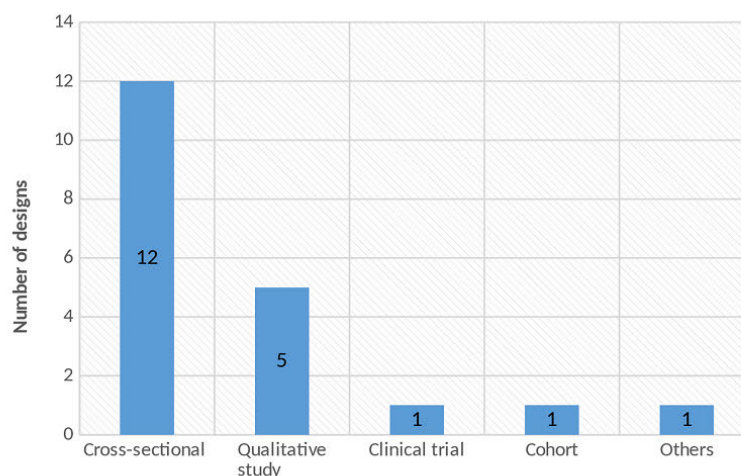


Figure 2 Distribution of study designs used in the study (n=20).

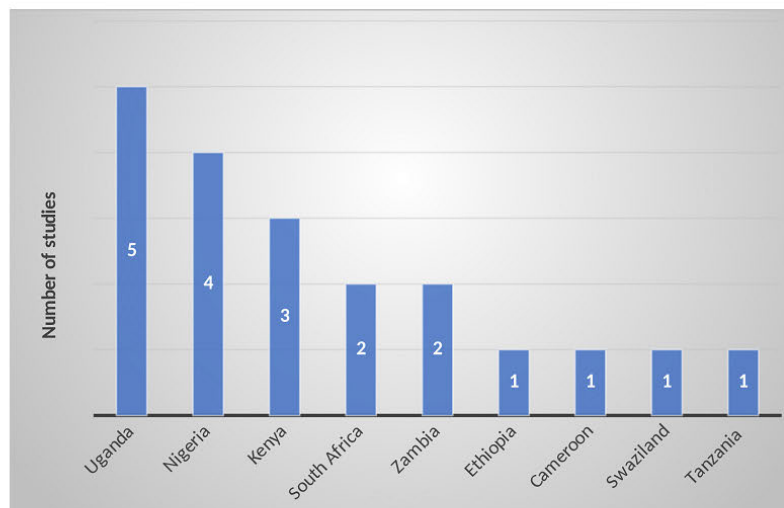


Figure 3 Distribution of countries represented in the included studies (n=20).

studies showed that some women kept their HIV serostatus a secret to prevent an adverse reaction.^{25,44} One study also presented evidence of early mixed feeding following the disclosure of an HIV-positive status.³³ Findings show that physical violence is the most prevalent form of IPV that occurs after status disclosure rather than sexual abuse.³⁴

Evidence of the association of sociodemographic characteristics with IPV

We found evidence of sociodemographic characteristics which were associated with IPV in four studies.^{35,38,40,42} One study identified that older age groups of women, those >40 years, were at risk for IPV.³⁵ Contrary to this, a study in Uganda showed that being older was associated with a lower risk for IPV.⁴² Similarly, one study in Nigeria showed that younger partners (20–39 years) were more at risk for IPV.³⁸

A study from Nigeria showed that multiparity, being a respondent with an HIV-positive child, and marital status (divorced women) were associated with IPV.³⁵ However, a study in Uganda showed that being married was associated with a higher risk of IPV.⁴²

Two studies revealed that non-formal education of husbands (ie, lack of education) was associated with IPV.^{30,35} Contrary to this, a study in rural Uganda showed that there was a significant, but inverse, the association between educational level and physical partner violence.⁴⁰ There was also an inverse association between the educational level of the respondent and sexual/psychological abuse, as well as psychological/sexual violence.⁴⁰

Only one study from Uganda reported that a higher household asset index score was protective from IPV.⁴² The sociodemographic factor of alcohol abuse by male partners was an essential factor associated with IPV among HIV-positive women.^{29,38,41} Additionally, IPV was associated with the experience of violence before women

had an HIV-positive diagnosis.³⁰ Moreover, a Ugandan study reported that the use of ART was associated with an increased prevalence of IPV.⁴⁰ One study result also showed that women experiencing controlling behaviour by the index partner was associated with IPV.⁴¹

Implications for future practice

Evidence from four studies indicated that the prevention of IPV is through the integration of partner violence identification and care into other healthcare services (sexual and reproductive services and services such as HIV testing and counselling).^{13,28,30,34} A study in Uganda recommended the integration of various stakeholders, including partners, family, policymakers, community members and funders and programme implementers who could work together to prevent IPV.²⁵

Healthcare workers (HCWs) should ensure safe disclosure to avoid post-disclosure abuse. Safe disclosure, including couple counselling, mutual disclosure between partners, separate counselling sessions for men and facilitated disclosure were recommendations.^{13,25,37} A study also reported that HIV/AIDS counsellors should evaluate the advantages and disadvantages of status disclosure among women.³⁴ Furthermore, a Zambian study indicated that IPV prevention required training counsellors to facilitate discussions with women about IPV.³⁴ Moreover, evidence from two studies showed the importance of ensuring that women's decisions to disclose their HIV serostatus are fully informed and voluntary.^{13,34} Evidence from five studies reported that routine screening for IPV to identify abused women during HIV/AIDS care services is necessary.^{26,30,32,40,42} Furthermore, evidence from a Ugandan study also highlighted that HCWs should inform HIV-discordant couples appropriately on their reproductive options and referral systems and link couples with counselling services on sexual violence.²⁹



A study also proposed a way forward by improving public awareness and family counselling as a strategy of IPV prevention.³⁷ Four studies recommended that promoting gender equity, empowering women economically, as well as promoting positive masculinities that support and protect women are measures to prevent IPV.^{25 28 37 41} Moreover, two studies reported the involvement of men in programmes of IPV prevention.^{25 37}

DISCUSSION

This scoping review was aimed at mapping the evidence of IPV against women living with HIV/AIDS in SSA. It revealed evidence of IPV experience among women with HIV/AIDS, how HIV/AIDS status disclosure influences its prevalence, and proof of the association of sociodemographic characteristics with IPV. The implications for future practice and recommendations were also made evident.

The experience of IPV varies among SSA countries. On average, 30.2% of HIV-positive women had experienced IPV. This overall finding corresponds to the results of Ugandan and Kenyan studies.^{13 40 42} Of the types of IPV, emotional abuse was the most common form of violence reported among HIV-positive women^{30-32 38 40}; sexual violence was found to be the least common type of abuse among HIV-positive women.^{26 31 32 38} As a result of this type of violence, women delayed accessing ART for fear of further violence, experienced denial of healthcare or discrimination in healthcare settings, employment, education, housing and enforced HIV testing.^{6 7 44} In light of these findings, studies highlighted strategies to protect women from IPV by the integration of violence identification and care into other healthcare services (sexual, reproductive and HIV/AIDS-related services such as HIV testing and counselling services).^{13 28 30 34} It was suggested that the integration of the family, policymakers, community members, as well as funders and programme implementers in gender-based violence prevention programmes, were a way forward.²⁵

The WHO data in 2018 showed that 25.7 million people are living with HIV/AIDS in Africa,⁴⁵ indicating that HIV/AIDS continues to be one of the significant causes of disease burden in SSA,^{45 46} causing substantial health problems in the region. However, studies have highlighted that the effect of the HIV/AIDS epidemic varies in different countries of SSA.⁴⁶ Significant to this study, research in Africa has also shown that there is a strong association between HIV infection and IPV.⁴⁷ This relationship between the two health problems is complex and iterative⁴⁸; because of this, countries with a high HIV/AIDS prevalence, for instance, South Africa and Nigeria, account for a high prevalence of violence (67.3%)²⁷ and (65.8%),³¹ respectively. The studies in this review included countries with a varying range of HIV/AIDS prevalence; as reported in 2016, these were Swaziland (27.2%), South Africa (18.9%), Zambia (12.4%), Uganda (6.5%), Kenya (5.4%), Tanzania

(4.7%), Cameroon (3.8%), Nigeria (2.9%) and Ethiopia (1.1%).⁴⁹ Moreover, IPV can itself also be both a risk factor for and a consequence of HIV/AIDS.⁵⁰ Therefore, IPV needs safe monitoring, screening and intervention among HIV-positive women in healthcare settings.⁴⁸

Evidence of IPV following HIV/AIDS status disclosure was found in nine studies reviewed.^{13 25 31 32 34-38} If our study had searched only for the effect of HIV/AIDS disclosure without IPV, more evidence of the consequences of HIV/AIDS status disclosure could have come to light. Moreover, stigma, abuse, marriage disruption and financial withdrawal were evident consequences of HIV test result disclosure.^{13 25 31 32 35 36} Therefore, there is a need for safe disclosure such as couple counselling, mutual disclosure between partners, separate counselling sessions for men and facilitated disclosure.^{13 25 37} One study also reported that HIV/AIDS counsellors should evaluate the advantages and disadvantages of status disclosure among women.⁵⁴ The Zambian study suggested training counsellors to facilitate discussions with women about IPV.³⁴ Moreover, evidence from two studies showed that ensuring women's fully informed and voluntary decision making to disclose their HIV/AIDS serostatus is required.^{13 34}

A study in Uganda showed that the sociodemographic status of being married was associated with a higher risk of IPV.²⁰ Another type of marital status, such as being divorced, was also associated with IPV in another context.¹² Hence, the prevention strategy for IPV should be emphasised for both married and divorced women. Age could also be a risk factor, depending on the country. A study in Zimbabwe identified that older women, >40 years, were at increased risk for IPV.¹² Contrary to this, a study in Uganda showed that older age represented a lower risk for IPV.²⁰ Corresponding with this, a survey in Nigeria showed that younger partners (20–39 years) were at increased risk of IPV.¹⁵ However, from these findings, we realised that violence could affect all age groups; hence, the importance of improving public awareness and providing family counselling as a strategy for IPV prevention.¹⁴

Women who are living with HIV/AIDS not only experienced with IPV but also other type of violence/stigma/discriminations. A study in South Africa showed that higher levels of depressive symptoms and greater perceived stigma were associated with physical and psychological IPV.⁴³ It also showed that psychological IPV and physical IPV were also individually associated with high perceived stigma and higher levels of depressive symptoms.⁴³

Studies revealed that other sociodemographic aspects, such as higher household asset value were protective against IPV.⁴² To this end, promoting gender equity, and empowering women economically, as well as promoting positive masculinities that support and protect women should be considered to protect against IPV.^{25 28 37 41} Concerned bodies are also aware that

traditional masculine norms, for instance, aggressiveness and male suppression of emotional vulnerability, can lead to physical violence.⁵¹ Moreover, a male partner's heavy drinking and aggressive behaviour, that men believe to be an accepted norm of masculinity lead to violence.⁵² Hence, wise disclosure of HIV/AIDS status assisted by HCWs, mutual disclosure and involving men in programmes for IPV prevention is advisable.

Health systems should address violence because of its significantly harmful effects on women's health and well-being, including their mental, sexual and reproductive health.⁵³ IPV seems to be a preventable health problem. Thus, the health system needs to develop a response that can provide women with a multisectoral and women-centred response providing privacy, confidentiality and accountability, empowerment of women's decision making and immediate assistance in a holistic way.⁵³

Strengths and limitations

We used an approved MMAT to check the quality of appraisal of the included studies. We also used public health and social science databases for title screening. By doing so, we obtained all relevant published studies; however, we could have found additional pertinent articles if other bibliographical databases had been searched. Other terms, rather than the keywords we searched, could have existed in a different database. In our search, we included articles published in the English language only; therefore, we may have missed critical points published in studies presented in another language. Furthermore, this scoping review was a huge undertaking, and it only includes results up to the date of 10 April 2019.

CONCLUSION

Overall, this scoping review provides a summary of the existing literature showing the evidence of IPV experiences among women with HIV/AIDS. We found evidence of IPV experience from almost all of the studies included. On average, one-third (30.2%) of HIV-positive women experienced IPV among the included studies. Psychological, emotional or verbal abuse was the most common form of violence reported among HIV-positive women. Furthermore, two other relevant categories of evidence reviewed are the negative influence of HIV/AIDS status disclosure on IPV and the association of sociodemographic characteristics with IPV and what the resulting implications are for practice. Psychological and emotional abuse were the most common form of violence reported. Sexual violence was found to be the least common type among HIV-positive women. The review showed the difficulty of women who experienced IPV in engaging in HIV/AIDS care, the interruption of their ART treatment, and that stigma, abuse and financial withdrawal were some of the consequences that followed from IPV. As this

review has shown, IPV was associated with HIV/AIDS status disclosure and having an HIV-negative spouse was a risk factor for IPV. In particular, there is evidence of a heightened risk for partner violence, shame, abuse, marriage disruption and financial withdrawal following serostatus disclosure.

Therefore, the review highlighted the need for strategies such as the integration of IPV screening and care into other healthcare services (sexual, reproductive and HIV/AIDS services). Moreover, safe disclosure such as couple counselling, mutual disclosure between partners, separate counselling sessions for men and facilitated disclosure is vital. The review has also emphasised routine screening for IPV to identify abused women attending HIV/AIDS care services. Most importantly, there is a need for further research among special population groups and on health systems barriers to screening for IPV and for a focus on how victims are treated.

Recommendations for future research

For future research, we suggest investigating the differences and similarities of the IPV experiences for women living with or without HIV/AIDS and the associated factors in the different regions of the various countries in SSA. The lived experience of women, both living with and without HIV/AIDS, and the HCW's experience of IPV screening and its barriers still need to be further studied.

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Contributors MM: conceived the topic and drafted the study as part of his PhD study; he was involved in the design and analysis. NK and MT: supervised and guided the review, engaged in the design, analysis and revisiting of the manuscript critically for relevant intellectual content. All three authors read and approved the final manuscript. MM, NK and MT agreed to be accountable for all aspects of the work.

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CHAPTER FOUR: INTIMATE PARTNER VIOLENCE AGAINST WOMEN LIVING WITH AND WITHOUT HIV, AND THE ASSOCIATED FACTORS IN WOLAITA ZONE, SOUTHERN ETHIOPIA: A COMPARATIVE CROSS-SECTIONAL STUDY

Bridging Statement

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Journal: PLOS ONE

Introduction: This chapter measured the prevalence and the various associated factors of intimate partner violence against women living with and without HIV in Wolaita Zone, southern Ethiopia.

Doctoral student's contribution

1. I conceived and formulated the project.
2. Study design: I designed the study with my supervisors.
3. Project management and field logistics: I supervised all data collection and managed the field logistics.
4. Data analysis: I developed the data entry template from EPIData, and analysed the data with the help of STATA 15 software.
5. Write up: I drafted and wrote the manuscript. My co-authors/supervisors guided, reviewed and approved it for journal submission.

RESEARCH ARTICLE

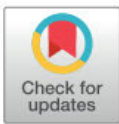
Intimate partner violence against women living with and without HIV, and the associated factors in Wolaita Zone, Southern Ethiopia: A comparative cross-sectional study

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Data Availability Statement: The data underlying this study contain sensitive and potentially identifying information. As such, they cannot be shared publicly. Interested and qualified researchers can request access to the data through the Biomedical Research Ethics Administration (BRECA@ukzn.ac.za) or through the authors (217082145@stu.ukzn.za; mengistu77@gmail.com; mengistumeskele@wsu.edu.et; Khuzwayone@ukzn.ac.za; TAYLOR@ukzn.ac.za; taylormyra@gmail.com).

Abstract

Objectives

This study aimed to measure the prevalence and associated factors of Intimate Partner Violence (IPV) among women living with and without HIV in Wolaita Zone, Southern Ethiopia.

Methods

A comparative cross-sectional study design was used to interview the 816 women between 18–49 years of age (408 = HIV positive, 408 = HIV negative). Using a multistage sampling technique, participants were recruited from nine health facilities based on probability proportional to the number of clients. After data entry (EpiData version 4.4.2.0) the data were exported to STATA/SE 15 software. Binary and multivariable logistic regression analysis were undertaken and the odds ratio (OR) and 95% confidence interval (CI) are presented.

Results

The lifetime prevalence of IPV among all women was 59.7%, [95% CI: 56.31%–63.05%]. IPV was slightly higher among women living with HIV, 250(61.3%), than those who were HIV negative, 238(58.1%). Lifetime prevalence of emotional violence 413(50.6%), physical violence 349(42.8%), sexual violence 219(26.8%), and controlling behaviours by husbands/partners 489(59.9%) were reported. Associations were found between IPV and controlling behaviour of husband/partner [AOR = 8.13; 95% CI: 4.93–13.42], income [AOR = 3.97; 95% CI: 1.81–8.72], bride price payment [AOR = 3.46; 95% CI: 1.74–6.87], women’s decision to refuse sex [AOR = 2.99; 95% CI: 1.39–6.41], age group of women [AOR = 2.86; 95% CI: 1.67–4.90], partner’s family choosing wife [AOR = 2.83; 95% CI: 1.70–4.69], alcohol consumption by partner [AOR = 2.36; 95% CI: 1.36–4.10], number of sexual partners [AOR = 2.35; 95% CI: 1.36–4.09], and if partner ever physically fought with another man [AOR = 1.83; 95% CI: 1.05–3.19].

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Competing interests: The authors have declared that no competing interests exist.

Conclusions

There is a high prevalence of IPV against women both living with and without HIV. Policy priorities should therefore involve males in programs of gender-based violence prevention in order to change their violent behaviour, and interventions are required to improve the economic status of women. Both sexes should be advised to have a single partner and marriage arrangements should be by mutual consent rather than being made by parents.

Introduction

Intimate Partner Violence (IPV) is increasingly recognized as a serious, worldwide public health concern. Violence Against Women (VAW) occurs in almost all countries, among women and girls of all ages, cultures, races, religions, educational levels and sexual orientation [1]. As a result, in the ever-partnered women, physical or sexual violence or both, by an intimate partner ranged from 15–71% [2]. The global prevalence of physical and or sexual abuse was 30% [3]. The prevalence was highest in the World Health Organization (WHO) African, Eastern Mediterranean and South East Asian regions, where 37% of women reported sexual and or physical violence. The magnitude decreased in high-income countries to 23.2% [3]. The elimination of such violence against women is emphasized in the Sustainable Development Goals (SDG) [4].

IPV is defined as “Any act or omission by a current or former intimate partner which negatively affects the well-being, physical or psychological integrity, freedom, or right to full development of a woman” [5]. IPV is a major public health problem strongly associated with HIV infection among women in Africa and includes different types of violence such as emotional and physical violence and the controlling behaviour by males of their partners [6].

Recent developments concerning IPV have heightened the need to emphasize the elimination of all forms of violence against women and girls in public and private institutions [4]. Moreover, the issue of IPV against women who are living with HIV is of concern and has received considerable critical attention [7].

Ethiopia is one of the countries with a large burden of Gender-Based Violence (GBV). In the international survey, the lifetime prevalence of sexual violence ranged from 6% (in Japan, Serbia and Montenegro), to 59% in one of the Ethiopian provinces; while physical or sexual violence, or both in Ethiopia has been reported at 54% among women [1]. In addition, a study conducted in Ethiopia by Semahegn, et al., (2015) showed that the lifetime prevalence of IPV ranged from 20 to 78% [8]. The 2016 Ethiopian Demographic and Health Survey (EDHS) also reported that more than one-third (35%) of ever-married women have experienced physical, emotional, or sexual violence by their partner, and this was supported by a study where 30.4% of ever married women in the southern region of Ethiopia had experienced physical, sexual or emotional violence by their partner [9].

Some studies have identified particular factors associated with IPV, but in Ethiopia IPV has not been well documented amongst women living with and without HIV. Therefore, this study aimed to assess the prevalence and factors associated with IPV among women living with and without HIV, in Southern Ethiopia.

Materials and methods

Study area and setting

This study was conducted in Wolaita Zone, one of the 14 Zones in the Southern Nations, Nationalities and People’s Regional State (SNNPR) of Ethiopia. Wolaita is one of the Omotic

languages spoken in Southern Ethiopia and is the native language of the Zone. The Amharic language is the official language of the region and the Zone. The capital city of the Zone, Wolaita Sodo, is 330 km south west of Addis Ababa, the capital city of Ethiopia. Currently, Wolaita Zone has a total of 19 health facilities which are providing ART services. The overall HIV prevalence in Ethiopia among men and women aged 15–49 was 0.9%, (CI: 0.7%–1.1%). It is higher among women than men (1.2% versus 0.6%). However, the prevalence of HIV was lower in Southern Ethiopia, 0.4% [10]. Regarding poverty, Ethiopia is one of the low-income countries and Wolaita Zone is categorized as such. The total population of the Zone was 2,492,887 as estimated on February 8, 2019 [11].

Design and population

A comparative cross-sectional study design was used to conduct the study among the 19 selected health facilities in Wolaita Zone, from November 2018–December 2018. The target population was all adult women (aged 18–49 years) who were known to be living with HIV, since they had already tested for HIV and were taking Anti-Retroviral Therapy (ART). The comparison group was women without HIV. These were women who were attending health facilities for PMTCT, antenatal care, postnatal care, family planning, and other health services and their HIV sero-status was already documented and it was known that they were HIV negative. No new HIV testing was conducted for this study, since there was available HIV testing information. Women were approached to give their permission to participate.

Inclusion criteria

There were two groups comprising a) Adult women, aged 18–49 years, who were living with HIV, and using Anti-Retroviral Therapy (ART), b) HIV negative women who were using the different health services mentioned above. The study enrolled women who currently had male partners, whether married or not.

Exclusion criteria

Women, below 18 and above 49 years, mentally ill or having any other severe illness which hindered the client from being interviewed were excluded. Women excluded from the study could however, also potentially benefit from the research findings.

Measurement and operational definition.

Intimate Partner Violence (IPV): Is an outcome variable and was measured when the women reported one or more acts of physical, sexual, and/or emotional violence by a current or former male partner, whether cohabiting or not, since the age of 15 years' [1, 3, 8, 12, 13].

Physical Violence: This was measured when women reported at least one experience of a current or former partner who had “ever slapped her, or thrown something at her that could hurt her, pushed or shoved her, hit her with a fist or something else that could hurt, kicked, dragged or beaten her up, choked or burnt her on purpose; threatened her with, or actually used a gun, knife or other weapon against her” [1].

Sexual Violence: This was measured when women reported at least one experience of the three sexual violence questions. “Being physically forced to have sexual intercourse against her will, having sexual intercourse because she was afraid of what her partner might do, and being forced to do something sexual she found degrading or humiliating” [1].

Psychological Violence/emotional violence: This was measured when the women reported at least one emotional violence item from the four questions listed in the WHO multi-country women and violence study questionnaire. Emotional violence occurs when someone says or does something to make a person feel stupid or worthless [1].

Controlled behaviour: This was measured when the women affirmed at least one item of the seven controlled behaviour questions set in the WHO multi-country women and violence study [1].

Sample size calculation

The sample size was calculated by using the sample size calculator for designing clinical research (<http://www.sample-size.net/means-sample-sizeclustered/>). Hence, the number of health facilities which are providing ART (clusters = 19), rejecting the null hypothesis (margin of error = 0.05), power = 80%, proportion of women exposed to IPV in South West Ethiopia = 0.415 [14], proportion of women unexposed to IPV = 0.585 (14), within-cluster correlation coefficient = 0.29, confidence interval = 95%. The sample size calculated by using the above formula was adjusted for clustering, and the fixed cluster was 817. The non-response rate and design effect were included in the 408 HIV negative women and the 408 HIV positive women who are using ART.

Sampling strategy

A multistage sampling technique was used for this study. In Wolaita Zone there are 12 woredas (districts) and three town administrative systems in which 68 health centers and 7 hospitals provide health care services. Though, Wolaita Zone has 68 health centers and seven hospitals, only 19 health facilities (12 health centers and 7 hospitals) which were providing ART in the Zone were included. The reason for this was this study focused on women who were living with HIV and using ART services. In order to compare similar populations, the comparison group, women who were not HIV sero positive were also selected from these 19 health facilities. We randomly selected half of these, namely, nine health facilities from the 19. The health facilities were stratified by the health centers and hospitals. Hospitals were further stratified into governmental and non-governmental. In total 9 health facilities (6 health centers plus 3 hospitals) were randomly selected and included in the study. The sample size for each health facility was allocated based on the probability proportional to the size of their previous six months' client flow. In order to determine this number, the previous 6 months' report of the Zonal Health Department was used. Finally, the K^{th} interval ($k = N/n$), where N = total number of women who were receiving health services in the nine health facilities ($N = 5301$), was divided by the calculated sample size ($n = 817$). Every 6th client was interviewed until the desired sample size was reached at each facility.

Data collection management and storage

The structured questionnaire was adapted from the WHO's multi-country study on women's health and domestic violence [5]. The structured questionnaires were prepared first in English and then translated to the local language (Wolaita Donna and Amharic) (S1, S2 and S3 Files). The wording of the questionnaires was adapted to be clear and unambiguous. In order to maintain consistency in the translation with the English version, the questionnaire was back-translated into English by another language expert. The contents of the questionnaire included socio-demographic variables, wealth index, controlling behaviour of partner, emotional, physical, and sexual violence, past violence experienced by husband/partner, and attitudes towards beating one's partner.

Two days' training was given to supervisors and data collectors in order to make them familiar with the objectives, the techniques, and the methodology of the research. The training aimed to standardize their interviewing skills and ensure interviews were done in a consistent manner.

Data were collected through interviewer-administered questionnaires in either the Wolaita Dona or Amharic language. Data collection was conducted by eight female health workers. Moreover, four supervisors (BSC/ MPH based on experience) supervised the data collectors.

Before the actual data collection, a pre-test was conducted on 5% of questionnaires in a similar setting but outside the intended study area. In order to maintain the internal consistency of the tool and to determine the reliability of the test, Cronbach's Alpha was applied. If the alpha was high (≥ 0.80) the item is considered to be reliable and the test is internally consistent. If the items in the test had a low correlation, rejecting the item that is inconsistent with the rest and retaining the item with the highest average inter-correlation was done via item analysis [15]. The supervisors and the principal investigator, in particular, closely supervised the performance of the data collectors. The completed questionnaires were checked by the supervisors on a daily basis. The raw data has been stored securely and confidentially, and will be kept for five years before being finally discarded appropriately.

Data analysis

Double data entry was done in EpiData software version 4.4.2.0. The data were then exported to STATA/SE 15, Texas 77845 USA software for cleaning and analyses. The errors identified were corrected after checking the questionnaires. Summary measures such as frequencies, and the regression analysis were computed. Binary and multivariable logistic regression analysis which provided odds ratio and 95% confidence interval were used to identify statistical associations. The variables from the binary logistic regression with (P-value < 0.25) were entered one at a time in the multivariable logistic regression to control for possible confounders. Finally, those variables with $p < 0.05$ were considered as statistically significant. The Hosmer-Lemeshow goodness of fit test was done as a post-estimation test by using the STATA command 'estat gof, group (10)' and it was not statistically significant (Prob $> \chi^2 = 0.8654$). The Receiver Operating Characteristics (ROC) graph was done and the result showed discrimination (0.8796), indicating the model's ability to discriminate between those subjects who experienced IPV and those who did not. Therefore, we concluded that the model fits. Multicollinearity was investigated using regress and VIF commands, and showed no multicollinearity as none of the variables' VIF was more than or equal to ten and tolerance was less than 0.1.

Ethical approval and consent to participate

Ethical approval was obtained from the Biomedical Research Ethics Committee (BREC) from the University of KwaZulu-Natal (BREC Ref No: BE387/18) (S4 File). Ethical clearance was also obtained from the Institutional Review Board of Wolaita Sodo University under Ref No: WSU15/04/147 (12 Sep. 2018) (S5 File). Formal permission was obtained from the health departments of Wolaita Zone and the respective health centers and hospitals where the study was conducted. The information regarding informed consent was explained to the participants in their own language. Respect for the person (autonomy) and protection of vulnerable participants were maintained. The purpose of the research, and the expected duration for the participant to complete the interview/questionnaire (25–30 minutes) was communicated. Referral for psychological support was made for some individuals. This study maintained the confidentiality of the participants; their name was not written on any result (anonymity was ensured). The participant had the right to withdraw or to interrupt their participation at any time without penalty or loss of benefits. We obtained the written consent from each of the participants. To maintain complete privacy, only one woman at a time in a private room or place was interviewed, except for children under age two years.

Results

Socio demographic characteristics of women living with and without HIV

A total of 816 women (408 HIV positive and 408 HIV negative) participated in this study. Over half of the women living with HIV, 238 (58.3%), were under the age of 29–39 years. Nearly half, 190 (46.57%) of the women without HIV were in the age group 18–28 years. More than three-quarters of women 324 (79.41) living with HIV were living in urban areas, as were 285 (69.85) of HIV negative women. The majority of women who were living with HIV 193 (47.3%) had primary education (grades 1–8), whereas the majority of women without HIV 154 (37.75%) had secondary education (grades 9–12). The majority, 371 (90.93%) of HIV negative women were currently married or lived with a man, whereas, among HIV positive women there were 252 (61.76%) with partners. Many of the HIV positive women were widowed 59 (45.38%). Bride price had been paid for 297 (90%) HIV negative women, while among HIV positive women the figure was lower 191 (71%). Regarding the wealth index, many of the HIV positive women, 165 (40.44%) were poor and few of them, 97 (23.77%) had a high wealth index, whilst many of HIV negative women had a higher wealth index 156 (38.24%) and relatively lower poverty, 118 (28.92%). Other than ethnicity, HIV status and a trend for differences in religion there were the significant socio-demographic differences between the HIV positive and negative respondents (Table 1).

Controlling behaviours by an intimate partner against women in Wolaita Zone

If the women reported at least one of the seven controlling behaviour questions listed in Table 2 below, then the woman was considered as reporting controlling behaviour. The composite prevalence of controlled behaviour among HIV positive women was thus reported by more than half of the women surveyed, 227 (55.64%), 95% CI (50.80%–60.49%), while nearly two-thirds of HIV negative women, 262 (64.22%), 95% CI (59.54%–68.89%), experienced controlled behaviour. The overall prevalence of controlled behaviour among both groups was 489 (59.93%) (Table 2).

Magnitude of emotional violence in Wolaita Zone, Ethiopia

If women reported at least one of the four emotional violence questions in Fig 1 below, they were considered as having experienced emotional violence. Accordingly, half of the women living with HIV, 204 (50%), [95% CI: 45.13%–54.87%] had experienced lifetime emotional violence, with a similar proportion, 209 (51.23%), [95% CI: 46.35%–56.10%] found among HIV negative women. The overall lifetime prevalence of emotional violence among all women (n = 816) was 413 (50.61%).

Of the total number of participants who had experienced emotional violence in the past 12 months, (n = 60), 22 (36.62%) [95% CI: 24.11–49.22] were among women living with HIV, whereas among HIV negative women (n = 18), there were 8 (44.44%), [95% CI: 19.02–69.87]. The overall prevalence of emotional violence in the past 12 months among all 78 women was 30 (38.46%) (Fig 1).

Prevalence of intimate partner violence in Wolaita Zone, Ethiopia

Lifetime physical violence among women living with HIV (n = 408) and without HIV (n = 408) was respectively 185 (45.34%) [95% CI: 40.49%–50.19%] and 164 (40.20%) [95% CI: 35.42%–44.97%]. Lifetime sexual violence among women living with HIV and without HIV was respectively 114 (27.94%) 95% CI: 23.57%–32.31% and 105 (25.74%) [95% CI: 21.48%–29.10%].

Table 1. Socio demographic characteristics of Women living with and without HIV in Wolaita Zone, Southern Ethiopia, from November-December 2018.

Characteristics (n = 816)	Women HIV Positive (n = 408)		Women HIV Negative (n = 408)		All women (816) Number (%)	P-value
	Frequency	Percent (%)	Frequency	%		
Age						P<0.001
18–28	119	29.20	190	46.57	309(37.9)	
29–39	238	58.30	193	47.3	431(52.8)	
40–49	51	12.50	25	6.13	76(9.3)	
Residence						
Urban	324	79.41	285	69.85	609(74.6)	P<0.001
Rural	84	20.59	123	30.15	207(25.4)	
HIV sero-status (HIV+ vs HIV-)	250	61.27	237	58.09	816(100)	P = 0.354
Women education						
No Education	118	28.98	65	15.93	183(22.4)	P<0.001
Primary Education (1–8)	193	47.30	139	34.07	333(40.8)	
Secondary (9–12 Grade)	75	18.38	154	37.75	229(28.1)	
Higher (Above 12)	22	5.39	50	12.25	71(8.7)	
Current marital status						
Currently married or lived with a man	252	61.76	371	90.93	623(76.4)	P = 0.004
Living with a man or not married or having a regular partner	24	5.88	10	2.45	34(4.2)	
Not currently married or living with a partner	132	32.35	27	6.62	159(19.4)	
Payment of bride price						
All paid	191	71	297	90	488(81.5)	
Partially paid or Non paid	78	29	33	10	111(18.5)	P<0.001
Religion						
Orthodox	183	44.85	135	33.09	318(40.0)	P = 0.073
Muslim	19	4.66	16	3.92	35(4.3)	
Protestant	178	43.63	207	50.74	385(47.2)	
Catholic	15	3.68	10	2.45	25(3.1)	
Traditional	13	3.19	1	0.25	1(0.1)	
Apostolic	-	-	39	9.56	52(6.3)	
Ethnicity						P = 0.593
Wolaita	337	82.6	350	85.78	687(84.2)	
Amhara	27	6.62	16	3.92	43(5.3)	
Gurage	12	2.94	21	5.15	33(4.0)	
Others	32	7.84	21	5.15	53(6.5)	
Occupation of women						
House wife	212	51.96	192	47.06	404(49.5)	P<0.001
Trader	67	16.42	66	16.18	133(16.3)	
Student	21	5.15	52	12.32	73(9.0)	
Government or NGO employ	41	10.05	87	21.32	128(15.7)	
Daily labourer	62	15.20	10	2.45	72(8.8)	
Others	5	1.23	1	0.25	6(0.7)	
Wealth Index						
Poor	165	40.44	118	28.92	283(34.7)	P<0.001
Middle	146	35.78	134	32.84	280(34.3)	
High	97	23.78	156	38.24	253(31.0)	

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Table 2. Controlling behaviours by an intimate partner against women living with and without HIV in Wolaita Zone, Southern Ethiopia, November-December 2018.

Characteristics (n = 816)	Women HIV positive	Women HIV negative	All women	P-value
	Yes, # (%)	Yes, # (%)	Yes, # (%)	p<0.001
Tries to keep you from seeing your friends	127(31.13)	130(31.86)	257 (31.50)	p<0.001
Tries to restrict contact with your family of birth	110(26.96)	110(26.96)	220 (26.96)	p<0.001
Insists on knowing where you are at all times	169(41.42)	188(46.08)	357(43.75)	p<0.001
Ignores you and treats you indifferently	80(19.61)	35(8.58)	115(14.09)	p<0.001
Gets angry if you speak with another man	153(37.50)	185(45.34)	338(41.42)	p<0.001
Is often suspicious that you are unfaithful	99(24.26)	47(11.52)	146(17.89)	p<0.001
Expects you to ask his permission before seeking health care for yourself	135(33.09)	187(45.83)	322(39.46)	p<0.001
Controlled behavior (composite)	227(55.64)	262(64.22)	489(59.93)	p<0.001

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The lifetime prevalence of physical and sexual violence among all the women interviewed (n = 816) was respectively 349(42.77%) [95% CI: 39.37%-46.17%] and 219(26.84%) [95% CI: 23.79%-29.88%].

The lifetime prevalence of IPV (women who had reported at least one incident from physical, sexual, and emotional/psychological violence) among all women surveyed (n = 816) were 487(59.68%), [95% CI: 56.31%-63.05%]. Although, the prevalence of IPV was a little higher among women living with HIV, 250(61.27%), [95% CI: 56.53%-66.02%] than women who were HIV negative, 238(58.09%), 95% CI: 53.28%-62.90%, there were no statistically significant differences (P = 0.354)

In the 12 months preceding the survey, the prevalence of IPV (physical, sexual, emotional / psychological violence) among all women, n = 230, was 78(33.91%). The physical violence in 12 months among all women, n = 81, was 25(30.86%), 95% CI: 20.59%-41.14%] while sexual violence in the same period amongst all the women, n = 71, was 23(32.39%), 95% CI: 21.24.43.55%] (Fig 2).

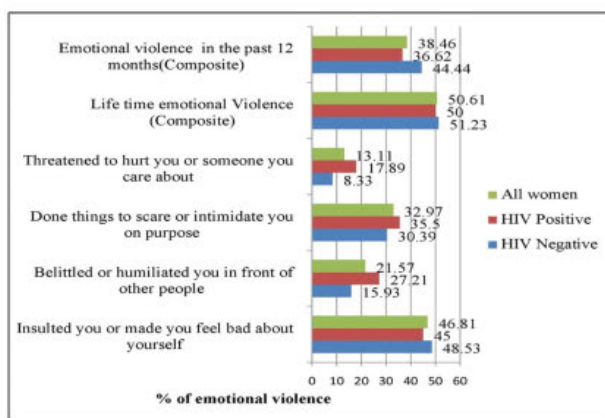


Fig 1. Emotional violence against women in Wolaita Zone, November-December 2018.

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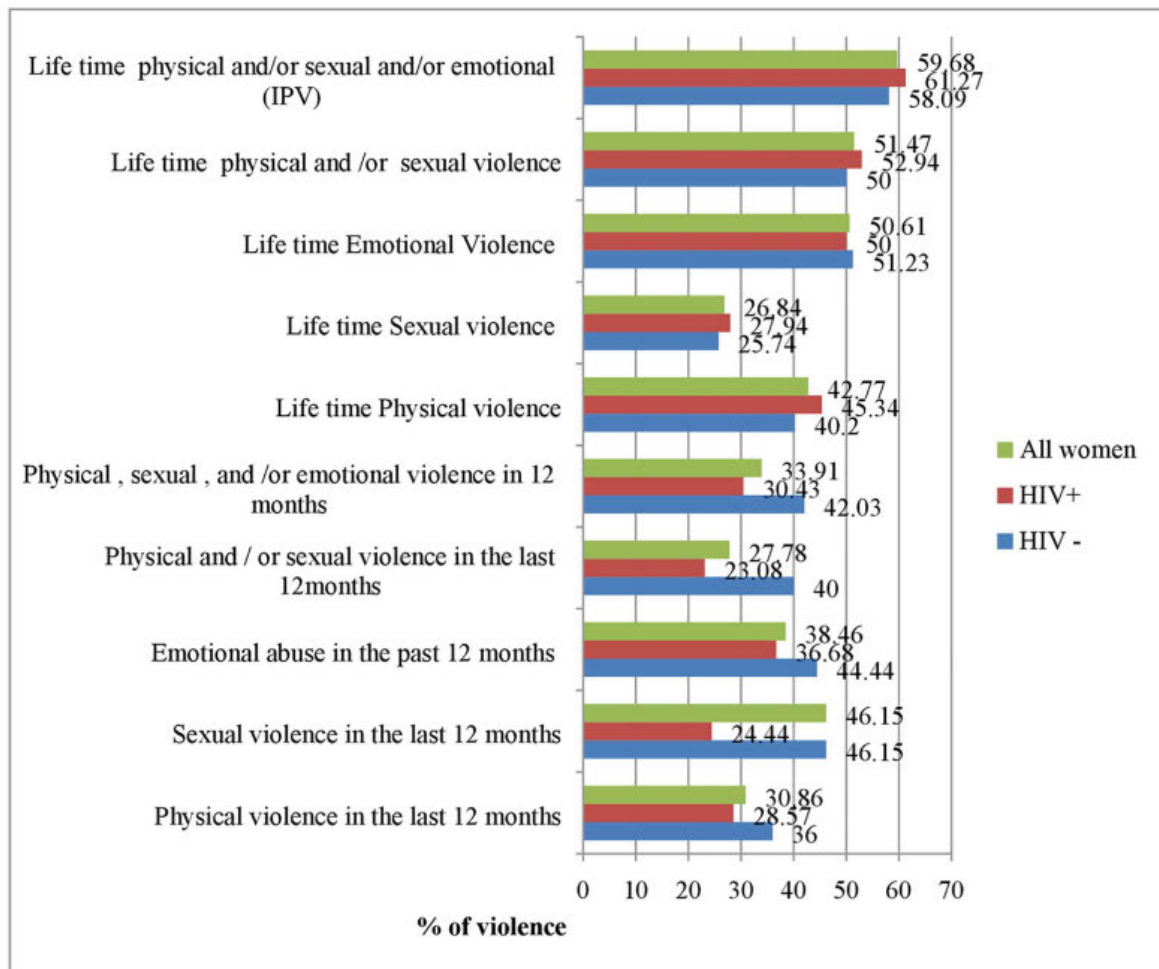


Fig 2. Prevalence of intimate partner violence in Wolaita Zone, Ethiopia, November-December 2018.

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Prevalence of lifetime physical and sexual violence among women in Wolaita Zone

Different features of physical and sexual violence were identified among women living with and without HIV in Wolaita Zone. Among the features of physical violence, more than one-third of the partner slapped women or thrown something at their partner that could hurt them among women living with HIV, 163(39.95%), while such figure was lower among women living without HIV, 151(37.01%). Moreover, some features of physical violence like male partner choked or burnt their spouse/ partner on purpose was relatively one of the lowest physical violence types among both of the women living with HIV, 9(2.21%), and also the women living without HIV, 4(0.98%), in Wolaita Zone.

Table 3. Prevalence of lifetime physical and sexual violence among women living with and without HIV in Wolaita Zone, Ethiopia, November–December 2018.

Characteristics of physical violence	Women HIV + (N = 408); Number (%)	Women HIV- (N = 408); Number (%)	All women (N = 816); Number (%)	P-value
Slapped you or thrown something at you that could hurt you	163(39.95)	151(37.01)	314(38.48)	p<0.001
Pushed you or shoved you or pulled your hair	115(28.19)	90(22.06)	205(25.12)	p<0.001
Hit you with his fist or with something else that could hurt you	96(23.53)	62(15.20)	158(19.36)	p<0.001
Kicked you, dragged you or beat you up	95(23.28)	68(16.67)	163(19.98)	p<0.001
Choked or burnt you on purpose	9(2.21)	4(0.98)	13(1.59)	P = 0.003
Threatened to use or actually used a gun, knife or other weapon against you	24(5.88)	11(2.70)	35(4.29)	p<0.001
Characteristics of Sexual Violence				
Your current husband/partner or any other partner ever physically force you to have sexual intercourse when you did not want to	86(21.08)	66(16.18)	152(18.63)	p<0.001
Had sexual intercourse which you did not want to because you were afraid of what your partner or any other partner might do	93(22.79)	88(21.5)	181(22.18)	p<0.001
Your partner or any other partner ever forced you to do something sexual that you found degrading or humiliating	57(13.97)	33(8.09)	90(11.03)	p<0.001

<https://doi.org/10.1371/journal.pone.0220919.t003>

Regarding the features of sexual violence, their current husband/partner or any other partner ever physically force women to have sexual intercourse when they did not want to practice was more common among women living with HIV, 86(21.08%), than women who were living without HIV, 66(16.18%). Similarly, women’s male partner or any other partner ever forced them to do something sexual that the women found degrading or humiliating was more common among HIV positive women, 57(13.97%) than their counterpart of women living without HIV, 33(8.09%) (Table 3).

Women’s attitudes towards partner beating

In order to better understand the attitudes of women they were questioned the reasons why a man would / could hit/beat his wife. The prevalence of an overall positive attitude towards wife beating among all women was 393 (48.16%). This attitude towards wife beating was somewhat higher among HIV negative women 211(51.72%) than women living with HIV, 182 (44.61%). However, the women’s positive attitude towards wife-beating regarding a refusal of sexual relations in circumstances such as sickness etc. was higher among HIV positive women, 352 (86.27%) than those HIV negative, 306 (75%). The overall prevalence was 658 (80.64%) among both groups of women who reported a positive attitude towards wife-beating as a result of the wife’s refusal to have sexual relations in some circumstances such as sickness etc.,(Table 4)

Factors associated with intimate partner violence against women living with and without HIV in Wolaita Zone, Ethiopia

To identify factors associated with IPV, the independent variables were analyzed in bivariate and multivariable logistic regression models. A total of 23 variables were included in the multivariable logistic regression model. Women who were in the age group 29–39 years were 2.86 times more likely to experience IPV than those in the age group 18–28 years, [AOR = 2.86; 95% CI: 1.67–4.90]. Women with low-income were nearly four times more likely to have experienced IPV than the women with high income, [AOR = 3.97, 95% CI: 1.81–8.72]. Women whose bride price as requested by her parent was partially paid or not paid at all were 3.46 times more likely to experience IPV, than women where the requested bride price had been paid, [AOR = 3.46; 95% CI: 1.74–6.87]. Women who indicated that a married women has no

Table 4. Women’s attitudes towards partner beating in Wolaita Zone, Ethiopia, November-December 2018.

Characteristics wife beating		HIV Positive Frequency (%)	HIV Negative Frequency (%)	All women	P-value
When she does not complete her household work to his satisfaction	Yes	111(27.21)	89(21.81)	200(24.51)	p<0.001
	No	297(72.79)	319(78.19)	616(75.49)	
When she disobeys him	Yes	137(33.58)	164(40.20)	301(36.89)	P = 0.001
	No	271(66.42)	244(59.80)	515(63.11)	
When she refuses to have sexual relations with him	Yes	101(24.75)	120(29.41)	221(27.08)	P = 0.008
	No	307(75.25)	288(70.59)	595(72.92)	
When she asks him whether he has other girlfriends	Yes	104(25.49)	88(21.57)	192(23.53)	P = 0.003
	No	304(74.51)	320(78.43)	624(76.47)	
When he suspects that she is unfaithful	Yes	128(31.37)	88(21.57)	216(26.4)	P = 0.006
	No	280(68.63)	320(78.43)	600(73.53)	
When he finds out that she has been unfaithful	Yes	149(36.52)	165(40.44)	314(38.48)	P = 0.024
	No	259(63.48)	243(59.56)	502(61.52)	
Attitude towards wife beating (composite)	No wife beating	226(55.39)	197(48.28)	423(51.84)	
	Beat wife	182(44.61)	211(51.72)	393(48.16)	
Characteristics refusal to have sex					
When she doesn't want to	Yes	241(59.07)	137(33.58)	378(46.32)	P = 0.004
	No	167(40.93)	271(66.42)	438(53.68)	
When he is drunk	Yes	256(62.75)	157(38.48)	413(50.61)	p<0.001
	No	152(37.25)	251(61.52)	403(49.39)	
When she is sick	Yes	319(78.19)	271(66.42)	590(72.30)	p<0.001
	No	89(21.81)	137(33.58)	226(27.70)	
When he mistreats her	Yes	296(72.55)	204(50)	500(61.27)	p<0.001
	No	112(27.45)	204(50)	316(38.73)	
When she suspects he has extra-marital sexual relations with another woman	Yes	293(71.81)	207(50.74)	500(61.27)	p<0.001
	No	115(28.19)	201(49.26)	316(38.73)	
When she suspects her husband has an STI/HIV	Yes	293(71.81)	235(57.60)	528(64.71)	p<0.001
	No	115(28.19)	173(42.40)	288(35.29)	
Attitude towards refusal of sexual relation(Composite score)	Unable to refuse sex	56(13.73)	102(25)	158(19.36)	p<0.001
	Can refuse sex	352(86.27)	306(75)	658(80.64)	

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right to refuse to have sex with her husband in some situations such as sickness etc. were thrice as likely to experience IPV as women who believed a woman could refuse sex in some situations, [AOR = 2.99; 95% CI:1.39–6.41]. Women whose partner drank alcohol were 2.36 times more likely to experience IPV than those whose partner did not drink alcohol, [AOR = 2.36; 95% CI: 1.36–4.10]. Similarly, women who had between two and nine sexual partners were 2.35 times more likely to experience IPV than women, who had one sexual partner, [AOR = 2.35; 95% CI: 1.36–4.09]. Women, whose partner had ever been involved in a physical fight with another man, were 1.83 times more likely to experience IPV than those women who did not report this, [AOR = 1.83; 95% CI: 1.05–3.19].

Women who had experienced their behaviour being controlled by their husband were 8.13 times more likely to suffer IPV than those women, who did not report this, [AOR = 8.13; 95% CI: 4.93–13.42]. Women whose partner’s family arranged their marriage were 2.82 times more likely to experience IPV, compared to those couples who chose marriage together [AOR = 2.82; 95% CI:1.70–4.69] (Table 5).

Table 5. Logistic regression model of factors associated the lifetime IPV against women living with and without HIV in Ethiopia, November-December 2018.

Characteristics (n = 816)	Lifetime physical, sexual and emotional violence (IPV)		COR(95%CI)	AOR(95%CI)	P-value
	Yes	No			
Age group of women					
18–28	141(45.63)	168(54.37)	1.00	1.00	
29–39	287(66.59)	144(33.41)	2.37(1.76–3.21)	2.86(1.67–4.90)*	p<0.001
40–49	59(77.63)	17(22.37)	4.14(2.31–7.42)	1.86(0.70–4.93)	P = 0.211
Wealth Index					
Poor	207(73.14)	76(26.86)	2.75(1.91–3.94)	3.97(1.81–8.72)*	P = 0.001
Middle	154(55)	126(45)	1.23(0.88–1.73)	1.46(0.82–2.59)	P = 0.199
High	126(49.68)	127(50.20)	1.00	1.00	
Women’s Education					
No Education	128(69.95)	55(30.05)	4.03(2.26–7.17)	0.63(0.20–1.98)	P = 0.431
Primary Education (1–8)	206(61.86)	127(38.14)	2.81(1.65–4.77)	0.72(0.28–1.86)	P = 0.503
Secondary (9–12 Grade)	127(55.62)	102(44.54)	2.15(1.24–3.73)	0.96(0.39–2.40)	P = 0.943
Higher (Above 12)	26(36.62)	45(63.38)	1.00	1.00	
Payment of bride price					
All paid	267(54.71)	221(45.29)	1.00	1.00	
Partially paid or Non paid	81(72.97)	30(27.03)	2.23(1.42(3.52))	3.46(1.74–6.87)*	p<0.001
Attitude to refuse to have sex in some situations					
Believe no right to refuse	121(76.58)	37(23.42)	2.61(1.75–3.89)	2.99(1.39–6.41)*	P = 0.005
Can refuse sex in some situations	366(55.62)	292(44.38)	1.00	1.00	
Partner consumed alcohol					
Yes	243(75.23)	80(24.77)	3.10(2.28–4.22)	2.36(1.36–4.10)*	P = 0.002
No	244(49.49)	249(50.51)	1.00	1.00	
Number of sexual partner					
One(1)	284(53.28)	249(46.72)	1.00	1.00	
Two-nine(2–9)	203(71.73)	80(28.27)	2.22(1.63–3.03)	2.35(1.36–4.09)*	P = 0.002
Partner ever involved in a physical fight with another man					
Yes	203(76.32)	63(23.68)	3.45(2.47–4.82)	1.83(1.05–3.19)*	P = 0.034
No	229(48.31)	245(51.69)	1.00	1.00	
Do not Know	55(72.37)	21(27.63)	2.80(1.64–4.78)	1.61(0.65–3.40)	P = 0.306
Controlled behaviour of husband (Composite score)					
Yes	389(79.55)	100(20.45)	9.09(6.58–12.55)	8.13(4.93–13.42)*	p<0.001
No	98(29.97)	229(70.03)	1.00	1.00	
Who chose marriage					
Both chose	199(49.63)	202(50.37)	1.00	1.00	
Respondent chose	17(58.62)	12(41.38)	1.44(0.67–3.09)	1.57(0.49–5.06)	P = 0.452
Respondent’s family chose	19(70.37)	8(18.18)	2.41(1.03–5.64)	1.34(0.27–6.74)	P = 0.716
Partner chose	9(81.82)	2(18.18)	4.57(0.97–21.41)	2.94(0.21–41.82)	P = 0.427
Partner’s family chose	239(70.71)	99(29.29)	2.45(1.81–3.33)	2.82(1.70–4.69)*	p<0.001
Others	4(40)	6(60)	0.68(0.19–2.43)	0.55(.01–49.53)	0.794

* = Statistically significant in multivariable logistic regression (AOR)

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Discussion

This study assessed the prevalence of IPV among women living with and without HIV and the associated factors, and demonstrates a significant burden of IPV among women, amongst both groups in Wolaita Zone, Ethiopia. The study found that the overall lifetime IPV among

all women surveyed was 487 (59.68%), [95% CI: 56.31%-63.05%], whereas ten previous studies reported IPV prevalence from 20 to 78% [16]. This study from Southern Ethiopia confirms the high prevalence of IPV in this region. In Ethiopia Dhairyawan et al. (2013) reported lifetime IPV prevalence of 52% [17], and Yizaw et al. in Northern Ethiopia in 2004 found an IPV prevalence of 50.8% [18]. These statistics are higher than the WHO African, Eastern Mediterranean, and South-East Asian regions study which reported a lower IPV prevalence of 37% [3]. A possible explanation for these results may be the lack of adequate awareness about women's reproductive health rights among the current study population and also differences in the study setting.

The current study found no significant differences in lifetime prevalence of IPV among women living with HIV, 250(61.3%), [95% CI: 56.53%-66.02%] compared to women who were HIV negative, 238(58.1%), 95% CI: 53.28%-62.90% ($p = 0.354$). This finding is in agreement with the study conducted in ten developing countries by Harling, et al., (2010), in which there was no association found between HIV infection and IPV[19].

The lifetime prevalence of each of the factors, emotional, physical, and sexual violence among all women interviewed ($n = 816$) was 413 (50.61%), 349(42.77%), and 219 (26.84%), respectively, indicating that emotional violence was the most common form of violence. The present findings appear to be consistent with other research which found that the mean lifetime prevalence of domestic emotional violence was 51.7% [8]. However, the findings of the current study were lower than a study conducted in North West Ethiopia, in which the psychological, physical, and sexual violence were 73.3%, 58.4% and 49.1%, respectively [16]. A possible explanation for this result may be that the North West Ethiopia study was conducted only in a rural setting, with a small sample size and cultural differences.

The prevalence of IPV among all women in the last 12 months preceding the survey was 78 (33.91%) ($n = 230$). This finding is in agreement with the WHO global study, where the prevalence was 30%, and for the study in India, 35% [20], and also 35% for the Ethiopian DHS 2016 study [9]. However, a prevalence of IPV (21%) was found in a study in Cape Town, Southern African, among 623 HIV-infected pregnant women in 2016 [21]. A possible explanation could be that in the Cape Town study, the participants were only from urban areas, where the women may have been more empowered and they may have different awareness levels to the women in this study.

The reported physical and sexual violence in the last 12 months among all the women in this study was, 30.86% and 32.39% respectively. The present findings seem to be consistent with other research which found similar prevalence of physical and sexual violence in the past year (28% for each) [14]. However, the findings of the current study are higher than that of the South African study in which the reported physical and sexual violence was 15% and 2%, respectively [21], and the Ethiopian DHS study, in which the prevalence of physical and sexual violence in the past 12 months preceding the survey was 15% and 7%, respectively [9]. A possible explanation for this might be differences in the study areas, and the beliefs and culture of the societies. This finding emphasizes that IPV is of public health concern in Ethiopia. The magnitude of the problem is not just from a human rights' perspective, but also because of the negative economic and health aspects affecting women in Ethiopia [12].

The results of this study did not show any significant association between the HIV status of the women ($COR = 1.14$; 95% CI: 0.86–1.51), nor their own or their husbands'/partners' education level or occupation, residence, or religion. These findings seem to be consistent with studies of South West Ethiopia and other research in ten developing countries [14, 19]. Contrary to this finding, the residence, occupation and educational status of women were significantly associated with IPV in the study conducted in Ethiopia among women of reproductive age [8]. Such differences may be related to the difference in the study setting among the

Ethiopian populations and their different cultures. The lower income and older age group of women (29–39 years) were significantly associated with IPV among the socio-demographic variables. These results are similar to those observed in earlier studies concerning the association of women with lower income with IPV [16]. Income is a key factor to assist women to protect themselves from violence. If women are less dependent on their partner and empowered economically, they are less likely to be abused, and hence women need to be assisted to engage in income generating activities [22–24]. When women start to earn their own income, they are less dependent upon their male partners, and this provides less opportunity for male partners to control their wives and the men may lose some of their power [22].

In contrast to this finding, a study conducted in the UK showed that the older age group of women was not significantly associated with IPV [17]. It could perhaps be explained by the differences in the study setting and economic independence of women in UK compared to Ethiopia.

The current study found that women whose husband/partner controls their wives' behaviour were more likely to experience IPV than women who did not experience such control over their behaviour. This finding is consistent with the studies conducted by Deribe et al. (2012) and Shamu et al. 2014 [14, 25]. Such controlling tactics are a risk for women's physical and mental health promoting pain / discomfort, sadness or depression, and perhaps even suicidal ideation (26). Controlling behaviours may restrict women from seeking medical care and contact from family and friends. Their partners' suspicions that women are unfaithful are also part of such controlling behaviours [26].

This study found that having a male partner who drank alcohol was significantly associated with IPV. This finding is in agreement with the previous research done by Semahegn (2015) and Yigzaw (2004) [16, 18]. A possible explanation for these results may be that a person who consumed alcohol might be likely to be aggressive and angry and to abuse women emotionally, physically and /or sexually. Different studies have shown that alcohol leads to IPV and sexual risk taking, such as engagement with commercial sex workers and reduced condom use [27, 28].

An interesting finding regarding the prevalence of violence was that the women who reported risky sexual behaviour, particularly having least two or more partners, and those whose partners had been involved in a physical fight with another man were at increased risk of IPV. These findings of the current study are consistent with those of Shamu et al. (2014) [25] who found that if a partner ever fought with another man this was statistically associated with IPV. Women who have multiple sexual relations with several partners appear to be at increased risk of experiencing abusive behaviour from their partners.

Regarding the decision making powers of a woman, those women who reported that they were unable to refuse sex in some situations, were at significant risk of being abused by their partner. This was associated with IPV and suggests these women's powerlessness placed them at risk ($P = 0.005$). This finding is in agreement with the study by Shamu et al. 2014 [25] who explained that women endorsing three to six sexual abuse attitudes, were more likely to experience IPV than those women who were less likely to have positive attitudes to abuse.

Women, whose bride price payment was only partially paid or not paid at all, were more likely to have experienced IPV than their counterparts. This is also in agreement with the finding of the study conducted in Western Ethiopia, 2016 [29]. This may occur since the cultural obligations have not been met and as marriages in Ethiopia are often arranged by the parents of the bride and groom, these require much negotiation. At the time of the wedding ceremony, the bride's parents give the groom a dowry. When the expected bride-price was not paid, the family or the groom might act violently. Women whose partner's family arranged their marriage were statistically more likely to experience IPV. In a marriage arranged by their parents, there might be difficulties as the couple had not known each other before such arrangement

[30]. In summary, IPV is highly prevalent in southern Ethiopia and mainly highly associated with male controlling behaviour, their alcohol drinking and low income of women. Therefore, changing male attitudes through awareness creation and involving them in IPV prevention programs are important. Moreover, the economic empowerment of women is a very crucial intervention (24).

Strength and limitations

The present study provides additional evidence with respect to IPV among women living with and without HIV and reports a high prevalence of IPV in southern Ethiopia. The strengths of this study are that it included the special population of women who are living with HIV. It also gave an opportunity for women living with and without HIV to share and explain their experience of violence to others and to contribute to the recommendations provided by this study. The study benefitted from the use of a large stratified random sample and the use of the standard WHO questionnaire. On the other hand, the generalizability of these results is subject to certain limitations as it is an institutionally based study. Women who have not tested for HIV and women who are HIV positive but not taking ART were not included when selecting the study sample. Further, a cross-sectional study cannot establish the temporal relationship, though the design helps to examine the association with a number of variables. The cross-sectional study thus cannot support conclusions regarding the inference on causality or on the risk of diseases or in this study, IPV.

Conclusion

These results indicate that there is a high prevalence of IPV against women in Wolaita Zone, both those living with and without HIV. Emotional violence was the most common form of IPV followed by physical and sexual violence. These results suggest an association between IPV and the age group of women (older women are at increased lifetime risk). Women's lack of power is indicated by the association of IPV and income, bride price payment, and women's attitude to refuse to have sex. IPV was also associated with alcohol consumption by the husband/partner, number of sexual partners, whether husband/partner ever physically fought with another man, the controlling behaviour of the husband/ partner, and the husband's family arranging their marriage. In order to tackle IPV there is a need to empower women to make their own decisions about their reproductive health. A key policy priority should be to involve males in programs of gender-based violence prevention in order to change their violent behaviour. Additionally, improving the economic status of women, advising women /men to limit the number of sexual partners and that marriage arrangements should be by mutual consent rather than made by parents, are also recommended. Further investigations are needed to monitor the physical and mental health impact of IPV among different groups of women and different regions.

Supporting information

S1 File. English questionnaire.
(PDF)

S2 File. Amharic questionnaire.
(PDF)

S3 File. Wolaita language version.
(PDF)

S4 File. Ethical Approval.

(PDF)

S5 File. IRB Approved WSU Ethiopia.

(PDF)

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Author Contributions**Conceptualization:** Mengistu Meskele.**Data curation:** Mengistu Meskele.**Formal analysis:** Mengistu Meskele, Nelisiwe Khuzwayo, Myra Taylor.**Investigation:** Mengistu Meskele.**Methodology:** Mengistu Meskele, Nelisiwe Khuzwayo, Myra Taylor.**Project administration:** Mengistu Meskele.**Software:** Mengistu Meskele.**Supervision:** Mengistu Meskele, Nelisiwe Khuzwayo, Myra Taylor.**Validation:** Mengistu Meskele, Myra Taylor.**Visualization:** Myra Taylor.**Writing – original draft:** Mengistu Meskele.**Writing – review & editing:** Nelisiwe Khuzwayo, Myra Taylor.**References**

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CHAPTER FIVE: LIVED EXPERIENCE OF INTIMATE PARTNER VIOLENCE AMONG WOMEN USING ANTIRETROVIRAL THERAPY AND OTHER OUTPATIENT SERVICES IN WOLAITA ZONE, ETHIOPIA: A PHENOMENOLOGICAL STUDY

Bridging Statement

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Introduction

Chapter three provided evidence of the IPV experience among HIV positive women and their experiences after an HIV test disclosure. It also documented the socioeconomic factors associated with IPV among women in Sub-Saharan Africa. However, the need to explore the lived experience of IPV against women using antiretroviral therapy (ART) and other outpatient services in Wolaita Zone, Ethiopia, is of paramount importance. Moreover, this study identified the country-specific IPV experience in Wolaita Zone, and the required prevention strategies as well as the roles and involvement of stakeholders.

Doctoral student's contribution

1. I conceived and formulated the project
2. Study design: I designed the study with my supervisors
3. Project management and field logistics: I collected the data through the in-depth interviews and Focus Group Discussions
4. Data analysis: I transcribed, translated and analysed the data.
5. Write up: I drafted and wrote the manuscript. My co-authors/supervisors guided, reviewed and approved it for journal submission.

RESEARCH

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Lived experience of intimate partner violence among women using antiretroviral therapy and other outpatient services in Wolaita Zone, Ethiopia: a phenomenological study

Mengistu Meskele^{1,2*} , Nelisiwe Khuzwayo³ and Myra Taylor¹

Abstract

Background: Ethiopia is one of the nations which has an enormous burden of intimate partner violence (IPV), and where it is usually difficult to talk about HIV separately from IPV.

Objectives: This research aimed to explore the lived experience of IPV against women using antiretroviral therapy (ART) and other outpatient services in Wolaita Zone, Ethiopia

Methods: We used an Interpretive (hermeneutic) Phenomenological Analysis design among purposively selected adult women aged 18–49 years. A total of 43 women participated in this study, of whom 30 were using ART, and 13 women were using other health services. We used an in-depth interview and focus group discussions until data saturation, while conscious of the need to maintain the scientific rigor, dependability, and credibility. The data were transcribed verbatim and translated into English. We read the transcripts repeatedly to understand the content. We used NVivo 11 software to assist with data organisation, and also, we used the framework analysis method.

Results: We identified five themes, namely: “women’s terrifying experiences of violence,” “the effect of violence on women’s health,” “support/lack of support /partner’s controlling behaviours,” “women’s feelings about the available services,” and “IPV prevention strategies from the perspective of women.” Interviewees described their violent experiences which included wife-beating, being stigmatised in front of others, having material thrown at the woman’s face, wife’s hand and teeth were broken, forced sex, restriction of movement, name-calling, threats to hurt, being insulted, being left alone, and the withdrawal of finances. The negative health impacts reported included abortion, infection with HIV and other sexually transmitted diseases, disability, child’s death, and depression. The disclosure of HIV test information resulted in violence. Inappropriate punishment of the perpetrator and the lack of a supportive women’s network to avert IPV were perceived as legal limitations.

Conclusions: IPV is a considerable health burden, varying in its presentation and its negative impact on women’s health. Improved laws should provide justice for all victims. Establishing a women’s network to assist women at risk of violence, should be emphasised. Unwise HIV test result disclosure leads to IPV; hence HIV disclosure should be facilitated through health care providers.

Keywords: Intimate partner violence, Phenomenology, HIV, Wolaita, Ethiopia

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Plain English summary

Intimate partner violence (IPV) and HIV infection present as an overlapping/ intersecting challenge. There are gender gaps in the justice system in Ethiopia, and to date, IPV and rape cases have been delayed and given low priority.

We interviewed 43 women who were using antiretroviral therapy and/or other health services from the 19 health facilities in Wolaita Zone, Southern Ethiopia. One or two women were picked from each facility purposively until we reached information satiety for the in-depth interviews. We also conducted four focus group discussions with different women.

We found five main themes from this study: "Women's terrifying experiences of violence," "The effects of violence on women's health," "Support/lack of support / controlling behaviours/," "Women's feelings about the available services," and "IPV prevention strategies from the perspective of women." Women who were HIV positive, suffered further at the hands of their partners. Alcohol consumption and the use of substances by male partners took a heavy toll on women's experience of IPV, and the psychosocial consequences of IPV reported were fear, discrimination and divorce.

The available legal system, women's affairs office, and the roles of women leaders were seen as ineffective. Besides that, the participants believed that there was an absence of a women's network actively working on IPV. They recommended that health care workers should assist women in the disclosure of HIV test results to their partners. Further, there existed weak and inappropriate punishment for perpetrators of violence.

In conclusion, IPV is a considerable health problem in Wolaita. There is a need to examine the relationship between IPV and HIV in the different parts of the country.

Background

Violence Against Women (VAW) takes place in almost all countries, amongst girls and women of all cultures, ages, race, educational level, religions and sexual orientation [1]. Accordingly, in the ever-partnered women, the prevalence of physical or sexual violence or both, by an intimate partner ranged from 15 to 71% [2]. The World Health Organization (WHO) defines VAW as "any act of gender-based violence that leads to or is probably going to end in, sexual, physical, or psychological suffering or harm to women, including threats of such acts, bullying or arbitrary deprivation of liberty, whether occurring publicly or privately in life," perpetrated by a current or former partner [1].

Globally, intimate partner violence (IPV) is a tremendous public health problem with a global prevalence of

30% for physical and/or sexual IPV among ever-partnered women [3]. Intimate partner violence is associated with HIV infection among women in Africa [4, 5]. Intimate partner violence and HIV are overlapping/intersecting challenges, with a significantly high prevalence among women who are living with HIV/AIDS [4–6].

To protect the rights of women and to promote gender equality and equity, Ethiopia revised its family law in 2000, as well as its criminal code in 2005 [7]. Moreover, Ethiopia is a signatory to the convention on international human rights. However, there are gender gaps in the justice system, insufficient investigations, and a lack of special handling of the cases involving women and children. Furthermore, to date, IPV and rape cases have been delayed and given low priority [8, 9].

In Ethiopia, some women and men tolerate and accept wife-beating, which makes IPV prevention difficult. For instance, 28% of men and 63% of women agreed that a husband is justified in beating his wife [10]. Although the government of Ethiopia is trying to empower women, some traditional and conservative elements in society still need an attitudinal change (both men and women), in their belief that wife-beating is normal, and in the practice of harmful traditions like marital rape, and the idea that women are not equal to men [9].

Currently, according to the 2016 Ethiopian Health and Demographic Survey (EDHS) report, IPV affects the economy and the health, and human rights of women. In Ethiopia, more than one in three of ever-married women (35%) reported that they had experienced physical, emotional, or sexual violence from their husbands or partner at some point in time. One quarter (24%) of women experienced psychological abuse, a quarter (25%) experienced physical violence, while (11%) experienced sexual violence. Most IPV incidents (38%) occurred amongst women in the older age groups (40–49 years) [10, 11]. Earlier studies also revealed that after HIV serostatus disclosure, one in three women experienced partner violence [12, 13]. Some women experienced controlling behaviour by their partner, including emotional abuse, denial of communication, blame, abandonment, refusal to use safer sex methods, withdrawal of marital support, and marriage dissolution, stigma, and violence [12, 13].

Ethiopia is no exception since the occurrence of VAW is also high. The government of Ethiopia has been revising different documents to guarantee the rights of women, and the country has highlighted that further reliable information is needed to protect these rights [11].

Therefore, this study aimed to explore the context and the lived experience of IPV among women who were using ART and other health services in Wolaita Zone, Southern Ethiopia.

Methods

Study area and setting

This study was conducted in Wolaita Zone, one of the 14 Zones in the Southern Nations, Nationalities, and People's Regional State (SNNPR) of Ethiopia. The Wolaita language is the native language of the Zone. Wolaita Sodo, the capital town of Wolaita Zone, is 330 km southwest of Addis Ababa, the capital city of Ethiopia. According to the 2007 Central Statistical Agency of Ethiopia (CSA), a total of 2,473,190 populations are living in the Zone [14]. In Wolaita Zone, we have 19 health facilities which were providing ART, from which we randomly selected nine health facilities.

Study design

We used an Interpretative (hermeneutic) Phenomenological Analysis (IPA) design to explore the lived experiences of women and to document the participants' lives [15]. We chose this method because it is very good at bringing out what is usually hidden in human experience and human relations. The IPA design requires the interpretation of the narratives provided by participants, and the expert knowledge on the part of the researcher is valuable. The IPA design can go beyond the descriptive, in looking for the meaning hidden in standard life practices [16, 17]. The use of IPA helped us understand how individuals make sense of their IPV experience [18]. The study participants were actively engaged in interpreting the events, objects, and people in their lives.

Moreover, we tried to understand our participants' perspectives of IPV to make the analysis more productive and more comprehensive [18]. We undertook the in-depth interviews and Focus Group Discussions (FGDs) with women until we achieved data saturation. These assisted in the understanding of their personal experiences, and several individuals shared such experiences [18]. These focused on what the participants have in common concerning their IPV experiences, the description of such events and how it affects their lives. The different meanings that women attach to their experiences were studied. The research questions were "What have the women who were using ART, and family planning, prevention of mother to child transmission (PMTCT), and antenatal care (ANC) experienced concerning IPV and what contexts have influenced their experience of IPV" [19].

Selection of study sample

We selected the participants for the in-depth interviews and focus group discussions (FGDs) from the 19 health facilities which were providing ART. One or two women were picked from each facility purposively until idea saturation was reached for the in-depth interviews.

Moreover, for the four FGDs, each FGD included eight to 12 participants who were also selected purposively. Three of the FGDs were with women who were using ART, while one of the FGDs was with HIV negative women who were using ANC and family planning services. The health care providers assisted in the selection of the study participants to obtain a rich explanation about the phenomenon.

We also included peer educators and adherence counselor supporter women who were using antiretroviral therapy (ART) in our FGDs. In total, we conducted 13 in-depth interviews and four FGDs among women who were using antiretroviral therapy (ART) and family planning, ANC, and PMTCT. A total of forty-three women participated in this study, of whom 30 were using ART, and 13 women were using other health services.

Data collection and procedures

We conducted the data collection from October to November 2018. The facilitator guides were adapted from the World Health Organization's (WHO) practical guide on researching violence against women [20] (Additional file 1: S1_file). The principal investigator (PI) conducted face to face in-depth interviews and facilitated the four FGDs. During the meetings and discussions, where necessary, the PI probed to get further clarity from the participants. Four experienced female research assistants (RAs), who were able to speak the local language Wolaita and the Amharic language fluently, assisted the PI with note taking and recordings during the FGDs. We conducted all in-depth interviews at offices in the health facility or the participants' preferred places to maintain privacy and confidentiality.

The PI initiated "warm-up" discussions to reduce the tension among the participants. After we had examined, analysed, and understood the first interviewee women's IPV experience in detail, we then moved to an equally attentive exploration of subsequent interviews until data saturation [18]. We purposively selected eight to 12 women for each FGD. We scheduled meetings based on women's preferences. The number of interviews was determined by achieving saturation of the ideas. We also provided refreshments for the FGD participants. We used the scientific rigor and integrity [21] to maintain trustworthiness of the study.

Data analysis

We used a framework analysis method, which followed seven steps. These were transcription, familiarisation with the interview, coding, developing a working framework, applying an analytical framework, charting data into the framework matrix, and interpreting the data [22, 23]. In the first transcription stage, the data were audio-recorded

and transcribed verbatim and translated into the English language by the principal investigator and research assistants. In the second familiarisation phase, the authors read and re-read the transcripts several times. This stage was followed by listening to the audio recordings a few times to get new insights. Also, we took notes and considered our observations and reflected on the interview experiences. The initial interpretive comments made were identified and recorded. Thirdly, we identified codes, which we produced from reading the texts of the transcripts. We used NVIVO 11 software to assist with the data organisation and analysis. Fourthly, we developed a working framework, in which we compared the labels and agreed on the set of codes to apply in the subsequent transcripts. Then the codes were grouped into categories. The process formed the working analytical framework. In the fifth step, we performed the analytical framework by indexing the succeeding transcripts using the available codes and categories. In the sixth step, we charted the data into the framework matrix, using a spreadsheet. It involved summarising the data by groups from the transcripts of the study. The final and seventh step was interpreting the data, which began with writing a narrative account of the study. Then themes were derived from the data. It also clarified each of the identified themes by describing them, and examples were given from interview(s), followed by analytical comments from the researchers.

Results

Socio-demographic characteristics of the study population

Of the total of 43 women, aged between 20 and 45 years, thirty of the participants were living with HIV. Over half of the participants were married, 25 (58.1%), but 9 (20.9%) were widowed, 6 (14%) were divorced, and the remaining 3 (6.9%) were separated. Most of the participants lived in urban areas, 90.6% (39 out of 43). Almost a fifth of the participants, 9 (18.6%), were not educated (Additional file 2: S2_file).

From the analysis, the following five themes emerged. "Women's terrifying experiences of violence," "The effects of violence on their health," "Support/lack of support /controlling behaviours/," "Women's feelings about the available services," and "IPV prevention strategies from the perspective of women." The first two themes explain the women's terrifying experience of physical, sexual, and psychological violence and the multiple health effects on the women, as reported below (Additional file 3: S3_file, Additional file 4).

Women's terrifying experiences of violence

Types of violence

Women's terrifying experiences of violence is a major theme of this study. The data revealed that most of the

participants had experienced mixed or overlapping types of terrifying abuse from their intimate partners. The interviewees reported recurrent physical and emotional abuse, but relatively few participants reported sexual abuse. According to the participants, they were beaten with sticks, had material thrown at their faces, and some even had their hands and teeth broken.

Additionally, some indicated that their partners had extramarital relationships, but male partners restricted women in socialising and having contact with other people. As reported by the participants, their extramarital relationships led some women to the acquisition of HIV. The behaviour of their intimate partners included repeated name-calling, threats to hurt, hostility, withdrawal of finances, and forced sex. Women in rural and urban areas shared the same experiences. Both younger and older women reported terrifying experiences of violence by an intimate partner; however, HIV positive status exacerbated IPV.

One of the in-depth interview participants explained:

"My husband was an alcoholic, and he was older than me. He used to stab me with a knife. One day I stayed the whole night with a knife in my body because no one can take it out of my body. He used to punch me in my face, and my teeth also changed their normal place. Here, the scars in my body that you see emerged because of the bleeding after he had beaten me. He used to drag me on the ground by my hair, and my hair disappeared in his hands two times. Also, my bone in the chest broke after he had beaten me." (Woman living with HIV, O#2, aged 32).

A discussant from one of the focus group discussions also explained:

"In public, when I am around my family and extended family, he belittles and insults me because of my HIV status, he says, you can't take care of your children, you are going to die because you have AIDS." He discloses my HIV status to everybody including my friends." (Participant S1#6, woman aged 37).

The discussant with HIV discordant result explained:

"We tested for HIV, and my results come back positive, but my husband was not. He decided to divorce; and torched me psychologically, mentioning, "You are living with HIV infection" Now I do not want to tell all the insults he heaped on me." (Participant S2#3, woman aged 40).

There were concerns in the interviews about the severity of the violence and the threats commonly used by

their partners to inculcate fear, with the partner threatening to kill or slaughter them. As in the example described above, women who were HIV positive suffered further at the hands of their partners, who stigmatised and belittled them in front of other people. Alcohol consumption and the use of other substances such as chewing “chat” and addiction to “shisha” (a way of smoking tobacco, mixed with molasses, sugar or fruit,) through a tube) by male partners, took a heavy toll on women’s experience of IPV. A discordant HIV result, the extramarital sexual contact of their partners, and women themselves having an affair with another man increased their husband’s aggressive behaviour, as did having children from another husband.

The effects of violence on women’s health

The violence affected both women’s physical and mental health. For instance, the physical effects reported could be both short and long term, as a result of abuse at the individual and social / community level. Participants described many health problems such as miscarriage, acquisition of STI/HIV infections, uterovaginal prolapse, the sequelae of pain around the ear and back, disability, and uterine infections. As two of the women explained, abortion and child death happened as a result of their male partners’ physical abuse when the two partners were quarreling. A few of the interviewees also reported the effects of violence and the resulting disability, which then hindered women from their activities demanding physical energy. Women also reported the negative impact of violence on their daily social engagement with others. For instance, according to the discussants, as a result of the discrimination from their community, women experienced loneliness, fear, and depression, and as a result of divorce, property loss, and the inability to remarry afterward, which were severe effects of violence.

One of the FGD discussants explained her experience:

“I lost one of my eyes and became blind. I didn’t get medical help. I don’t have one of my organs, but I feel good because I am still alive. He was not giving me financial support all my life.” (Participant S2#3, woman aged 40).

Another of the participants reported:

“He divorced his wife after three months of marriage. He infected her with HIV/STI. He had multiple sexual partners. He was abusing them sexually. One of his wives had a miscarriage as a result of his beatings. He kicked his wife while she was three months pregnant, and unfortunately, she had a miscarriage.” He was drinking alcohol, chewing “khat,” and smoking (Participant T#2, woman aged 28).

The FGD discussant described her experience:

“After two months of giving birth, when we were quarreling, our son fell and died. My husband threatened me if I disclose this issue to other people; “I am going to cut your neck, he said.” I left his home, and I went to my mother’s house.” (Participant S1#1, woman aged 38).

According to the reports from the interviewees, violence not only hurts women’s and children’s health, but it also has an effect on their economy as well as their social and psychological wellbeing. Moreover, the violence affected women’s social status and resulted in their experiencing emotional turmoil. Its effects further resulted in men withholding finances from their female partners.

Support/lack of support/ women receive from the partner (controlling behaviour of partners)

According to most of the participants, the controlling behaviour of their male partners denied them any possible support. Data from the interviewees indicated that older women were less likely to experienced controlling behaviour than younger women. Women also reported that their husbands closed/locked the door so that they were left in the house, but were not allowed to leave the house, which disturbed their lives. Participants also indicated that men prevented their women from going outside their home, and they even limited their contact to only communicating through the windows.

Moreover, they reported that their husbands/partners also restricted their speech. Additionally, participants received repeated phone calls from their partners who threatened the women, as they were suspicious that their wives were having sex with other men. For, example, one of the interviewees explained this:

“No person could enter my home. Even if I became ill, no friends were allowed to ask me. When my husband was going to the office, he used to lock the door, and no friend can access and suppose a person is in the home. I couldn’t make a call to contact my friends because I had no phone.”(Participant S1#7, women aged 37).

Other discussants also explained the condition as:

“He was restricting my movements. When I was out of my home, he usually makes repeated calls and threatened me as he already knows the place where I was and accuses me of also having sex with other men. My husband doesn’t trust me. I will never forget how he violated me when I was in labor.” (Participant S1#9, women aged 40).

Further, another FDG discussant explained:

"He closed and locked the door when I was four months pregnant, I spoke through the window, and he severely beat me over and again, asking me why I was hanging out with my friends without his consent. I became dizzy and fell." (Participant S1#1, women aged 38).

These actions hindering women from accessing support from their friends, relatives, and neighbors, as described above, and made it difficult for women to access the available support. Moreover, women expressed their psychological trauma, as men were disturbing their lives, insulting them, and preventing them from leaving their own homes.

Women's feeling about the available services

The majority of the participants were worried about the lack of implementation of the possible legal service, its inappropriateness, and the weak punishment (which they reported as only 2–3 days' imprisonment), for the perpetrators. The available legal services are similar in Wolaita Zone, which the government provides to its people. As the participants pointed out, the religious leaders and elders of the communities are also involved in resolving the conflicts among couples. A few participants, however, noted the absence of a legal service to which to report their abuse. Many participants also believed that women lacked awareness about how to use the existing legal service. Some women had sought help from the justice system, but this did not appear to be a typical response. According to the participants, women who live in urban areas and who were educated, were able to defend themselves and received the legal service.

An interviewee also reported that there was no women's network, effectively working to support women experiencing gender-based violence. However, the majority of women described the availability of other women's organisations (these comprised one leader to five members and extended to one leader for each of 30 members). One leader to five members is the subset of the one leader to 30 women division aiming to reach women at the grassroots level. In Ethiopia, these organisations were established to accomplish certain governmental activities like infectious disease prevention, vaccination programs, and specific agricultural and educational duties. However, the majority of the women felt that the existing one leader to five members, does not play a functional role in the prevention of IPV and lacks the ability to take strong actions against the perpetrators. Likewise, some women considered that there are no influential women leaders

or organisations explicitly working on violence prevention in their community. Moreover, they believed that the available governmental women's affairs' office was not functioning very well. Women felt that such an organisation was not doing its duties correctly and was reluctant to punish perpetrators which was not satisfactory. For example, one participant explained this as:

"The justice office has only punished the perpetrator with three to four days in prison. The government's justice is nothing. Though the police took them to jail, the perpetrator could not stay a night in jail; rather, the police were releasing the attacker from jail very soon. The punishment is loose." (Participant T#4, woman aged 30).

One of the FGD discussants explained it as:

"There are no strong and organised women leaders (1 leader for five members), but they were supposed to be resolving some conflicts between women and men. The women's leader is not functioning, although they are supposed to be in place to do the job." (Women, code = S#1, aged 38).

Another discussant explained it as:

"The governmental women's affairs office is a symbol. It cannot give us a solution. They hear our problem, and then they let us write an application letter for our case and to submit it to the court. They do not solve our problems; rather, they let us go back to the community elders for mitigation." (Participant T#1 and T2, women aged 32 & 28 respectively). According to the participants, the religious leaders have an essential role in resolving the violence. However, a few women emphasised that it is difficult to get support from the religious leaders and that they are inaccessible to women who need to report the abuse.

There were also contrary views from other participants who disagreed with this view stating that:

"The religious leaders are also concerned with violence, and they follow the case if women report it to them. They also have a good role and sacrifice their time to resolve the issues. The religious bodies are helpful." (Participant S2#5, woman aged 40).

Most of the participants reached consensus about the available legal system, women's affairs office, and women leaders' role and perceived these as too weak to safeguard women from violence. Besides, the participants believed that there was an absence of a women's network actively working on violence in Wolaita Zone.

Intimate partner violence prevention strategy in the perspective of women

Participants mentioned many possible IPV preventions strategies. Most of the participants reported that after their HIV test result disclosure, their partners abuse them, and this needs a proper prevention strategy. Some of the participants believed that the right time to disclose an HIV test result, to prevent a sudden violent reaction from their partners, should be when they are pregnant, sick, and at night time when they are about to go to bed. The majority of the participants pointed out that the health care provider should offer HIV testing to both partners at a time when the couples are together. Most of the women believed that disclosure of an HIV test result to their partner was beneficial in that they were able to receive care and treatment. Nevertheless, unwise disclosures (sudden and unplanned revelation, not assisted by health care providers) had resulted in different types of violence.

The discussants also explained that if women knew their positive HIV status before their partners, health care workers should test them again as a new case along with their male partners, and assist the disclosure.

Women believed health care providers had a role as did other women who had some awareness about violence, and that they should teach each other how to obtain legal services. Participants also felt that women should know how to generate their own income. Moreover, a few participants also reported that women should discuss their violent situation with their neighbors, to get advice and support from them.

One of the discussants explained the preferred approach of HIV counselors as:

"But while she is going to disclose her status, she should be counseled by the health care providers and bring her husband to the health facility, and she should be tested again as a new client together with her husband to convince him, then the health professional should counsel her husband very well. Otherwise, in case if she discloses her issue carelessly, the husband can hurt/abuse her by assuming that it was his wife who infected him with HIV"(Discussant S1#8, women aged 30).

The participants described the need for IPV prevention strategies since women are dependent on their husbands.:

"Women are economically dependent upon their husbands. When women accuse their husbands, they cannot pay home rent; they cannot raise their children because husbands immediately leave them alone." (Participant S1#9, women aged 40).

Other participants also mentioned that women who were already affected by abuse should teach others how to handle the situation in an organised manner.

"It is better if the women, who were already affected by abuse, teach others in an organised manner. It is better if the government also takes strong action upon perpetrators. It is also nice if a specific association of women is working on this issue."(Discussant S1#8, woman aged 30).

Some women mentioned that reporting the issue to public prosecutors or the women's affairs' office or the justice office is crucial. As a solution, women indicated that there is a need to establish a strong women's network, with members of such a network individually working against violence. Moreover, participants highlighted that the available "one leader to five members and one leader to thirty members" of the women's army and women's affairs' offices of government, has to emphasise IPV prevention activities. Most women agreed that the available laws should be stringent and provide justice for all the victims.

One of the participants explained it as:

"The one leader to five member's organisation should work strongly because the women are hiding their secret of abuse. Then the one leader to five members association should wisely ask the abuse experience of women and come up with a possible solution. Also, the woreda women's affairs should work hard to help women."(Participant T#1, women aged 32).

Other participants had further suggestions; for example, one interviewee said:

"In my opinion, it is better if you gather men and teach them in a group to prevent their abusive behaviours against women. Education is essential for men. It is also better if women and men get education together in violence issues." (Participant S1#7, women aged 38).

The discussants were interested in and pointed out IPV prevention strategies that needed to be implemented or implemented more effectively, including wise disclosure of HIV, teaching others in the community, establishing a strong women's network, teaching male partners together with females, and that the available law should be stringent and provide justice to all victims.

Discussion

Our study confirms the results of the studies conducted in Ethiopia, such as the Demographic and Health Survey (EDHS) conducted in 2016, and South African studies

(11, 24,25). Participants reported similar experiences of IPV, including physical, sexual, and psychological violence. However, the findings of our study further showed that HIV positive women were more vulnerable to IPV than their counterparts. Furthermore, women from rural areas reported many cases of traumatic violence.

We found that IPV in Woloita district was extensive, and the analysis of the results of our study identified and documented women's terrifying experiences of IPV, including physical, sexual, and psychological violence. Most of the time, such violence was experienced as mixed or overlapping types of violence. Our study further identified that the women reported recurrent physical and emotional violence, but relatively few participants reported sexual abuse. Such violence is not a new occurrence in Ethiopia [11, 24, 25], and it affects both women living with and without HIV. Our research found that the bullying behaviours of the husbands/ partners wear down the women's self-esteem, and the consistent pattern of abusive words undermines their mental health. A study in South Africa showed that emotional violence was the most prevalent form of abuse reported [24], and the qualitative research in Kenya also reported women's terrifying experience of IPV in that country [12], indicating the need for further work to address this significant problem in many African countries. Researchers in the WHO study agree that between 10 and 69% of women reported physical abuse, while between 6 and 47% of adult women worldwide reported sexual violence [26]. The overall world estimate of physical and / sexual violence experienced by an intimate partner was that one in three women (30%) had been affected [26].

Previous studies conducted on HIV and IPV in countries, including Kenya [12] and Swaziland [27], show that HIV disclosure of sero-status increased the risk of stigma and withdrawal of financial support to the affected women. The finding that emerged from our analysis indicates that an HIV discordant result and unwise disclosure of an HIV test result to the male partner, also lead women to IPV and stigma. Therefore, it is sensible that women who are planning to disclose their HIV status to their partners must use caution while they are revealing their HIV status, to avoid being physically abused by their partner. Our study participants also emphasised that health care providers should assist in the disclosure of the women's HIV results to prevent abuse from their partners. These current study findings were also confirmed by previous studies [13, 28].

We report the negative effects of violence on the women's health, and that they had reported many adverse health effects arising from IPV. Consumption of too much alcohol was an important factor exacerbating the women's IPV experience. Other substance use,

complementing the alcohol consumption that emerged from our study included the use of 'khat' (from a tree, *Catha edulis*, which is a stimulant and causes excitement and euphoria) and 'shisha' addiction, (which is a way of smoking tobacco mixed with molasses sugar or fruit, through a tube) by male partners. This result supports the finding observed in previous studies by WHO, South Africa, South Western Uganda, and the Center for HIV law policy study [6, 7, 24, 29–31]. Other earlier studies also revealed that men who are alcoholics quickly become aggressive, which contributes to IPV [32]. The physical violence that occurred during the fighting or quarreling among couples can lead to severe health impacts like abortion, child injury, and death. The previous WHO study of global and regional estimates on IPV confirmed our results [6]. Earlier studies conducted in Togo [33] and South Africa [34] show that IPV has resulted in depression. In this study, the women emphasised the physical suffering to which they were exposed through IPV, but IPV also had severe adverse effects on women's mental health. Women who live with HIV reported it most frequently. Victimisation by an intimate partner has been shown to lead to mental health problems, including anxiety, depression, and attempted suicide [35, 36]. However, this study did not include the harmful effects of IPV on children in the household who grow up in such a milieu [37].

Earlier studies in South Africa and Zimbabwe also support the idea that gender inequality and the lack of decision-making power of women resulted in women experiencing IPV [28, 29]. An innovative study by Pronyk et al. reported a reduction in IPV as a result of women being economically independent [38]. Therefore, eliminating gender inequalities and strengthening women's economic and legal rights, needs to be encouraged and facilitated by governments [6].

Our study found the controlling behaviour of their partners had a debilitating and frustrating effect on women's lives. The previous study conducted in Addis Ababa, Ethiopia, shows that partner controlling behaviour was one of the most prevalent types of violence [39]. It disconnected women from any possible support that they could obtain from neighbors, friends, relatives, and health care providers. It is also a violation of a person's human right (as promulgated in the Ethiopian national revised family law in 2000 and the criminal law in 2005 [7, 9]), to be free from interference regarding one's privacy, regarding one's family, and home. The FGD discussants in this study suggested the need to enforce and teach both women and men together about human rights and IPV.

Women in this study believed that the legal service exists in Ethiopia to prevent violence, but that the

implementation is weak, in that punishment on the ground is insufficient to teach the perpetrators a lesson to prevent them from continuing to engage in violent actions. Currently, however, this is a significant concern in many countries since the available law was not able to provide legal protection for women from violence in India, Sub-Saharan Africa, in the Middle East, nor in Ethiopia [9, 40]. Violence elimination is recognised as one of the international community's priorities, and women have a right to live free from IPV [41]. In countries around the world (Brazil, Nepal, Spain, the United Kingdom, Uruguay, Venezuela, and several states in the USA), the government has set up special courts to deal expeditiously with these urgent cases since the health and lives of women are at stake [41, 42]. In Wolaita, however, women did not benefit from the legal services as they expected. Ethiopia needs a special court that deals with the IPV cases separately, and there is a need to decentralise the system as well as to train the legal bodies. The Sustainable Developing Goals (SDGs) emphasised the unacceptability of IPV by stating that all forms of discrimination and violence against women and girls will be eliminated (SDG, goal 5, article 5.2) [43]. The elimination process also proposed to engage men and boys, and Ethiopia can use this strategy in developing effective intervention programs for the prevention of violence against women.

Most of the women who were living both with and without HIV infection reported that educating women and men together about IPV is the best solution to prevent IPV. This finding accords with the World Development Report, which indicated that education should include both men and women and that the entire community should participate [40].

Finally, the new lessons learned from this study are the overlapping existence and nature of IPV and its prevention strategy. The prevention strategy proposed by women was that even when women knew their positive HIV status before their partners (in the case of very violent and aggressive partners), health care workers should test the women again as a new case along with their male partners and assist with the disclosure. Further, the results that emerged from this study highlighted the existence of weak and inappropriate punishment for perpetrators of violence, the absence of a women's network working effectively on IPV, and that the existing groups of one leader to five women lacked an IPV prevention role. The women's affairs office involvement in IPV was also found to be weak. However, the study found that the religious leaders' role in IPV prevention is beneficial in Wolaita Zone.

Strengths and limitation

The IPA design in this research allowed a detailed and in-depth description of Wolaita women's IPV experiences and its meanings. Among other strengths, the unique perspective of the design provided a comprehensive understanding of the IPV phenomenon as experienced by the women, and the findings reported from the study result from the rich data and the open-ended structured guide that permitted the participants to talk freely so that the investigator gathered rich data for the analysis. Our research also provides evidence from multiple sources of the benefits from incorporating two methods of data collection namely, in-depth interviews and FGDs, and using data triangulation of the different sources of information (women on ART, family planning ANC/PMTCT users, etc.). We addressed the scientific rigor such as the credibility of the study to ensure that the data presented in the study reflects the views of the participants. During the data collection period, the team had peer debriefing, and the PI and the co-authors conducted the data analysis, and in the results section, we provided verbatim quotes. Moreover, we also offered transcripts to some participants to confirm their comments. To ensure transferability, we provided thick descriptions in the results section, to allow other researchers to decide whether the results are transferable to their context. The team conducted an audit trail with the supervisor and co-supervisor to ensure that the analysis is grounded in the data to maintain dependability. To ensure confirmability, this study triangulated data collection using in-depth interviews and FGDs.

However, our research has some limitations. Among these are the transferability and generalizability of these findings. Since we made every attempt to keep the descriptions faithful to the raw data, pure bracketing cannot be possible because the investigators interpreted the data based on their phenomenological world and experience. Hence, this process, in turn, may bring investigator-induced-bias to the study, but the researchers were aware of this and took note, and tried to avoid this possibility.

Conclusion

The evidence from this study confirms that IPV is a considerable problem in Wolaita Zone and the extent of the different forms of violence (physical, sexual and psychological) which frequently overlapped, highlights the urgency of intervention measures. The five themes that emerged are: "women's terrifying experiences of violence", "the effects of violence on their health", "support/lack of support /controlling behaviours/", "women's feelings about the available services", and "IPV prevention

strategy in the perspective of women". Unwise disclosure and discordant results of HIV testing also exacerbated IPV. Women reported that the legal service exists but that the available punishment of perpetrators is insufficient and does not act as a deterrent. The study identified the lack of strong women's networks, explicitly working on violence to resolve the conflict between partners and to punish the perpetrator. Among IPV prevention strategies, the participants mentioned that women should discuss the abuse they experienced with their neighbors, they should generate income in order not to be dependent on men, and they should teach their friends who lack awareness, how to obtain legal services. The law needs to be applied strictly and provide justice for all victims. Establishing women's networks, which explicitly work on violence prevention, should be emphasized. Where women knew their serostatus before their husband/partner, they should be tested as a new patient together with their partners and disclosure should be assisted by health care providers. It would be essential to provide additional training for the health care providers giving counseling in such complex situations. Further investigation of the relationship between IPV and HIV should be examined in different parts of the country, to develop situation-specific approaches that may be needed.

Supplementary information

Supplementary information accompanies this paper at <https://doi.org/10.1186/s12978-020-01044-0>.

Additional file 1. Interview guide (unstructured questionnaire).

Additional file 2. Socio demographic characteristics of the study participants.

Additional file 3. Code, category and themes.

Additional file 4. COREQ check list for qualitative study.

Abbreviations

ART: Antiretroviral Therapy; EDHS: Ethiopian Demographic and Health Survey; FGD: Focus Group Discussion; IPV: Intimate Partner Violence; IPD: Interpretive Phenomenological Design; VAW: Violence Against Women.

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Authors' contributions

MM: Conceived the topic, conducted and facilitated the interviews and FGDs, supervised data collection process, involved in the design, analysis, and drafted the study as part of his Ph.D. study; NK, and MT: supervised and guided the study, engaged in the design, analysis and revisited the manuscript critically for valuable intellectual content. Both three authors read and approved the final manuscript. MM, NK and MT are agreed to be accountable for all aspects of the work. All authors read and approved the final manuscript.

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Availability of data and materials

The datasets generated and/or analyzed during the current study are not publicly available due to the sensitive nature of violence reported in this study, but are available from the corresponding author on reasonable request.

Ethics approval and consent to participate

Before commencing the study, ethical clearance was obtained from the Biomedical Research Ethics Committee (BREC) of the University of KwaZulu-Natal (BREC Ref No: BE387/18). Also, ethical approval was obtained from the local university, Wolaita Sodo University Institutional Review Board, under the Ref No: WSU15/04/147 (12 Sep. 2018). Moreover, the formal permission letter was obtained from Wolaita Zone Health Department and the respective health facilities. We also explained the consent to the participants in their language. We received written informed consent from all participants. We took notes for the cases where the participants refused permission to record, and we incorporated such results with the other data. We conducted the FGDs in a meeting room at each of the health facilities to maintain women's privacy and comfort. We communicated the purpose of the research and the expected duration of one hour for the participant to complete the interview. This research maintained the confidentiality of the participants, whose names were not written on any result, ensuring anonymity. The participants had the right to interrupt or withdraw their participation at any time without penalty or loss of benefits. We interviewed women in a private room or place of their choice to maintain the participants' privacy.

Consent for publication

Not applicable.

Competing interests

All authors declare that they have no conflict of interest.

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CHAPTER SIX: HEALTHCARE WORKER EXPERIENCE AND THE CHALLENGES IN SCREENING FOR INTIMATE PARTNER VIOLENCE AMONG WOMEN WHO USE ANTIRETROVIRAL THERAPY AND OTHER HEALTH SERVICES IN WOLAITA ZONE, ETHIOPIA: A PHENOMENOLOGICAL STUDY

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Introduction

Chapter five identified IPV as a considerable problem in Wolaita Zone, the lived experience among women and the extent of the different forms of violence (physical, sexual and psychological), which frequently overlapped. The study highlights the urgency for intervention measures. However, the need to explore the experiences and challenges in screening for intimate partner violence among women who use antiretroviral therapy and other health services in Wolaita Zone in Ethiopia is essential, in order to obtain an overall picture of the phenomenon from the health system's perspective. Accordingly, this chapter identified the healthcare worker related challenges in screening for IPV. Besides this, it explored the health systems' related IPV screening challenges; the types of IPV observed in victims by the healthcare workers on their first visit to a health facility, and proposed interventions and strategies for prevention of such violence.

Doctoral student's contribution

1. I conceived and formulated the project.
2. Study design: I designed the study with my supervisors.
3. Project management and field logistics: I collected in-depth interviews with healthcare workers.
4. Data analysis: I transcribed, translated and analysed the data.
5. Write up: I drafted and wrote the manuscript. My co-authors/supervisors guided, reviewed and approved it for journal submission.

Healthcare Worker Experience and the Challenges in Screening for Intimate Partner Violence Among Women Who Use Antiretroviral Therapy and Other Health Services in Wolaita Zone, Ethiopia: A Phenomenological Study

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Background: Intimate partner violence is a crime against humanity. This study aimed to explore the experiences and challenges in screening for intimate partner violence among women who use antiretroviral therapy and other health services in Wolaita Zone in Ethiopia.

Methods: A descriptive phenomenological qualitative study design was used, and 16 in-depth interviews were conducted with healthcare workers from 19 health facilities who were providing healthcare services in Wolaita Zone. We selected participants purposively until data saturation was reached. Colaizzi's descriptive phenomenological method was used for the data analysis, and the Open Code software was used to assist with the data coding. We maintained the scientific rigour of credibility, transferability, dependability, and confirmability.

Results: Analysis of the study data identified the following five themes: type of IPV identified by HCWs among women, provider-related barriers, healthcare system barriers, patient-level barriers, and providers' recommendations for improvements. Issues that emerged from these findings were a gap in medico-legal report provision, absence of a separate record-keeping for IPV cases, lack of client follow-up, absence of routine assessment of violence for women who have injuries, and lack of specific coordination with an external organisation. Moreover, the absence of staff training, weak referral systems, and a shortage of necessary medical equipment challenged IPV screening.

Conclusion: This study has shown that there are healthcare provider and health system challenges relating to screening clients for intimate partner violence in Wolaita Zone. Provision of separate record-keeping of intimate partner violence cases in the healthcare facilities, standardising the medico-legal reporting system, improving women's access to education, and executing more gender-equitable policies, are needed. Moreover, the inclusion of intimate partner violence-specific policy frameworks in national legislation is necessary.

Keywords: healthcare workers, intimate partner violence, screening, Wolaita Zone

Background


Intimate partner violence (IPV) is a challenging public health problem that affects the health of women in different ways. Intimate partner violence "refers to any behaviour within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship".¹ The World Health Organization (WHO) multi-country study showed that 13–61%; 4–49%; 6–59%; and 20–75% of women

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1047

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reported ever having experienced physical, severe physical, sexual, and emotional violence, respectively.¹ The adverse health effects ranged from physical injury, to emotional harm, disability, mental health problems, suicide, and even death.^{1,2} Intimate partner violence entails different forms of violence that aim at exerting control over an intimate partner. The most visible are injuries sustained from physical assault. However, some victims disguise evidence of these injuries by wearing less revealing clothes or by denying an attack has happened.³

The World Health Organization's international study shows that in different countries, there are multiple challenges at different levels of the health systems while screening for IPV. Among these difficulties concerning IPV screening, the service providers' attitudes and their lack of knowledge about IPV were significant challenges. Besides these, non-inclusion of IPV-specific training in the national medical curricula, lack of coordination among various actors, and a lack of departments involved in planning integrated services also affected a country's response.⁴ The WHO study stated the importance of the health sectors to ensure the efficient provision of healthcare related services to victims of IPV.⁴ It also emphasized the vital policies and practices for IPV screening which could aim to integrate responses to violence, into the existing services in low- and middle-income countries.⁴

Studies have, however, revealed a low rate of IPV screening by healthcare workers (HCWs), ranging from 1.5% to 12% in primary care settings.^{5,6} The identified challenges of IPV screening by HCWs are lack of provider education on IPV, the shortage of time to screen for IPV, the absence of effective IPV interventions, client reluctance to disclose their experiences of violence, and their fear of the perpetrators.^{5,6} Similarly, a study conducted in the north-eastern United States showed a low rate of IPV/sexual violence screening at 15%.⁷ Moreover, a study conducted in Tanzania also showed that lack of adequate resources, ethical dilemmas, staff competency, lack of consultation rooms, and healthcare worker views that IPV screening was a waste of time, were systemic limitations for IPV screening.⁸

In Ethiopia, more than one in three ever-married women (35%) reported that they had experienced IPV inflicted by their husband or partner at some point in time. This finding showed that the rate of IPV was high in Ethiopia. Intimate partner violence in Ethiopia is, therefore of great concern from the perspectives of economics, health, and human rights.^{9,10} In a study conducted in East Gojam Zone in

Ethiopia, the majority of nurses had not received training on the detection of IPV.¹¹ However, there is limited information concerning healthcare worker experiences of screening for IPV in the country. Therefore, this study aimed to explore healthcare workers' experience of screening for IPV among the special population group of women living with HIV, using antiretroviral therapy, and accessing other health services in Wolaita Zone in Ethiopia.

Methodology

Study Area and Setting

We conducted the study in Wolaita Zone, which is in southern Ethiopia. Most of the people in this area speak Wolaita, the native language. The total population is 2,473,190, of whom 578,726.46 [23.4% of the total population] are women of reproductive age.¹² From the 19 health facilities we included in this study, we recruited a total of 16 HCWs for the interviews. We chose the special population, women living with HIV and following ART. We have noticed that violence leads to HIV infection and we wanted to investigate these experiences; as well as IPV screening among this population groups that were previously not studied in Ethiopia.

Design

The design for this study is a descriptive phenomenological qualitative one. This design helped us to gain the essence of the lived experiences and allowed detailed descriptions of the HCWs' IPV screening and the barriers that they experienced.¹³ In descriptive phenomenology, the perception of researchers is set aside or bracketed, to obtain the real experience of the participants.¹⁴ In this study, the meaning attributed to the 16 purposively selected HCWs were not influenced by the researchers' experiences and beliefs.¹⁴

Selection of the Study and Sample

We selected the HCWs (medical doctors, nurses, health officers, and midwives) purposively. We interviewed those who were providing healthcare services in the 19 health facilities (both private and government) until saturation of ideas was reached and no new information was presented. In doing this, we conducted 16 in-depth interviews.

Data Collection and Procedures

The data collection for this study took place from October to November 2018. We adapted the interview guides from the World Health Organization's (WHO) document on

researching violence against women¹⁵ ([Supporting file section 1](#)). We included the interview guides based on the challenges of HCWs' IPV screening, the role of HCWs, follow-up care, documentation and medico-legal report provision. The guides included the following questions. What are the most common types of abuse that you identify? Do you or your staff members routinely ask questions to determine if the patient was a victim of family violence? Why? How? What instruments do you use for the examination? How often? What tests or examinations do you routinely perform when a woman indicates that she has been the victim of violence? What are the challenges in screening for abuse? Were you trained to screen for abuse? What types of abuse do you detect? Do women disclose, without being asked, the abuse they experienced? What is the procedure for obtaining an official report from the medical examiner? Do you have a way of keeping records of cases? Is there a form and procedure for recording them? Do you or your staff provide follow-up care to women who have been victims of family violence? Are there mechanisms for referring them to other institutions? Do you think the record-keeping system is adequate to identify women affected by family violence, refer them to the appropriate services, and provide timely follow-up services?

The principal investigator conducted face-to-face, in-depth interviews by using the local languages of the HCWs, Wolaita and Amharic. During the meetings, the investigator probed to get further clarity from the participants. Two experienced research assistants supported the principal investigator with note-taking and digital recordings during the interviews. To maintain the privacy of the healthcare workers, we conducted in-depth discussions at the participants' offices or their preferred venue.

Trustworthiness

We maintained the scientific rigour and trustworthiness of the data collection based on five criteria¹⁶ Credibility: To ensure that the study reflected the participants' views, the principal investigator spent time in the field and collected the data from the healthcare workers. The results' section provides verbatim quotes to document the participants' perspectives, and we undertook peer debriefing after each of the interviews. Transferability: We provided thick descriptions to allow readers to determine whether or not the findings were transferable to their context. Dependability: The research team conducted an audit trail with the supervisor and co-supervisor to ensure that the analysis was grounded in the

data and that the findings would be consistent and stable over time. Confirmability: Applying the audit trail (the primary researcher maintained detailed procedural records of the research process) helped us assess the accuracy of the results and truthfulness of the participants' perspectives. Reflexivity: The results show that the principal researcher thought about himself and the participants, and continuously recorded, as a way to offset predetermined thinking about the research that might interfere with the data analysis. By doing so, we aimed to prevent our motives, perspectives, experiences, backgrounds and prior hypotheses influencing the data interpretation.

Data Analysis

We used the seven steps set in Colaizzi's descriptive phenomenological method, which is used in health science research, for the data analysis.¹⁷ The steps are 1) Familiarisation (reading all the participants' data and familiarising oneself with the data); 2) Identifying significant statements (recognising the pertinent statements related to the phenomenon); 3) Formulating meanings (identifying the meanings close to the event with the researchers bracketing their knowledge about the meaning); 4) Clustering themes (clustering the meanings into themes); 5) Developing an exhaustive description (writing complete and inclusive explanations of the phenomena, including all the themes that were developed); 6) Producing the fundamental structure (ensuring that the reports cover the essentials); 7) Seeking verification of the underlying structure (returning the primary structure statements to all the participants for confirmation). We used Open Code software for the data analysis, and we used the Consolidated criteria for Reporting Qualitative research (COREQ) Checklist, for maintaining the quality of data.

Ethical Consideration

Ethical clearance was obtained from the Biomedical Research Ethics Committee (BREC) of the University of KwaZulu-Natal (BREC Ref No: BE387/18) and from Wolaita Sodo University Institutional Review Board (IRB), RefNo: WSU15/04/147 (12 Sep. 2018). Permission was also obtained from Wolaita Zone Health Department and the respective healthcare facilities. Written, informed consent was received from individual participants. The participant informed consent included the publication of anonymized responses. Permission also was obtained for audio recording, and in cases where the participants refused permission to record, notes were taken instead, and the results were

incorporated into the other data. Each interview took 50 minutes, and before beginning, the purpose of the research was communicated. This study maintained the confidentiality and privacy of the participants. To this end, they were conducted at the participant's offices, and nothing was written on any part of the results that could reveal their identities. It was the participant's right to interrupt or withdraw their participation at any time without penalty or loss of benefits, but this did not occur.

Results

Overall, we conducted a total of 16 in-depth interviews among HCWs with different educational backgrounds. Six (37.5%) were females, while the other 10 (62.5%) were males. Healthcare workers involved in this study were aged between 24 and 42 years. They had different roles and responsibilities at their respective healthcare facilities such as ART focal person, emergency department leader, outpatient worker, obstetrics and gynaecology department coordinator, and mother and child health (MCH) clinic workers (Table 1).

Themes

Analysis of the study data identified the following five themes: Types of IPV identified by HCWs among women; provider related barriers; healthcare system barriers; patient-level barriers; and providers' recommendations for improvements (Supporting file section 2).

Theme 1. Types of IPV Identified by HCWs Among Women

Most HCWs reported that they observed two to three IPV cases per month. However, few healthcare facilities reported more than five to ten IPV cases per month. According to the report from the HCWs, most of the women were visiting their clinic after physical violence trauma, followed by rape. However, they reported that sexual violence victims visited their clinic infrequently. Healthcare workers discussed the reason for fewer incidents of sexual violence being reported to them. They reasoned that this was because the women did not as openly disclose sexual abuse as they did physical abuse.

Healthcare workers reported traumatic experiences of violence that they usually see when screening victims of IPV. These included physical, sexual, and psychological cases of violence. Most HCWs indicated that in mostly, they screen many physical abuse victims and also other

Table 1 Socio-Demographic Features of Healthcare Workers in Wolaita Zone in Ethiopia, November–December 2018

Participant's Code	Education	Role of Healthcare Workers (HCWs)
#1	Health officer	ART focal person
#2	Health officer	ART focal person
#3	Health officer	Emergency case team
#4	Health officer	ART focal person
#5	BSC Nurse	ART focal person
#6	MSc in Reproductive Health	ART focal person
#7	Health officer	OPD case team
#8	Medical doctor	Gynecology department, GPs coordinator
#9	Nurse	ART focal person
#10	Medical doctor	Clinician
#11	Clinical nurse	Nurse at emergency department
#12	Midwifery	MCH coordinator
#13	Health officer	OPD case team
#14	Health officer	Under-five OPD and ART focal
#15	Health officer	Coordinator of MCH case team
#16	Health officer	ART focal person

Abbreviations: OPD, out-patient department; ART, antiretroviral therapy; MCH, mother and child health; GP, general practitioner.

victims that experienced traumatic rape. Few health providers reported that instances of violence were uncommon in their facilities.

One of the HCWs Explained

For example, I have seen during my examinations a woman with a head injury, pregnant women who miscarried, and hair follicles removed during a fight. I observed during my physical examination that a man beat his spouse in her birth canal, and I referred her sample [case] to Black Lion Hospital. Usually, women hide such cases. I know a woman who has been suffering from pain for six years due to the violence that she experienced from her husband (HCW, #6)

Another HCW Stated

When I was working in the emergency department, I saw physical violence cases. I also observed a husband who stabbed his wife with a knife. I haven't seen any other sexual violence cases. I remember a sexual violence case where four people raped the 28-year-old woman. She was unconscious when she visited [was brought to] our clinic. (HCW, #5)

Another HCW Stated

There were women on ART who disappeared from their follow-up. When I searched for the reasons in detail, I identified that most of them were discordant, and they disappeared due to stigma/violent pressure from their partners. (HCW, #6)

Theme 2. Provider Related Barriers Training

According to the HCWs, most of them had not received on-the-job training on gender-based violence, and it was one of the significant challenges that hindered them in screening cases of abuse. They also highlighted that the lack of training limited them in providing the required quality of care for clients. However, there were very few trained as only one healthcare provider from a private hospital had received training on gender-based violence.

I was not trained and also no one [else is] trained on gender-based violence in this hospital. (HCW, #4)

We did not get training, but there are some staff who were working in the youth-friendly health service who got training. There is also a training manual there. (HCW, #13)

I didn't train on gender-based violence, but I tend to receive training in gender-based violence. (HCW, #3)

Medico-Legal Issues

Most of the HCWs reported that they offered a medico-legal certificate at the client's request. However, some of them said that the provision of the medico-legal story of their patient was the responsibility of senior staff, and it was one of the significant challenges for clients to receive it timeously. Moreover, most of the HCWs reported their difficulty in reporting sexual violence after a rape case. The HCWs mentioned various factors that influence screening and provision of the accurate medico-legal report to the victims of IPV. Most healthcare providers explained that rape survivors delay seeking medical help to the degree that on their arrival in the health facility when HCWs conduct a physical examination, they do not find new lacerations or bleeding. The challenge arises when health providers are expected to give a medico-legal report in court.

One of the HCWs Explained This Thus

Sometimes, we may not observe any sign of physical injury, even if they are affected by physical abuse. We have to report it medico-legally, but we couldn't. Some women who

had previous sexual experience come to our clinic and report their rape; however, we couldn't observe the recent signs of laceration or bleeding of rape. We observe only an old scar, but women report they have no previous sexual experience. It is the biggest challenge when women take the case to court; the report can't help them. I have seen 18-year-old lady two weeks back who reported a rape case and no previous history of sexual experience. During the physical examination, I observed that the hymen did not tear recently, and I saw an old scar. I haven't even written her report. She denies it, and the examination report is different from her report. Both physical and sexual violence cases are difficult to report. (HCW, #8)

Another HCW Explained Thus

Since the issue is medico-legal, it puts pressure on the care providers. The victims ask you to over-report while their counterparts ask to under-report the level of damage. (HCW, #10)

Disclosure of physical violence, but not on sexual abuse was explained by another HCW thus:

Yes, women disclose physical violence cases, but they don't disclose sexual violence cases, but we probe them. (HCW, #11)

Theme 3. Healthcare System Barriers

According to healthcare workers, there are many health system-related problems in testing for IPV. Among these, HCWs reported that there was no separate record-keeping, nor were there registration mechanisms for IPV cases, IPV specific referral systems, or follow-up care for IPV victims. A few HCWs also reported that there was a shortage of medical equipment such as HIV kits, pregnancy kits, ultrasound, and x-ray machines to diagnose IPV. Moreover, HCWs explained that there was no collaboration with external organisations established to prevent IPV cases. Furthermore, HCWs also reported that there was a gap in providing medico-legal reports timeously for their clients. Besides this, HCWs confirmed that it is challenging to do follow-up and routine assessments of IPV clients, because of poor record-keeping.

Follow-Up

HCWs reported that they did not follow up on their clients who were victims of IPV. Moreover, they were not routinely asking questions of patients who were victims of family violence.

One of the HCWs Explained

No follow-up for the IPV affected clients. I do not know if there exists any registration book. Since emergency surgeons manage cases, they know about it. I don't know whether they have a follow-up or not. (HCW, #3)

There is a shortage of material/equipment. For example, there is a shortage of HIV test kits as well as pregnancy test kits. Also, there was a shortage of equipment for haemoglobin and haematocrit tests. We usually refer such cases due to the shortage of such equipment. (HCW, #12)

Record-Keeping

Healthcare workers also mentioned that there was a gap in the issuing of medico-legal certificates to their clients. The scenario was explained thus:

Only senior physicians write a medico-legal report, and a formal letter with an institutional stamp in a sealed envelope will be sent directly to the requesting legal body, whether to the police or justice office. There is a gap in providing timely medical reports. (HCW, #10)

A Healthcare Provider Also Explained

We don't have a separate register for violence. We manage them as any other case. I don't think that the record-keeping is adequate because there is no one trained on gender-based violence, and we do not start to give sufficient services. Also, we don't have ultrasound and x-ray [machines]. We consider a case as a violence case based on the client's report, and there is no other device to detect the violence case. (HCW, #7)

There is no form for keeping records of violence cases separately. I don't think that the record-keeping system is adequate. It is [would be] good if there is [was] a separate registration book. We don't do screening routinely of the women who are the victims of family violence. I routinely ask them when they come in for their monthly follow-up. (HCW, #2)

We don't register it separately; rather, we register it as a trauma case in the Health Management Information System (HMIS). (HCW, #4)

Lack of Inter-Sectoral Support

HCWs Also Mentioned

No organisation or person is working on partner violence except the women's and children's affairs office. The

women's and children's affairs office did not come to me, and I did not go to them. (HCW, #2)

There are no organizations specifically working in gender-based violence. Also, many non-governmental organizations are working in other health programs, but not specifically on gender-based violence. (HCW, #15)

Theme 4. Client-Level Barriers

HCWs reported that disclosure related problems, inequality of power between women and men, female beliefs concerning male rights to abuse women, and fear and stigma were patient level barriers to screen IPV. Most of the HCWs reported that women do not disclose their history of abuse unless they are asked by the HCWs. They explained that women were trying to hide their violence experiences because they feared the social challenges. Moreover, they reported that this situation affected HIV-positive women's adherence to medication, its discontinuation, and family intrigue among all the women. Healthcare workers also said that women's absence of income limits their disclosure and decisions about an exit plan. This is because they fear that a husband could withdraw his wife's financial support if he heard about her complaint. Similarly, they reported that there is male dominance in Wolaita society. The same action was feared if husbands became aware of their wives' disclosure to others about the abuse they experienced. The participant expressed this issue in this way:

One of the challenges is that women who faced sexual violence or rapes do not report their case appropriately due to fear and cultural sensitivity. It makes the screening of sexual violence difficult even though it exists. (HCW, #2)

HIV Disclosure

Mostly in our clinic, women do not disclose due to the fear of the consequence of disclosure. Some women do not have an income, and they fear that if they divorce, they have no place else to go. (HCW, #6)

Most of the time, women don't disclose their cases without being asked. They have a fear of social stigma. They also fear the confidentiality of their status. (HCW, #9)

One of the HCWs Also Mentioned That

Most men hide their test result from their spouse. They take ART from other health facilities or us, and they don't want to bring their wives. Some women have a fear of

disclosing their status to their husbands. I usually appoint them to bring their husbands, and we screen them together. Then we inform [them of] their test results together. It is to safeguard their marriage. (HCW, #2)

Culture Promoting Male Superiority

Most of the HCWs explained that there is inequality between men and women. They said that women hide reports regarding their issue of violence to male HCWs because of the fear of male dominance. Healthcare workers also reported that husbands' violent behaviour occurred after consuming alcohol and from having multiple sexual partners. Moreover, they said that women had no decision-making power.

One of the HCWs Explained Further

Since most women live under the influence of men, they don't tell us. Usually, men have more than one partner, and they treat one of the women in a better way, but they mistreat the other woman. There is violence, but they don't tell us. I have seen a case where both the husband and wife came after fighting. (HCW, #3)

Healthcare workers explained that women believed that a man has a natural right to abuse women, to insult them and force sex. Hence, they hide their abuse; this made the screening process very difficult for healthcare workers, who believe that to avert this mindset, awareness creation is needed.

One of the HCWs Explained Thus

In our community, it is believed that men are above women in marriage. Some men exploit women financially; however, they did not consider it as violence. Forcing women for sex without their consent is not believed to be violence. Insulting wives is also not considered as violence. There is a saying: 'If a man does not insult and beat women, he is not a man.' Women also consider this as men's natural behaviour. (HCW, #3)

Women don't think that they are equal to men; they always believe in male dominance and give priority to males. Females don't feel that they are equal to men in any matters like decision making. Therefore, training on gender equality should be given in all circumstances. (HCW, #16)

Theme 5: Provider Recommendations for Improvements

Most of the HCWs mentioned different IPV prevention strategies. Among these was a need for improved legal,

community, and spiritual support for the violence victims and involving males in programs of violence prevention. They reported the need for collaboration with other stakeholders in the violence prevention programs, capacity building of staff through in-service training, the importance of treating clients with respect and dignity, the need for a separate unit or clinic to treat gender-based violence victims together, and improving the equality of women and men through women's empowerment. Most of the HCWs also mentioned awareness creation, and that efforts to establish the economic independence of women should be aggressively made.

Women's Empowerment

One of the Interviewers Reported

For me, the most important intervention is empowering women. The government should empower women in every aspect. The concerned bodies should educate women to the level of men, and the economic and social gap between men and women should be minimized. (HCW, #1)

HCWs suggested that in cases where women do not know how to get help from legal, local, and religious leaders, the HCWs should be able to guide women in that regard. Moreover, HCWs reported that consulting seniors, and linking the victims with local and religious leaders might help resolve the conflicts.

Community and Partner Participation

One of the HCWs Explained Thus

When they report physical violence, we assess the level of damage, and if the problem is significant, we consult our seniors. If she decides to take the case to court, community elders, or to the church and women do not know the process; we guide them. (HCW, #2)

Most HCWs highlighted the importance of the participation of husbands and wives together in education programs aimed at violence prevention. Moreover, they emphasized that special education programs should be established for male partners to tackle their violent behaviours, such as excessive alcohol drinking and extra-marital sexual relationships, which lead couples into conflicts.

One HCW Explained Further

I believe that education should be given for husband and wife together on the roles and responsibilities of both. The responsibility of women is so heavy, and husbands don't think that they have the responsibility of raising their children and preparing food. They should be advised

how to support their wives in all activities as well as in sharing responsibility. (HCW, #2)

The study participants explained that collaboration with different stakeholders, for instance, legal services, schools and health facilities, is essential. Additionally, they highlighted the importance of educating men, ensuring proper documentation and reporting of violence cases, and aggressively improving the referral systems. One of the participants stated:

The health facilities should work with legal services, schools, and others. If we integrate the work, we can be effective. We should also educate men and make them responsible. We usually focus on women, and we neglect men in different areas. Gender-based violence education should be implemented independently in schools and other institutions. Reporting, documentation, and referral systems should be strengthened. (HCW, #3)

Role of HCWs

According to the participants, HCWs provide care and respect for the victims of violence and treat these clients compassionately. As most HCWs reported, routine assessment of IPV with women with injuries from violence, counselling of both women and men together and respectfully approaching clients, was an excellent strategy for treating clients. Besides this, addressing the IPV problem, and support and advice from the case manager and adherence counsellor should be beneficial to prevent marriage dissolution and violence. One of the participants was of the opinion

It is better if HCWs provide compassionate care. It depends on the behaviour of individuals. No matter how good the healthcare worker, if he/she does not respect the clients, the clients are not willing to disclose their violence experience. Therefore, there should be rapport/good relations between the two. (HCW, #14)

Another Healthcare Provider Also Supported This View

HCWs should see violence cases as if it happened to them. They should give the victim good care and ease their psychological feelings. If we mistreat them, they may not come to us because of our behaviour. (HCW, #3)

Another Healthcare Provider Gave Suggestions About Prevention of IPV

It is good if we educate young girls about violence, at school. We can also give education to local media. Fliers can also transmit a lot of information. (HCW, #8)

A few HCWs mentioned the need for special legislation and policy to treat IPV cases in separate clinics, at the given health facilities. They also pointed out that the economic gap between women and men should be minimized, and that there is a need for decentralizing the programs to all facilities, and mainstreaming IPV prevention into schools and other social spaces. Moreover, they highlighted the need for particular prevention strategies such as community-based interventions, a focal person at health facilities for IPV, the establishment of clubs working on IPV, and home-to-home visits and follow-up education through health extension workers.

Other HCWs Expanded on This

The government has a poor focus on violence cases, and it is good if they form a special unit for better follow-up, reporting, and psychiatric or psychosocial management. For example, TB and HIV have a separate system, and it is good if violence has a similar separate unit with trained healthcare workers. It is also good to have a reporting and recording system. (HCW, #8)

Discussion

This research identified IPV screening challenges at the different levels of the health system, and from the perspectives of HCWs and their clients. The current study also proposed different prevention strategies. The findings in Wolaita Zone confirmed the results of the WHO and other studies.^{2,5,6} However, the significant results that emerged from the current study were about the delays in medico-legal reporting for the victims, the absence of separate record-keeping for IPV cases, the absence of referral systems for IPV victims, and a lack of follow-up care for IPV-affected women.

Types of IPV

As far as the types of IPV identified by HCWs are concerned, physical violence trauma was most common, followed by rape. However, HCWs reported that sexual violence cases visited their clinic infrequently. These findings are supported by the WHO global and regional estimates, South African studies and EDHS 2016 reports, confirming the findings that higher numbers of women in Ethiopia (25%) experienced physical violence, while fewer (10%) experienced sexual abuse.¹⁸⁻²⁰ A probable explanation for these findings is that the women did not as openly disclose sexual abuse as they did physical abuse.

It may also be due to the women's fear of blame and shame in speaking of sexual violence issues, whereas this is not the case for physical trauma. The body of literature also revealed that victims do not even report their abuse to friends, the police, and others, because they do not trust others, and do not think the police will help them.¹ Therefore, capacity building is needed to equip HCWs to counsel and assess their clients wisely to allow them to disclose the level of their abuse.

Provider Related Barriers and Training

The findings of this study show that there are many healthcare worker-related challenges for screening IPV in Wolaita Zone. The literature revealed that a considerable gap exists in HCW in-service training, and there is an absence of specific education regarding IPV cases.^{5,21,22} Therefore, we suggest on-the-job training of staff and the establishment of IPV-specific education for HCWs in Wolaita Zone. However, contrary to our findings, earlier studies found another challenge was the attitude of HCWs towards performing IPV screening, which was seen as an unreasonable activity.²¹ Moreover, the body of literature has shown the lack of provider education regarding IPV, the lack of time, and the lack of effective interventions for IPV cases.⁵ The WHO report recommended that HCWs should give adequate time to examine IPV cases.²³ In the current study, HCWs had not received any training about IPV. Therefore, we suggest that the government of Ethiopia should give due attention to on-the-job training for IPV screening.

Moreover, there is a need for HCWs to be trained to help women to develop a safety plan as the best strategy to prevent violence. Women who have experienced IPV are likely to have fears about their safety, but women may not expect that violence will happen again. HCWs need training to teach their client that IPV is not likely to stop on its own. Violence tends to continue and may become worse. Therefore, assessing and planning for safety is an ongoing process.²³

The literature highlighted the need for HCWs to be open-minded, ready to listen to their clients, unhurried, and to respect confidentiality.²⁴ The HCWs in this study, however, did not meet this recommendation of WHO's IPV prevention strategy.²⁵ Therefore, we suggest that HCWs should give particular emphasis by taking adequate time in screening IPV at all healthcare facilities. Despite all the challenges reported by the HCWs, there has been little information about the clients' difficulty in obtaining

medico-legal reports from their service providers after IPV screening. The lack of IPV patient follow-up is another concern needing attention. The concerned body in the country should provide specialized training for staff and initiate follow-up care for clients; for example, home visits. The victims of IPV may have different requirements from other healthcare patients since they require a response to their emotional needs - they may also be frightened and need reassurance and support. Women may not need physical, but emotional care instead, and they may require this on an ongoing basis.²³

Healthcare System Challenges

Concerning health system-related challenges to screening for IPV, the health facilities in Wolaita Zone had several problems, including the absence of separate record-keeping for IPV, the absence of a referral system for IPV, and a lack of follow-up care for IPV victims. Comparable to the results of the current study, a north-eastern United States study also showed that there were health system-related challenges for IPV screening. However, the health system challenges in the present research are different from the United States' study. In that investigation, there was a limited time for patient visits, absence of a screening strategy in the health system, and clinicians were so busy with other activities that they took no responsibility for IPV screening.²⁶ The discrepancy in these studies could be due to the economic and health system structural differences between the two countries. The findings of a Togo study is similar to the current result since none of the victims had been referred to local organizations to receive appropriate support.²⁷ Our study found that there were, in fact, no local organizations to support violence prevention. Furthermore, the body of literature showed that only 15.8% of victims were referred for IPV assistance by HCWs.²⁸ The current study found a shortage of medical equipment, which is in line with research in Tanzania.⁸ The current study findings also showed that there was no collaboration with external organizations to prevent IPV and that a gap existed in the medico-legal reporting system, match a study in Serbia,²¹ in which there was a weak support network for screening IPV. This is despite the body of literature in the WHO document revealing a need for immediate referral and the need for resources to treat IPV victims.²³ Therefore, Ethiopia has to arrange medico-legal reporting and referral systems for counseling victims in the short term. In addition, establishing external collaboration with stakeholders who work on

gender-based violence in the medium term, and ensuring all the necessary medical equipment to screen IPV cases, is required for the longer term.

The women/partner-related challenges in our study revealed that the clients chose not to disclose their history of abuse to the HCWs. This is because women fear the potential social challenge after their disclosure. Similarly, an earlier study revealed that patient non-disclosure of their abuse was one of the IPV screening challenges.⁵ Another study also revealed that only half of the women disclosed their IPV experience to HCWs.²⁹ The strategy for the non-disclosure is that HCWs should not pressure women, but give them time to decide what they are willing to disclose. When clients disclose their abuse to HCWs, they need to receive emotional counselling and treatment support, and HCWs should also advise women on a strategy to protect themselves from the perpetrators. Disclosure of HIV status appears to place women at increased risk of IPV, and IPV may prevent them from regular attendance to obtain ART. IPV is not the common medical reason women seek health care more than trauma, car accidents and other emergency cases. However, gender-based violence, and particularly physical violence and sexual violence cases do visit the health facilities in Ethiopia. It is one of the prevalent health problems that may affect the health of women negatively. Women may require counselling, trauma care, and other examinations related to their specific cases.

Client Level Concerns and Follow-Up Care

This study suggests the need for the provision of follow-up care and information on the effects of violence on women's and children's health, and as was indicated in the literature²³ Besides this, our research found that the inequality of power between women and men and women's mindset in accepting a man's natural right to abuse women were IPV screening challenges related to the clients. There is a need to change these perceptions in the Wolaita communities. HCWs have a counselling role in this regard, which they should enact during IPV screening at their clinic. The government of Ethiopia should train their HCWs regarding IPV through specific on the job training. There is also a need for a referral system to link clients to more specialized counselling. This finding matches a study in Bangladesh in which attitudes toward wife-beating, and men who believed wife-beating to be

acceptable, were risk factors for IPV.^{2,30} Additionally, the current study is similar to another study in which male dominance, low social and economic status of women, gender inequality, and men having multiple partners were all factors that challenged IPV screening.^{2,25}

Strategies to Prevent IPV

In our study, regarding the proposed interventions and strategies for the prevention of violence, HCWs suggested a number of different prevention strategies. A feasible short-term strategy is addressing the need for spiritual support, and male involvement in the programs of violence prevention. In the medium term, HCWs also suggested that the government should enhance legal services and empowerment of women. These results are supported by an earlier study by the WHO, in which changing laws that discriminate against women, increasing their access to education, implementing more gender-equitable policies, and reducing acceptance of violence were stated as IPV prevention strategies.^{2,25} The current study also revealed the need for collaboration with other stakeholders, staff training, and treatment of clients with respect. These findings have also been reported previously where the need for collaboration with other stakeholders, advocacy and awareness creation, integration of services, and the use of behavioural change communication for social change, was found to be important.² For instance, the involvement of the law office in developing IPV-specific laws, the involvement of the health sector in implementing and treating the cases, and involvement of the psychological and social work departments in counselling IPV victims are considered crucial. Specific laws for IPV are not yet developed and in practice in developing countries; however, the findings of this study suggest the need for a separate unit to treat gender-based violence victims. This would be made feasible by allocating the HCWs who are trained to deal with IPV.

Moreover, our study found the need for different documentation of IPV cases in the healthcare management system. A survey in Togo revealed that screening of IPV in healthcare facilities should be systematic.²⁷ This could make it easier to access the available data for implementers and in the intervention of IPV cases. Also suggested by HCWs is the need for resources for IPV prevention. Similarly, the body of literature strongly suggests availing possible resources (crisis centres, helplines, social workers, support groups, legal support, mental health counselors, and psychologists) in a particular health system, to

manage IPV victims.²³ Therefore, we suggest that the collaboration and the availability of the various resources mentioned here should tackle IPV.

Furthermore, the HCWs confirmed that IPV is a public health problem that is exacerbated by male dominance in the society, by alcohol consumption, and discordant HIV test results, a finding in line with other literature.^{23,31} Therefore, a comprehensive strategy to reduce alcohol consumption in Wolaita society is needed.²⁵ Among the specific approaches which may help to curtail alcohol drinking is for men to record in writing reasons to reduce drinking (e.g. for improved health and sleep) and keeping a diary of drinking habits for three to four weeks; in addition, avoiding keeping alcohol in the home, choosing drink-free days, and deciding not to accept peer pressure is also suggested.³²

Strengths and Limitations

Our study has the following three strengths. Firstly, we attempted to put our knowledge and personal biases aside. This means that in the descriptive phenomenological design, the meaning of the research findings was not influenced by our belief systems and experiences. This bracketing also supported the validity of interpretation. Secondly, a profound and detailed understanding of IPV screening challenges were identified and illustrated in the results. Thirdly, the HCWs appear to have contributed well to the study in their support and interest, in that they revealed a delay in medico-legal reporting to the victims, an absence of separate record-keeping for IPV cases, and the lack of follow-up care for IPV and the lack of specific laws for gender-based violence prevention.

However, we can also consider a possible limitation of this study. Although we tried to maintain pure bracketing in placing our presumptions aside, it may, in reality, be difficult to ensure complete bracketing and avoid researcher-induced bias entirely. We also cannot generalize the qualitative finding to other settings.

Conclusions

This study has shown that there is healthcare worker, health system, and client-related IPV screening challenges in Wolaita Zone for women who have injuries or conditions that they suspect may be related to IPV. The issues that emerged from the findings are the gap in medico-legal report provision, absence of separate record-keeping for IPV cases, lack of client follow-up, absence of routine assessment of violence victims, and lack of specific coordination with an

external organization. Moreover, the absence of staff training, a weak referral system, and shortages of necessary medical equipment were other challenges. In the Wolaita Zone, among the types of IPV, physical violence trauma was the most commonly reported abuse, followed by rape. Therefore, we recommend the need for improvement in separating record-keeping systems in health facilities, explicit provision of the medico-legal report to clients, improving women's access to education, and executing more gender-equitable policies. Moreover, the need for an active community and religious leader interventions, involving males in programs of violence prevention, creating a network of support with stakeholders, the inclusion of IPV-specific policy frameworks in the national legislation, and compassionate care is imperative. Additionally, further study with more focus on IPV screening challenges in other parts of the country is suggested.

Data Sharing Statement

The datasets used and/or analysed during the current study are available from the corresponding author on reasonable request.

Ethics Approval and Consent to Participate

We obtained ethical approval from the Biomedical Research Ethics Committee (BREC) of the University of KwaZulu-Natal (BREC Ref No: BE387/18) and the Institutional Review Board approval from Wolaita Sodo University under the Ref No: WSU15/04/147 (12 Sep. 2018). Written consent was obtained from individual participants.

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Author Contributions

All authors made a significant contribution to the work reported, whether that is in the conception, study design, execution, acquisition of data, analysis and interpretation, or in all these areas; took part in drafting, revising or critically reviewing the article; gave final approval of the

version to be published; have agreed on the journal to which the article has been submitted; and agree to be accountable for all aspects of the work.

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CHAPTER SEVEN: SYNTHESIS

7.1. Main findings

This study has confirmed the presence of a high prevalence of lifetime IPV among women who were living with and without HIV (59.7%, 95% CI: 56.31%-63.05%) in Wolaita Zone, Ethiopia. This has also been reported by other studies in Ethiopia (20% to 78%) (Semahegn and Mengistie, 2015), in South Africa (67.3%) (Brown et al., 2018), and in Nigeria (65.8%) (Ezechi et al., 2009). The IPV prevalence in the current study is one of the highest among the studies conducted in SSA countries, and when compared to Uganda (29%) (Young et al., 2018), Nigeria (23.6%) (Olowookere, 2015) and South Africa (21%) (Bernstein et al., 2016). However, the results may differ within countries; for example, in Uganda, where a study reported a lower prevalence of 10.1%, (Bikinesi et al., 2017). The quantitative analysis for our study further shows that although the lifetime IPV was somewhat higher among HIV-positive women, 250 (61.3) than among women who were HIV-negative, 238 (58.1), the difference is not statistically significant ($P=0.35$). This finding was also reported in the research conducted in low-income countries (Harling et al., 2010), which showed no significant statistical association between HIV and IPV. Overall, our research indicates that IPV is high, among women who were living both with and without HIV in Wolaita Zone in southern Ethiopia. Moreover, we identified the extent of IPV and its presentation in its different forms (physical, sexual and psychological) which frequently overlapped with one another (Chapter 4).

We also explored the HCW's IPV screening experiences, and the study revealed the gaps in IPV screening and medico-legal report provision (Chapter 6). United Nations data also shows that about 61% of new adult and children HIV infection in 2018 was from SSA (United Nations, 2019). However, IPV can be both a risk factor for and a consequence of HIV (Centers for Disease Control and Prevention [CDC], 2014). Therefore, there needs to be safe monitoring, screening, and interventions regarding IPV among all women, including HIV-positive women in a healthcare setting (Orza et al., 2015).

In its objectives to explore the experience of IPV against women who were living with and without HIV and its associated factors in Wolaita Zone in southern Ethiopia, this study used a range of methods in order to obtain an extensive understanding of the problem, to corroborate findings and to enable statistical analyses for generalisability. The problem was considered both from the perspective of the women affected by IPV, and from HCWs who can contribute to the solution. These methods are discussed further in this synthesis.

Chapters one to two presented the introduction to the study, the literature review, and the methodology used in this research. In Chapters three to six, the following IPV related topics were presented: Chapter three: “Mapping the evidence of intimate partner violence among women living with HIV/AIDS in Africa: A scoping review” (The protocol was published in *BMJ Open*, and the results of the review (Chapter 3) were also published in *BMJ Open*); Chapter four: “Intimate partner violence against women living with and without HIV, and the associated factors in Wolaita Zone, southern Ethiopia: A comparative cross-sectional study” (The paper was published in *PLoS One*.) Chapter five: “Lived experience of intimate partner violence among women using antiretroviral therapy and other outpatient services in Wolaita Zone, Ethiopia: A phenomenological study” (This paper was published in *Reproductive Health*); Chapter six: “Healthcare worker experience and the challenges in screening for IPV among women who use ART and other health services in Wolaita Zone, Ethiopia: A phenomenological study” (The paper was published in the *Journal of Multidisciplinary Healthcare*.); chapter four to six (Papers 3 to 5) present new evidence concerning the extent of the problem of IPV in Wolaita Zone, and this synthesis will highlight how this evidence was obtained, the negative health impacts reported in this study as a result of IPV, factors associated with IPV, the new and additional information generated by this study, and how this current information can be used to reduce the prevalence of IPV.

7.2. A comprehensive approach to the methods used in this study

In order to identify gaps in the body of literature and to understand the phenomenon in detail, we initially mapped the existing research findings of IPV among women living with HIV in SSA. Four themes emerged from the identified studies. These are: evidence of IPV experience among women who were living with HIV, evidence that HIV status revelation to partner influences IPV, confirmation of the association of socio-demographic characteristics with IPV, and implications for practise or the way forward. The review described the multiple experiences of IPV among women living with HIV and how these vary among SSA countries. On average, the studies also indicated that one-third of HIV-positive women experienced IPV (Colombini et al., 2016; Osinde et al., 2011; Wilson et al., 2016). The review showed that following HIV status disclosure, there was evidence of IPV (Ezeanochie et al., 2011; Hampanda and Rael, 2018; Iliyasu et al., 2011; Mulrenan et al., 2015).

This scoping review assisted in conceptualizing the primary research as to whether IPV experiences were different or similar amongst women who were living with or without HIV. The study was directed at factors associated with IPV, the lived experience of women both living with or without HIV and the HCW's experience of IPV screening and the barriers. This study used a pragmatic worldview or

perspective, in which we used the varied approaches available to understand the research problem (Creswell, 2014).

7.3. Use of mixed methods

Each type of data collection, whether using quantitative or qualitative methods, has its own strengths and limitations. Therefore, we considered how the strengths could be combined to gain a greater understanding of IPV and to overcome the limitations of each. This blending or mixing of data provided a more robust understanding of the experience of IPV against women than either approach by itself (Creswell, 2014). Moreover, IPV is a sensitive issue and women may not be able to disclose their experience simply. Therefore, the use of mixed methods was preferable.

We thus used both quantitative and qualitative methods to collect the data. The research followed an exploratory sequential mixed-methods design. It also used different types of data from respondents. These included women who were living with and without HIV and HCWs. The approach that was used was one of analysing the research being conducted in the two different groups, HIV-positive and HIV-negative, in the population (Tashakkori & Teddlie, 2010). We triangulated the data from the interviews, FGDs and questionnaires from the women, with the HCWs' responses. The HCWs acknowledged the problem of IPV that was described by the women participants. The mixed-methods design helped us to gain complementary views of the same IPV phenomena. It also assisted in achieving completeness to ensure the study obtained a complete picture (Bergman 2008). For instance, in our qualitative research, Paper 3, women reported their experience of overlapping types of physical, emotional, sexual, and controlling behaviour from male partners.

The quantitative study similarly showed the high prevalence of IPV in Wolaita Zone. Chapter 5 used the IPA design which required the interpretation of the stories presented by participants, and the valuable expert knowledge on the part of the scholar (Lopez and Willis, 2004; Rodriguez and Smith, 2018). The qualitative research provided a picture of the women's experiences of IPV. The themes identified in chapter 5 were "Women's terrifying experiences of violence," "The effects of violence on their health,"; "Support/lack of support /controlling behaviors/," "Women's feelings about the available services," and "IPV prevention strategies from the perspective of women." These themes categorized IPV in Wolaita Zone very well. The themes described women's violent experiences which included physical violence of wife-beating, having material thrown at the woman's face, and the wife's hand and teeth being broken. There were the emotional components such as being stigmatized in front of others, having their movements restricted, name-calling, threats to hurt, being insulted, and being left alone. Women reported being forced to have sex, and also the withdrawal of finances, as described in the themes. The qualitative

study further showed that the IPV in Wolaita Zone was widespread, and the findings of our study showed and documented women's terrifying experiences of IPV, which included sexual, physical, and psychological violence.

Usually, such abuse was experienced as overlapping or mixed forms of violence. Our research reported that the women testified to recurrent physical and psychological violence, but sexual violence was reported by relatively few participants. The results confirmed the findings of previous studies (EDHS, 2016; Bernstein et al., 2016; Yitbarek et al., 2019). In quantitative research, the prevalence of women living both with and without HIV was high, but the relationship was not statistically significant (quantitative study, chapter 4). However, the finding of the qualitative study showed an increased IPV experience among women living with HIV after they disclosed their HIV-positive test result to the male partner (qualitative study, chapter five).

In chapter six, we explored the HCW experiences and challenges in screening for IPV among women. This part of the study also assessed health systems related barriers to identifying, treating and examining women with IPV. We used a descriptive phenomenological qualitative study design to explore the experience of HCWs. A total of 16 in-depth interviews were conducted among HCWs serving out healthcare tasks from the 19 health facilities in Wolaita Zone.

We answered objectives two and three using qualitative methods to explore the women's IPV experiences and the HCW's IPV screening experiences (chapters 5 and 6). Using these methods of FGDs and interviews, we were able to obtain thick and in-depth descriptions to inform our understanding of the IPV phenomena. Additionally, the prevalence and factors associated with IPV against women were answered by the quantitative study (chapter 4). The quantitative research was institution-based, and the generalisability of this research is subject to certain limitations as it was not undertaken in the community. However, the policymakers and implementers who are working in contexts that are similar to our ART sites (attended by women living with HIV), and among other women attending health facilities and hospitals in Wolaita and Ethiopia, can use our findings. The study may feasibly be generalised to other similar areas in Ethiopia and similar developing countries.

7.4. Health impacts of IPV

In this study, we found major negative health impacts reported by the women who comprised discrimination, infection with HIV and other sexually transmitted diseases, abortion, disability, divorce, fear, depression, and child death (chapter 5). The scoping review results in Paper 2 showed similar effects. They highlighted the difficulties of women who experience IPV in engaging in HIV/AIDS care, the interruption of their ART treatment, and that stigma, abuse, and financial withdrawal were some of the consequences that followed from IPV.

7.5. Factors associated with IPV

We found various factors associated with IPV against women who were living with and without HIV in Wolaita Zone (See Figure 5 below). These factors are further discussed as “Socio-demographic and cultural factors” (7.6); “Male masculinities, gender inequalities and partner’s characteristics” (7.7), and “Reproductive health-related factors or sexual risk factors” (7.8).

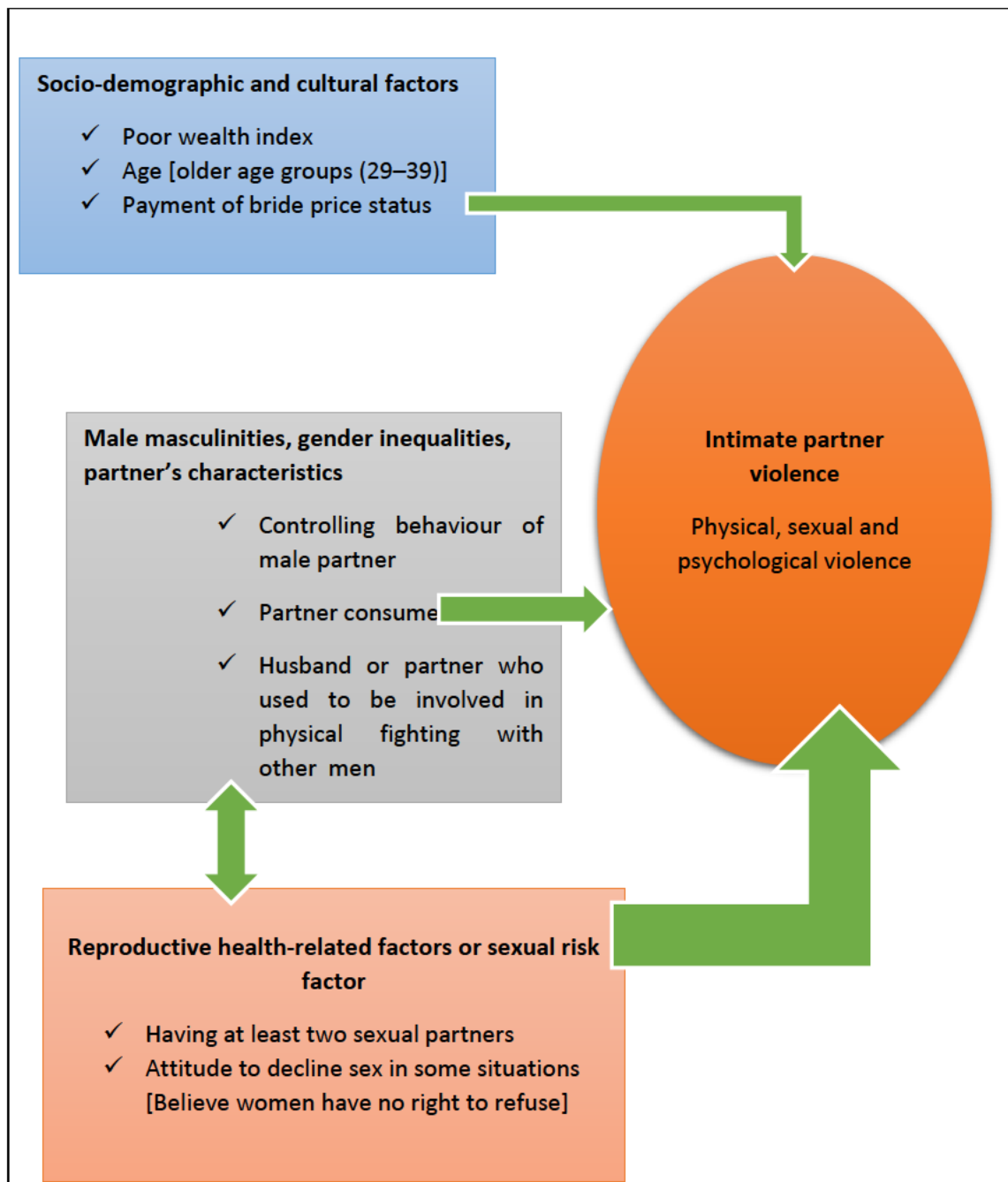


Figure 5. Various factors associated with IPV against women living with and without HIV in Wolaita Zone, Ethiopia (Chapter 4)

7.6. Socio-demographic and cultural factors

The factors placing women at risk include their lower-income [AOR=3.97;95% CI:1.81-8.72] and an older age group (29-39) [AOR=2.86; 95% CI:1.67-4.90], findings that confirmed the study of Semahegn and Mengistie (2015). Our study also found an association between IPV and women whose bride price payment was partially paid or not paid at all [AOR=2.83; 95% CI:1.70-4.69].

7.7. Male masculinities, gender inequalities, partner's characteristics

These factors were reported both from the quantitative and qualitative results. Controlling behaviour by partners [AOR=8.13; 95% CI: 4.93-13.42] was reported, which has also been found in other studies (Shamu et al., 2014, Deribe et al., 2012). The FGDs and interviews reported that controlling behaviour of partners or spouses ranged from a debilitating to an annoying effect on women's lives, confirming the findings of an earlier study in Addis Ababa in Ethiopia (Mohammed et al., 2017). This behaviour detached women from any possible benefits that they could get from friends, neighbours, relatives, and healthcare providers. Feminist theory explains the power difference between men and women, the so-called lack of gender equality, to understand how this affects women's health (Crossman, 2017). Accordingly, this study found men's dominance or controlling behaviour affected the health of women negatively and is a result of the inequalities between men and women among women living with and without HIV in Wolaita Zone.

The current study also showed substance abuse to be a problem, as having a male partner who drank alcohol was associated with IPV [AOR;2.36;95% CI:1.36-4.10]. This was also noted in a previous study (Semahegn et al., 2013). Therefore, education about alcohol consumption is needed as part of the school and health system education programmes. Moreover, this study showed that if a partner had previously been involved in a physical fight with another man, it was statistically associated with IPV [AOR=1.83; 95% CI:1.05-3.19]. A similar finding on prior physical violence, as associated with IPV was reported in another study (Shamu et al., 2014).

Culture-related factors that emerged from this study and are associated with IPV were the beliefs of women. Women who did not believe in their right to refuse sex in some situations [AOR=2.99; 95% CI: 1.39-6.41] reported experiencing IPV. The WHO study also suggested that some norms and beliefs, for example, that a man has a right to discipline a woman physically when she "behaves incorrectly" or regarding sexual intercourse as a husband's or partner's right, could support violence against women (WHO, 2012). In Paper 4, women emphasised that religious leaders have an indispensable role in

resolving violence, but some women noted the difficulty in getting support from religious leaders. However, our quantitative data did not show any association between religious beliefs and IPV.

7.8. Reproductive health-related factors or sexual risk factor

Sexual risk factors, such as having at least two sexual partners was associated with IPV [AOR=2.35; 95% CI:1.36-4.09]. Our research also found that the inequality of power between women and men, and women's mindset in accepting a man's natural right to abuse women, leads to violence, as it is considered by them to be "understandable". This concept was also supported by the evidence from the qualitative study (Paper 4), indicating that women lacked decision making powers in some situations, such as the inability to decide in a sexual relationship, and their powerlessness appeared to be associated with their experiencing violence. This concept was supported by previous studies (Shamu et al., 2014; WHO, 2012).

7.9. Intimate partner violence prevention approaches from the perspective of participant women

The results described provide evidence of the extent of the burden of IPV experienced by many women in this study. Although the women acknowledged that IPV was prevalent, they made suggestions as to how this should be addressed. These are discussed as follows:

7.9.1. Legal route

The findings that emerged from this research underline the existence of weak and unsuitable punishment for perpetrators of violence. Women testified that although the legal service exists, the presently available punishment of perpetrators is inadequate and does not act as a deterrent.

7.9.2. Social support

The research showed that strong women's networks are absent, as unambiguously working on violence prevention to resolve the conflicts between women and their husbands/partners and to punish the perpetrators. The women's groups that were in existence were found not to be functioning correctly in IPV prevention activities. Similar to the current finding, the body of literature also showed that only 15.8% of victims were referred for IPV assistance by HCWs (Ballan et al., 2017).

As the way forward, the discussants highlighted that women should talk over the abuse that they experience with their neighbours, in order to develop practical approaches to prevent such incidents occurring. The publicity in the community could possibly act as a deterrent.

7.9.3. Income-generating initiatives

The need for women to become more financially independent was also seen as an essential step, and they considered that women should generate income to avoid dependency on men. The discussions also raised the possibility of women empowering one another in that they too could, or should, provide information to their friends who have no awareness of how to acquire legal services.

7.9.4. Role of healthcare workers

The intervention strategy proposed by the women was that the right time or period to disclose the result of an HIV test to prevent a sudden abusive reaction from their husbands or partners would be when they are either sick, pregnant, and at night time. They also proposed the need for HCWs to assist or support in the disclosure of HIV test results to avoid abuse.

7.9.5. Health system

The current study also found a shortage of medical equipment, which is in line with research in Tanzania (Laisser et al., 2011), where there was no collaboration with external organisations to prevent IPV and a gap in the medico-legal reporting system existed.

7.10. Intimate partner violence prevention strategy in the education and health system

To prevent IPV requires social learning in order to change attitudes and such practices (Bandura, 1971). Intimate partner violence is a learned behaviour, and school programmes starting at an early age are required to question the ideas of male hegemony. These could begin to introduce alternative viewpoints so that those children who have observed their father abusing their mother during their childhood will perceive this as bad behaviour and may not abuse women in adulthood. This could assist in children's past abuse experience having a negative influence on their development and perpetrating IPV against women who are living with HIV and those who are not HIV infected. The pathway framework of prevention is presented in Figure 6.

The findings of this research also suggest that the health facilities should establish cooperation with external organisations that work in IPV prevention, and they should provide timely medico-legal reports to their clients. Figure 6 below shows the details of IPV prevention pathways outlined from the results of this study.

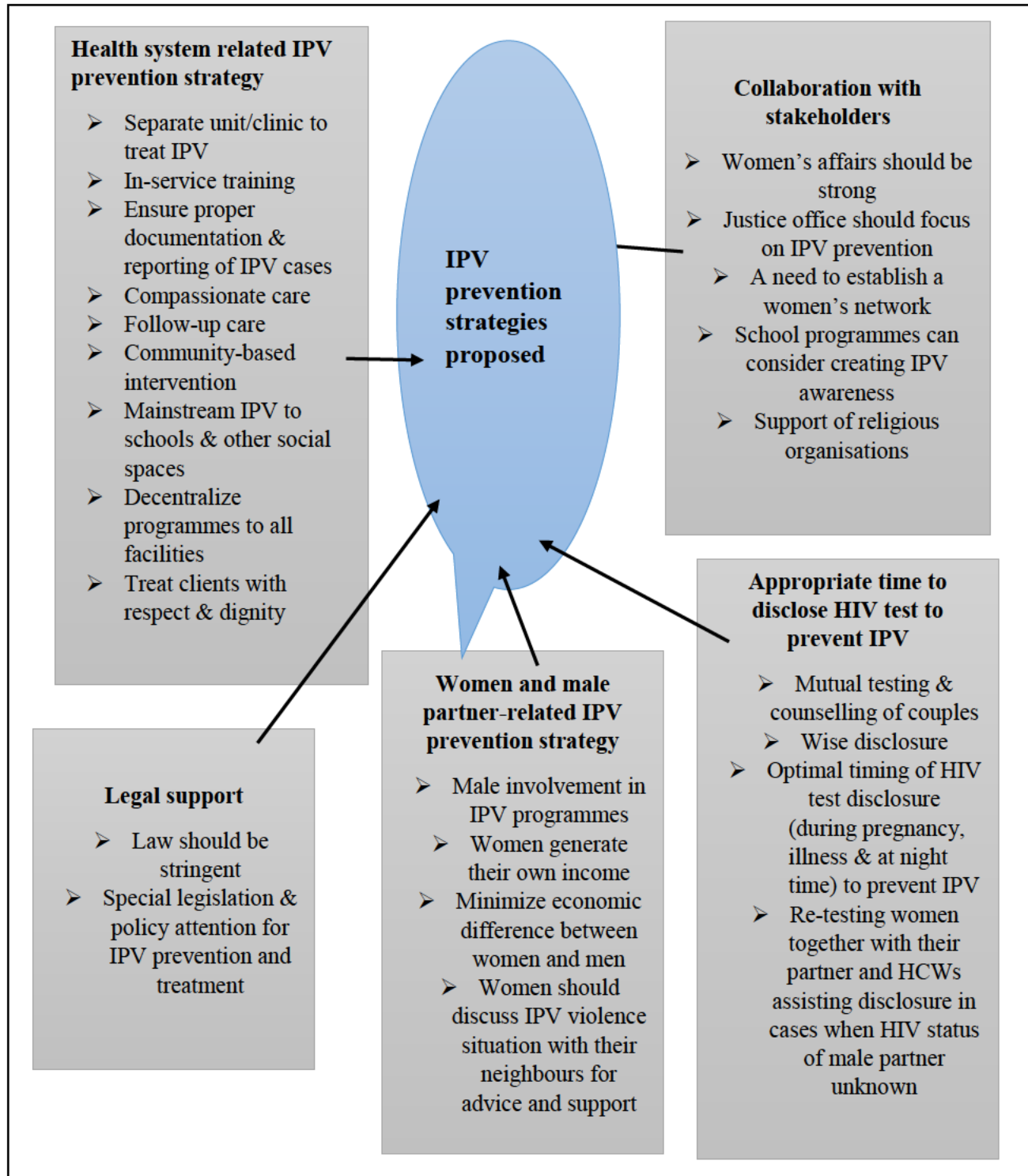


Figure 6. The pathway framework of IPV prevention

7.11. New knowledge

We obtained new information from the current study regarding IPV among women who were living with and without HIV on the factors associated with IPV, and the prevention strategies suggested both by the participating women and the HCWs. The results provide information about the women and their experiences at the individual level, but also describe practical steps that can be taken at the community level and how policies and programmes can be developed to target this highly prevalent practice and the multiplicity of negative consequences. We identified that the IPV experienced by women, regardless of their HIV status, comprised physical, sexual and emotional abuse and that prevention strategies would be required for both groups of women. This study also identified a practical role for the health services in reducing IPV. Paper 4 proposed a new approach towards prevention, in that those women who know their HIV-positive status (for example, as a result of ANC testing) before their partners do (since they may have violent and aggressive partners), should be tested for HIV again as a new case together with their husbands or male partners. Participants reported that the potential abuse could be minimized if HCWs assisted with the disclosure at a time when the couple was informed together.

Our study highlighted the need for effective women's networks or groups to fight against IPV at the community level, and this was reported in Papers 4 and 5. The participants saw women's networks as having the potential to reduce the prevalence of violence in Wolaita Zone. The participants also reported that the current strategy, comprising a local women's group, which was established to work on the prevention of IPV, was dysfunctional. The role of community groups in supporting women at risk offers a feasible solution to reducing their feelings of isolation. Moreover, the involvement of the official women's affairs office in IPV was also found to be weak, and the participants additionally reported that there was insufficient and inappropriate punishment for abusers or perpetrators of violence in southern Ethiopia. Ethiopia, as a developing country, has not sufficiently emphasised the education of its women, who constitute 40% of the population (EPHI and ICF, July 2019). Both rural and urbanized women feel isolated and have little understanding of their rights and little experience in obtaining help. Their stories present a picture of the perpetration of extreme violence with no consequences for the perpetrator. Thus, the suggestion of the study participants that the local women's support groups that already exist, be empowered and become active appears to be a feasible option.

The study highlighted important issues that emerged from Paper 4, and this was the delay in the medico-legal reporting for the victims. The absence of separate record-keeping for IPV cases, the absence of

referral systems for IPV victims and a lack of follow-up care for IPV affected women, was reported and has been emphasised in the study's recommendations.

7.12. Contributions of this study to what is known in order to provide recommendations to reduce IPV

7.12.1. Prevalence

The study confirmed that IPV in the Wolaita region is high but similar to other African countries. It found that the whole lifetime of IPV among all women interviewed was 487 (59.68%), [95% CI: 56.31%-63.05%], which concurs with other studies reported in Ethiopia (IPV ranged from 20% to 78%), and south-east Ethiopia (59%) (Semahegn and Mengistie, 2015; Lencha et al., 2019). It is interesting that the prevalence appears to differ in different parts of Ethiopia, and that this finding had a lower percentage than the research done in the northern part of the country, which was 78% (Semahegn et al., 2013). It could be due to the difference in sample size, setting, study period, and population. The magnitude of the results of this study shows that gender-based violence in Ethiopia is a substantial public health problem, and, as a result of this, the government of Ethiopia should emphasise its prevention. This study in the Wolaita Zone provided new information for this part of Ethiopia. The results were often similar to other developing countries in Africa, but at times differed. No comparative study had been conducted earlier among the two population groups of HIV-positive and HIV-negative women, either in Wolaita Zone or in other areas of Ethiopia. In the results reported in the qualitative Paper 4, we reported on the enormous problems of IPV experienced by women in Wolaita Zone. Therefore, based on those findings, the zonal Department of Health should work vigorously to reduce IPV, both among women living with HIV and among those without HIV. The various factors associated with IPV in the Wolaita region that need attention by the government, in particular by the Department of Health, are explained below.

7.12.2. Association between HIV and IPV

Our study confirmed the results of the low-income country studies (Harling et al., 2010), in which there was no significant association between HIV and IPV; the overall IPV prevalence among both HIV positive and negative women was high. However, the differences between the two population groups were not statistically significant. Chapter 4 showed that there was no significant association between the HIV status of the women and IPV (COR=1.14; 95% CI: 0.86-1.51). Contrary to these findings, HIV has been found to be associated with IPV in ten Sub-Saharan African countries (Shi et al., 2013; Durevall and Lindskog, 2014).

The findings of Papers 2, a scoping review result, also showed that HIV disclosure of status increased the risk of stigma and the financial support withdrawal to the affected women. Our results are in line with the studies in the Sub-Saharan African countries, Kenya, Uganda, Cameroon, Nigeria, and Zambia (Colombini et al., 2016; Ashaba et al., 2017; Fiorentino et al., 2019; Ezeanochie et al., 2011; Hampanda and Rael, 2018). Our research showed that an HIV discordant test result and reckless disclosure of an HIV test result to husbands or the male partner also lead to IPV and stigma. Thus, it is advisable that women intending to disclose their HIV-positive status to their husbands or partners be very cautious while they are revealing their HIV status to escape being physically violated. Studies to date have emphasised that HCWs should ensure safe disclosure of HIV status to prevent post-disclosure abuse. These suggestions have included either couple counselling, mutual counselling between partners and independent advice (Colombini et al., 2016; Ashaba et al., 2017; Mulrenan et al., 2015).

7.12.3 The problem of male controlling behaviour

The current study found that the controlling behaviour of a husband or partner was statistically associated with IPV. This result is consistent with the investigations of Deribe et al. (2012) and Durevall and Lindskog (2014). Such controlling strategies are a danger for women's mental and physical health, leading to sadness, pain, depression, discomfort, and even suicidal ideation (Krantz and Vung, 2009). This behaviour of the partner or husband may prevent women from obtaining medical care and may restrict their contact with friends and family (Krantz and Vung, 2009). Paper 2 also indicated that the controlling behaviour deprived women of any possible benefit from others. It was interesting that data from the interviewees noted that older women were at lower risk of being affected by controlling behaviour than their counterparts (Paper 3). Women also revealed that their partners or husbands locked or closed the door so that they were left in the home and were not permitted to leave the house, which troubled their lives. This behaviour is because boys and girls socialized differently in Ethiopia so that girls are held inferior to boys (UNFPA, October 2008). More emphasis is given to boys regarding learning, feeding, and provision of different activities during the process of their upbringing.

Moreover, girls are brought up to conform to, and specialize in indoor activities, and to be obedient and dependent on others (UNFPA, October 2008). Additionally, in most parts of the country, for followers of the Christian religion, marriages are usually arranged by the parents of the bride and groom with a pronounced deal of conciliation. However, today, in urban areas, in contrast to rural society, people do not follow the tradition of prepared marriage, but it is still important to marry someone of whom the family approves (Teklehaimanot, 2020). In addition, in chapter 5, as stated by the study participants, the religious front-runners have a vital role in resolving the abuse, but a few women pointed out it is

problematic to get assistance from the religious leaders. Since half the population of Ethiopia are females, the government must address the development of girls and women in accordance with the equality principles of the Sustainable Development Goal 5, for which the target date is 2030 (United Nations, 2015).

7.12.4. Alcohol and other drug abuse

Chapter 3 and chapter 4 showed that consumption of too much alcohol by the male partner was an important factor exacerbating the women's IPV experience. In Ethiopia, alcohol consumption is higher among males than women (11.58% vs 1.21%) (Ayano et al., 2019). Moreover, another substance usage also exacerbates the alcohol drinking; the use of 'khat' (from a plant, *Catha edulis*, which has a stimulating effect and leads to euphoria and excitement) and 'shisha' addiction (a way of smoking tobacco mixed with molasses fruit or sugar through a tube) by husbands or male partners, are practices increasing the risk of abuse. These findings are concur with those of other studies (WHO, 2013; Bernstein et al., 2016; Semahegn and Mengistie, 2015). A possible explanation for these results may be that a person who consumes alcohol is likely to be aggressive and angry and to abuse women emotionally, physically and/or sexually. Different studies have shown that alcohol leads to IPV and sexual risk-taking such as engagement with commercial sex workers and reduced condom use (Karim and Baxter 2016). Under the influence of alcohol, men may abuse women due to a lack of empowerment of women, who still accept wife-beating for unknown reasons (UNFPA, October 2008). Furthermore, women also believe that they have no right to negotiate or refuse sex with their partners, even if there are health risks (UNFPA, October 2008).

7.12.5. Health system challenges

The HCWs emphasised the extent of IPV and their difficulties in addressing the problem. Our findings confirmed the studies which revealed a considerable gap in HCW in-service training and the absence of specific education regarding how to address IPV cases (Waalén et al., 2000; Djikanovic et al., 2010; Sprague et al., 2012). Our study also indicated a willingness on the part of the HCWs to become involved, provided they received the requisite training and support. However, HCWs have not received any training about IPV. Therefore, we suggest that the HCWs should give particular emphasis to possible IPV cases by taking adequate time in screening for it at all health facilities. Spending sufficient time with women can ease their distress (WHO, September 2014). Provision of IPV counselling, care, and treatment should be private, confidential, and the information only be disclosed with the consent of the woman (WHO, September 2014). The WHO also framed six steps of prevention policy and programmes for violence

against women, and Ethiopia can use this available resource (WHO, 2010). The prevention pathway framework of IPV developed from the current study is shown in Figure 5 above.

Chapter 6 further identified IPV screening challenges at the different levels of the health system, and from the perspectives of HCWs and their clients in Wolaita Zone. Moreover, a weak referral system and shortages of necessary medical equipment were other challenges. Therefore, we suggest the need of active community and religious leader interventions, involving males in programmes of violence prevention, creating a network with stakeholders, including IPV-specific policy frameworks in the national legislation, and the awareness that compassionate care is imperative.

7.13. Strengths and limitations

7.13.1. Strengths of the study

This research has various strengths. The use of triangulation of the research at multiple levels of pragmatism (philosophical triangulation), method triangulation (mixed methods research) and data triangulation (numerous sources of data) are an important strengths of this research. This study allowed women living with and without HIV to share and explain their experience of IPV to others and to contribute to the recommendations provided by this study. Moreover, this study maintained the validity, reliability and generalisability of the quantitative study. For internal validity, we supervised the data collectors to ensure that they had collected the actual information from the participants. In order to ensure reliability, we undertook a random checking of the collected data. We enrolled a large sample (816) in the survey, which increased the generalisability of the results. Furthermore, the study used a large stratified random sample and I adapted and employed the use of the standard and valid WHO multi-country gender-based violence and women's health questionnaire. The study maintained scientific rigour, and we used credibility (study reflects the views of the participants), dependability (the analysis is grounded in the data), transferability (to ensure that the findings of this study are transferable to other contexts, we provided thick descriptions), confirmability (study triangulated data collection using in-depth interviews, FGDs and a questionnaire using different analysis methods). In quantitative study, we used the post-estimation diagnostics (Hosmer-Lemeshow goodness of fit test and the Receiver Operating Characteristics (ROC) graph after multivariate analyses to rule out significant interactions, confounders, and the model's ability to discriminate between those subjects who experienced IPV and those who did not. Moreover, we explored various associated factors of IPV among women living with and without HIV. The IPA design in this research allowed a detailed and in-depth description of Wolaita women's IPV experiences and its meanings. The unique perspective of the IPA design provided a comprehensive understanding of the IPV phenomenon as experienced by the women, and the findings reported from the

study result from the rich data and the open-ended structured guide that permitted the participants to talk freely so that the investigator gathered rich data for the analysis. Furthermore, we have tried to put our knowledge and personal biases aside. Thus, in the descriptive phenomenological design, the meaning of the research findings was not influenced by our belief systems and experiences. This bracketing also supported the validity of the interpretation.

7.13.2. Limitations of the study

The cross-sectional study design is unable to establish the temporal relationship between independent and dependent variables. This design cannot support conclusions regarding the inference on causality, or the risk of diseases, or, in this study, IPV. Moreover, this was an institution-based study, thus, the generalisability of the quantitative research is subject to certain limitations as it was not undertaken in the community, thus women who did not attend health facilities were not included. When selecting the study sample, we did not include women who had not tested for HIV, and for women who were HIV-positive, but not taking ART. Therefore, the result of the quantitative study can be generalised with these limitations.

In the collection of the qualitative data, there may have been issues of social desirability or stigma, although the similar reports from the participants suggest that these factors were not an issue in obtaining valid responses. Moreover, in the IPA design, we made every attempt to keep the descriptions faithful to the raw data, but pure bracketing may not be possible because the investigators interpreted the data based on their phenomenological world and experience. Hence, this process, in turn, may bring investigator-induced bias to the study. However, the researchers were aware of this, took note of it, and tried to avoid this possibility.

7.14. Recommendations based on the study's results

The study recommendations address the health and legal systems in Ethiopia (District health office, Department of Health, Regional Health Bureau and Minister of Health). The more urgent, and thus short term proposals, are provided first, followed by longer-term recommendations.

A. Short-term recommendations

Health systems should establish women's networks which need to work on violence prevention explicitly and should be supported. The absence of referral systems for IPV victims and a lack of follow up care for IPV affected women should be addressed. Moreover, the health systems' barriers are reflected in need for

separate record-keeping of IPV cases in the health facilities, standardizing the medico-legal reporting system, and executing more gender-equitable policies as the way forward. Health departments should raise awareness in the community of the benefits of marriage arrangements being by mutual consent between the partners rather than being made by parents. Chapter four found that if the husband's family arranged the marriage, there were issues regarding bride-wealth and the lack of such payments was associated with IPV.

The Ethiopian health policy should involve males in all the programmes of gender-based violence prevention to change their violent behaviour. This study also recommends community mobilization by using various strategies (media and advocacy, encouraging selecting community activists, and strengthening skills among community members, trying to promote new more equitable behaviours, and promoting change, by involving community members, leaders, and institutions in the IPV prevention strategy. We also recommend the local governmental and cultural leaders have to receive training on IPV. Community mobilization has to be emphasized.

This recommendation is prompted by our results showing that alcohol consumption and controlling behaviour by a male partner were factors associated with IPV. Moreover, the different socialisation of boys and girls in Ethiopia, and that girls are held to be inferior to boys are an indication that for Ethiopia's development and progress, values must change (UNFPA, October 2008). Education about alcohol consumption should become part of the school and the health system's provision of education. Furthermore, safe disclosure of HIV test results is essential to avoid violence. Therefore, couple counselling, mutual disclosure between partners, separate counselling sessions for men, and facilitated disclosure is vital to prevent IPV. The health facilities should assist the women in the disclosure process of HIV test result. This can be done by testing women who know their serostatus before their husband/partner do as new patients together with their partners, with healthcare providers assisting in the disclosure. Provision of in-service training for the healthcare providers regarding counselling and IPV screening is essential in such complex situations. Moreover, HCWs should teach women to discuss their abuse experience with their neighbours. This study also recommends that the country has to arrange a referral system for counselling victims urgently. Finally, I have a broader call to a political commitment by the government authorities at all government sectors to fulfil medical equipment to treat IPV and empowering women economically to prevent IPV in Wolaita Zone, Ethiopia.

A. Long term recommendations

Women should generate their own income in order not to be dependent on men, and this requires new promotional policies for this and the provision of training. Moreover, women should teach their friends who lack awareness of how to obtain legal services. Support is required for HCWs for them to be able to address the needs of women affected by IPV adequately. Healthcare workers also require the necessary

medical equipment to screen IPV cases. In order to learn from others regarding the best practice for what is useful, establishing external collaboration with stakeholders who are working in gender-based violence is vital.

To the legal department

In addressing the legal needs, our research has emphasised that Ethiopia must establish a special court that deals with IPV cases separately, to decentralize the system and to train the legal bodies in the long term. These requirements are highlighted by the women participants in Wolaita not benefitting from the legal services as they expected. The United Nations (UN) handbook that was designed to reduce IPV shows the need for the establishment of specialized organisations and officials to implement legislation on IPV (UN, 2010). To date, Ethiopia has yet to fulfil these requirements, and the results of this study will be presented to the relevant authorities to provide the evidence. Our research emphasised that the law needs to be applied strictly and ensure justice for all victims in the short term.

Recommendations for further research intervention

We recommend an investigation of the relationship between IPV and HIV, which should be examined in different parts of the country to develop situation-specific approaches that may be needed. For instance, further study with more focus on IPV screening challenges in other parts of the country is suggested. Other investigations are required to identify and manage the physical and mental health impact of IPV among different groups of women and different regions. For the critical societal changes needed to prevent IPV, it is suggested that the education system introduce programmes in schools to advocate for gender equity. The evaluation of such programmes will require innovative research. It is also essential to monitor changes in the health system to ensure that women experiencing IPV receive adequate care.

7.15. Conclusion

There was a high prevalence of IPV among women, both living with and without HIV. The extent of IPV and its presentation in the different forms (physical, sexual and psychological), which frequently overlapped, highlights the urgency of the recommended intervention measures. In Wolaita Zone in southern Ethiopia, women had reported terrifying experiences of violence which affected their physical, mental and social health. The various factors that place women at such risk include their lower-income, older age group, having a male partner who drank alcohol, having at least two sexual partners, whether a male partner had previously been involved in physical conflict with another man, not believing that they have the right to refuse sex in some situations, and women whose bride price payment was partially paid or not paid at all.

Furthermore, this study has shown that there are HWCs, health systems, and client-related IPV screening challenges in Wolaita Zone. The results have highlighted the gap in the medico-legal report provision for victims, the absence of separate record-keeping for IPV cases, lack of client follow-up, absence of routine assessment of violence, and lack of specific coordination with any external organisation. Therefore, establishing a particular women's network that emphasises IPV and the inclusion of IPV specific policy frameworks in the Ethiopian national legislation is required. Perhaps most importantly, at a grassroots level, compassionate care is the way forward to a resolution.

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Appendix 1: Sample size calculation

Appendix 1: Calculate sample sizes without adjustment for clustering

Step: 1

α (two-tailed)	<input type="text" value="0.050"/>	Threshold probability for rejecting the null hypothesis. Type I error rate.
β	<input type="text" value="0.200"/>	Probability of failing to reject the null hypothesis under the alternative hypothesis. Type II error rate.
q_1	<input type="text" value="0.415"/>	Proportion of subjects that are in Group 1 (exposed) (Deribe et al., 2012)
q_0	0.585	Proportion of subjects that are in Group 0 (unexposed); $1 - q_1$ (Deribe et al., 2012)
E	<input type="text" value="0.500"/>	Effect size
S	<input type="text" value="1.000"/>	Standard deviation of the outcome in the population
N_{total}	129.32	Total group size (without adjustment)

Table 2: Calculate sample sizes with adjustment for clustering

Step:2

b.	Fixed	cluster	size
With a fixed cluster size, ρ can take any value between 0 and 1.			
N_{total}	129.32	Total group size (without adjustment)	
q_1	0.415	Proportion of subjects that are in Group 1 (exposed)	
m	<input type="text" value="19"/>	Cluster size	
ρ	<input type="text" value="0.29"/>	Within-cluster correlation coefficient (must be greater than 0 and no greater than 1)	

Calculate

Design Effect = $1 + (\rho(m-1)) = 6.22$

Clusters in Group 1 = $C_1 = N_{total} * \text{Design Effect} * q_1 / m = 17.57$, rounded to 18

Clusters in Group 0 = $C_0 = N_{total} * \text{Design Effect} * q_0 / m = 24.77$, rounded to 25

N'_1 : 342

N'_0 : 475

N'_{total} : 817

N'_{total} : 817

Appendix 2: Research approval by the Research Ethics and Higher Degrees Committee



21 June 2018

Student No: 217082145

Mr MM Koyira
Wolaita Sodo University
PO Box 138
Ethiopia

Dear Mr Koyira,

DOCTOR OF PHILOSOPHY (PHD) PUBLIC HEALTH

Title: Intimate partner violence against women living with and without HIV: Contexts and associated factors in Wolaita Zone, Ethiopia

Supervisor: Dr N Khuzwayo
Co-Supervisor: Professor M Taylor

The above-mentioned application was reviewed and the protocol has been approved for your PhD degree.

Please note:

- The study may not begin without the approval of the Biomedical Research Ethics Committee (**BREC**) / Humanities and Social Sciences Research Ethics Committee (**HSSREC**) / Animal Ethics Committee (**AEC**).

Yours sincerely



Michelle Ramlal
Postgraduate Administration

cc: Dr N Khuzwayo
Prof M Taylor

School of Nursing and Public Health
Howard College Campus
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Appendix 3: Ethical clearance from the University of KwaZulu-Natal (UKZN)



28 September 2018

Mr MM Koyira (217982145)
School of Nursing and Public Health
College of Health Sciences
217082145@stu.ukzn.ac.za / monjo@sw77@gmail.com

Protocol: Intimate partner violence against women living with and without HIV: Context and associated factors in Wolaita Zone, Ethiopia
Degree: PhD
BREC Ref No: BE387/18

EXPEDITED APPLICATION; APPROVAL LETTER

A sub-committee of the Biomedical Research Ethics Committee has considered and noted your application received on 25 June 2018.

The study was provisionally approved pending appropriate responses to queries raised. Your response received on 12 September 2018 to BREC letter dated 27 July 2018 have been noted by a sub-committee of the Biomedical Research Ethics Committee. The conditions have now been met and the study is given **full ethics approval** and may begin as from 28 September 2018. Please ensure that the permissions are obtained and forwarded to BREC for approval before commencing research at a site.

This approval is valid for one year from 28 September 2018. To ensure uninterrupted approval of this study beyond the approval expiry date, an application for recertification must be submitted to BREC on the appropriate BREC form 2-3 months before the expiry date.

Any amendments to this study, unless urgently required to ensure safety of participants, must be approved by BREC prior to implementation.

Your acceptance of this approval denotes your compliance with South African National Research Ethics Guidelines (2015), South African National Good Clinical Practice Guidelines (2006) (if applicable) and with UKZN BREC ethics requirements as contained in the UKZN BREC Terms of Reference and Standard Operating Procedures, all available at <http://research.ukzn.ac.za/Research-Ethics/Biomedical-Research-Ethics.aspx>.

BREC is registered with the South African National Health Research Ethics Council (REC-290408-009). BREC has US Office for Human Research Protections (OHRP) Federal-wide Assurance (FWA 678).

The sub-committee's decision will be noted by a full Committee at its next meeting taking place on 13 November 2018.

We wish you well with this study. We would appreciate receiving copies of all publications arising out of this study.

Yours sincerely


Prof V Ramdath
Chair: Biomedical Research Ethics Committee

ix postgraduate administrator: Ramdath.V@ukzn.ac.za Supervisor: koyira@sw77@gmail.com
Co-supervisor: ix@ukzn.ac.za

Biomedical Research Ethics Committee
Professor V Ramdath (Chair)
Westville Campus, Govan Mbeki Building
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Telephone: +27 (0) 31 260 2488 Facsimile: +27 (0) 31 260 8800 Email: ix@ukzn.ac.za
Website: <http://www.ukzn.ac.za/research-ethics/Biomedical-Research-Ethics.aspx>



Appendix 4: IRB from Wolaita Sodo University, Ethiopia

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Wolaita Sodo University
Wolaita Sodo

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Vice President for Research and Community Services

#T/C/Ref.no WISU 15/D4/147

#Y/Date 12-09-2018

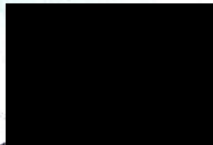
To: Mr.Mengistu Meskele Koyira

Wolaita Sodo University

Subject: Ethical Clearance

Your research project proposal entitled "Intimate Partner Violence against Women Living with and without HIV: Contexts and Associated Factors in Wolaita Zone, Ethiopia" has been reviewed by the Institutional Review Board of Wolaita Sodo University for its ethical soundness, it is found to be ethically acceptable.

Thus, the Research and Community Service Vice President Office has awarded this ethical clearance for the stated study to be carried by Mr.Mengistu Meskele Koyira as of September 10, 2018. The investigators are expected to submit their research progress report to the Research and Community Service Vice President Office of the University.



ዶ/ር ታደሰ ልብረት
Takele Tadesse Adafrie (PhD)



የምርምርና ግብይት ህዝብ አገልግሎት ጽ/ቤት
Vice President for Research
Community Services

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In replying, please quote our ref. number.

Appendix 6: Site permission (Sample 1)

ቁጥር:Ref.No: 4/609/2011
 ቀን/Date: 7/2/2011



ለ-ወለይታ ስዩኒቨርሲቲ ሪፖርት-----ሆስፒታል/ጤና ጣቢያ

ጉዳይ: **ለምርምር ሥራ ፈቃድ ስለመስጠት ይሆናል/Site permission**

ከላይ በርዕሱ እንደተገለጸው መ/ር መንግሥቱ መስቀሌ በወላይታ ስዩኒቨርሲቲ መምህርና በኩዋንዙሉ-ናታል ዩንቨርሲቲ የ"Ph.D" ተማሪ ሲሆኑ በወላይታ ዞን ላይ ስለ እናቶች ጤና እና የሕይወት ተሞክሯቸውን ላይ ጥናት ለማካሄድ ከደቡብ አፍሪካ ኩዋንዙሉ-ናታል ዩንቨርሲቲ "Ethical Approval" በቁጥር BREC : Ref.No: BE 387/18 Date: 18 Sep. 2018 እንዲሁም ከወላይታ ስዩኒቨርሲቲ ተጨማሪ "Ethical Approval" በቁጥር : WSU:15/04/147 በቀን: 12 Sep. 2018 ያገኙና ከዞን ጤና መምሪያ : ወዘጤ/10341224 ቀን: 16/12/2010ዓ/ም ፈቃድ ያገኙ ስለሆነ በ-ወለይታ ስዩኒቨርሲቲ ሪፖርት-----ሆስፒታል /ጤና ጣቢያ ምርምራቸውን እንዲሠሩ የተፈቀደ መሆኑን እንገልጻለን።

Mr. Mengistu Meskele's research study on women's health and life experience has been ethically approved from University of KwaZulu-Natal, BREC : Ref.No: BE 387/18 Date: 18 Sep. 2018 , Wolaita Sodo University and also got permission from Wolaita Zone Health Department under the Ref.No: ወዘጤ/10341224 Date: 16/12/2010 E.C. Hence Wolaita Sodo Teaching & Ref Hospital/health center has permitted Mr. Mengistu Meskele to conduct the research.

ግልበጭ/CC ሪፖርት
 ለ-ወለይታ ስዩኒቨርሲቲ ሪፖርት-----ሆስፒታል/ጤና ጣቢያ

ከሠላምታ ደርግ

ዶ/ር ሉቃስ ድንጋቱ ዲዳና
Dr. Lukas Dingato Didana
ጅና ክሊኒካል ዳይሬክቶር
Chief Clinical Director



Appendix 7: Site permission (Sample 2: Obtained from nine facilities)



P.O. Box 305
 Wolaitta Soddo, Ethiopia
 Phone: 046 551 1163
 hospluke@ethionet.et

Reference no. SC/10166/11
 Date: 12/02/2011

ሰለቶ መንግሥቱ መስቀል
ባለ-ቤት!

ጉዳዩ:- ለምርምር ሥራ ፈቃድ ስለመስጠት ይሆናል/Site permission!

ከላይ በርዕሱ እንደተገለጸው መ/ር መንግሥቱ መስቀል በወላይታ ሶዶ ዩኒቨርሲቲ መምህርና በኩዋንዙሉ ናታል ዩኒቨርሲቲ የ"Ph.D" ተምሪ ሲሆኑ በወላይታ ዞን ላይ ስለ እናቶች ጤና እና የሕይወት ተምክሯቸው ላይ ጥናት ለማካሄድ ከደቡብ አፍሪካ ኩዋንዙሉ-ናታል ዩኒቨርሲቲ "Ethical Approval" በቁጥር BREC: Ref.No: BE 387/18 Date: 18 Sep. 2018 እንዲሁም ከወላይታ ሶዶ ዩኒቨርሲቲ ተጨማሪ "Ethical Approval" በቁጥር: WSU: 15/04/147 በቀን 12 Sep. 2018 ያገኙና ከዞን ጤና መምሪያ: ወ/ጤ/10341224 ቀን: 16/12/2010 ዓ.ም ፈቃድ ያገኙ ስለሆነ በሶዶ ክርስቲያን ሆስፒታል ምርምራቸውን እንዲሠሩ የተፈቀደ መሆኑን እንገልጻለን።

Mr. Mengistu Meskele's research study on women's health and life experience has been ethically approved from University of KwanZulu-Natal, BREC: Ref. No: BE 387/18 Date: 18 Sep. 2018, Wolaitta Sodo University and also got permission from Wolaitta Zone Health Department under the Ref. No: ወ/ጤ/10341224 Date: 16/12/2010 E.C. Hence Soddo Christian Hospital/health center has permitted Mr. Mengistu Meskele to conduct the research.

ገልባጭ:-

- ለሶዶ ሆስፒታል
ሰዶ!

Officers
 Duane Anderson, M.D.
 Field Director

Desalegn Enaro, M.
 Chief Administrator

Ephrem G/Selasie
 Chief Operations Officer

Dr. Ephrem Goh
 Medical Director

Ephrem G/silassie
 Chief Operations Officer

To Serve, Not to be Served.

Appendix 8: Information sheet, consent form and questionnaire (In-depth-interview with women)

Information Sheet and Consent to Participate in Research

Date: -----

Greetings, my name is -----I am Mr. Mengistu Meskele Koyira, a Ph. D student at the University of KwaZulu-Natal (UKZN), and a former staff member of Wolaita Sodo University, my contact address is (+251913177996 or E-mail address: mengistu77@gmail.com). You are being invited to consider participating in a study that involves research in **“Intimate Partner Violence Against Women living with and without HIV: Contexts and associated factors in Wolaita Zone, Ethiopia”**. The aim and purpose of this research is to learn about women’s health and life experiences and to generate evidence from this area. The study is expected to enrol up to 25 interviewees, but it depends on the information we get. We will conduct similar interviews at nine health facilities in Wolaita Zone. It will involve the following procedures. We are going to interview you, record the audio and take notes. The duration of your participation, if you choose to enrol and remain in the study, is expected to be 45 minutes.

The study may involve the following risks and/or discomforts. By participating in this research project, you may have minimum discomfort to disclose your painful experience, though, many women have found it helpful to have the opportunity to talk. We will also refer to psychological intervention or a counselling service at a healthcare facility in case you get discomfort. We (the research assistant) will also provide counselling at the end of the interview. The study will help to generate local evidence to assist with the initiation and implementation of programmes to address intimate partner violence against women.

This study has been ethically reviewed and approved by the UKZN Biomedical Research Ethics Committee (approval number-----).

In the event of any problems or concerns/questions you may contact the researcher Mr Mengistu Meskele (at +251913177996 or E-mail address: mengistu77@gmail.com) or the UKZN Biomedical Research Ethics Committee, contact details as follows:

Biomedical Research Ethics Administration
Research Office, Westville Campus
Govan Mbeki Building
Private Bag X 54001
Durban
4000
KwaZulu-Natal, SOUTH AFRICA
Tel: 27 31 2604769 - Fax: 27 31 2604609

Email: BREC@ukzn.ac.za

Your participation in this research is entirely voluntary. Your experiences could be beneficial to other women in Ethiopia. You may withdraw from participation at any point, and in the event of refusal/withdrawal from participation, the participant will not incur penalty or loss of treatment or another benefit to which they usually are entitled. There is no direct benefit to your participation, but many women have found it helpful to have the opportunity to talk.

I kindly let you know that all of the answers you provide me will be kept secret. The researcher will not keep the record of your name or address. We will record the audios, but all will remain secret, and your names will not be mentioned in any documents. Any information from the participants like raw data will be stored securely and kept confidential. The publications that will arise from this study will exclude any information that will make it possible to identify the participants' name or identity. In case others enter the room during the interview, dummy questionnaires will be used.

Consent

I (-----) have been informed about the study entitled Intimate partner violence against women living with and without HIV: Contexts and associated factors in Wolaita Zone, Ethiopia by Mr Mengistu Meskele Koyira.

I understand the purpose and procedures of the study.

I have been given an opportunity to answer questions about the study and have had answers to my satisfaction.

I declare that my participation in this study is entirely voluntary and that I may withdraw at any time without affecting any treatment or care that I would usually be entitled to.

I have been informed about any available compensation or medical treatment if an injury occurs to me as a result of study-related procedures.

If I have any further questions/concerns or queries related to the study I understand that I may contact the researcher Mr Mengistu Meskele at +251913177996 or E-mail address: mengistu77@gmail.com.

If I have any questions or concerns about my rights as a study participant, or if I am concerned about an aspect of the study or the researchers, then I may contact:

Biomedical Research Ethics Administration

Research Office, Westville Campus

Govan Mbeki Building

Private Bag X 54001

Durban

4000

KwaZulu-Natal, SOUTH AFRICA

Tel: 27 31 2604769 - Fax: 27 31 2604609

Email: BREC@ukzn.ac.za

Agree to audio recording Yes ----- No-----

Signature of participant Date

Witness name

1.-----

2.-----

Interviewer name

Questionnaires for In-depth-Interview with Women

1. I would like you to tell me a little about yourself.
Have you attended a formal school?
Where is your residence now?
Do you have children?
How do you usually spend your days?
What things do you like to do?
2. Tell me about your husband. How did you first meet? When did you get married?
What does he do? When did your problems with your husband start? How long has this continued?
3. Are there times when this has improved or got worse?
4. Can you give examples of physical violence in your community? In your life?
When and where does physical violence occur?
5. Are women forced to have sex with their partner/husband? Under what circumstances?
Who usually decides how, when and how often to have sex between partners? Do men force their partners to have sex even if they do not want to? Can you give examples of sexual violence in your community? In your life? When and where does sexual violence occur?
6. Who are the perpetrators? For physical or sexual violence (PROBE: Your husband/ family member, people you know/don't know)? What happens to the perpetrators?
7. What are the problems that women face after an attack? (PROBE: physical, psychological, social problems)
8. How do survivors of physical violence cope after the attack? How do survivors of sexual violence cope after the attack?
9. What are community responses when sexual/physical violence occurs? What is done to prevent violence?
10. What is done to help survivors? How could these efforts be improved? Do women's support networks exist to help survivors?

11. What social and legal services exist to help address these problems? (PROBE: health, police, legal counselling, social counselling) Who provides these services? How could these efforts be improved?
12. Has the problem of physical/sexual violence got worse, better, or stayed the same since you arrived in Wolaita?
13. Has it had a significant effect on your physical well-being? In what ways? How has it affected your feelings about yourself? Do you think that it is having an effect on your children? In what ways?
14. Has it affected your ability to provide for the family or go to work?
15. Has it made it difficult for you to meet friends or relatives? How?
16. Have you ever discussed your problems with others? How did they respond?
17. Was there more that you would have liked them to do?
18. What sort of things would have helped?
19. Looking back at your situation, what advice would you give another woman?
20. Who has just started to have these sorts of problems with her husband?

Questions for people living with HIV

21. Do you think it is good for a woman to inform her partner about her HIV test results? Why do you say so? PROBE.
22. Why do some women fail to collect their HIV test results?
 - a. Fail to join PMTCT/ART programme?
 - b. What makes some women decide to accept the test?
23. What is the best time/opportunity to inform the male partner?
24. How would you inform him if you wanted to?
25. How do you think a husband/partner might react after you tell him your status (that you are HIV-positive)
26. Who else do you think women inform about their HIV status?
27. What do you think happens to a woman who makes her status known to her partner? Probe several actions and behaviours!
28. What do you think happens when women tell other people about their status?
29. How involved are men in the ART programme? Are men supportive of women to test during pregnancy and at other times?

Thank you very much for your time!

Appendix 9: Information sheet, consent form and focus group discussion guide for women living with and without HIV

Information Sheet and Consent to Participate in Research

Date:-----

How are you? My name is ----- I am Mr Mengistu Meskele Koyira, a PhD student at the University of KwaZulu-Natal, and former staff of Wolaita Sodo University, my contact address is (+251913177996 or E-mail address: mengistu77@gmail.com). You are being invited to consider participating in a study that involves research in “Intimate Partner Violence Against Women living with and without HIV: Contexts and associated factors in Wolaita Zone, Ethiopia”. The aim and purpose of this research is to learn about women’s health and life experiences and to generate evidence from this area. The study is expected to enrol up to four Focus Group Discussion participants, but it depends on the information we get. We will conduct similar other discussions in the nine health facilities in Wolaita Zone. It will involve the following procedures. We are going to interview you, record the audio and take notes. The duration of your participation, if you choose to enrol and remain in the study, is expected to be 55 minutes.

The study may involve the following risks and/or discomforts. By participating in this research project, you may have minimum discomfort to disclose your painful experience, though, many women have found it helpful to have the opportunity to talk. We will also refer to psychological intervention or a counselling service at a healthcare facility in case you get discomfort. We (the research assistant) will also provide counselling at the end of the interview. The study will help to generate local evidence to assist with the initiation and implementation of programmes to address intimate partner violence against women.

This study has been ethically reviewed and approved by the UKZN Biomedical Research Ethics Committee (approval number-----).

In the event of any problems or concerns/questions you may contact the researcher Mr Mengistu Meskele (at +251913177996 or E-mail address: mengistu77@gmail.com) or the UKZN Biomedical Research Ethics Committee, contact details as follows:

Biomedical Research Ethics Administration
Research Office, Westville Campus
Govan Mbeki Building

Private Bag X 54001
Durban
4000

KwaZulu-Natal, SOUTH AFRICA

Tel: 27 31 2604769 - Fax: 27 31 2604609

Email: BREC@ukzn.ac.za

Your participation in this research is entirely voluntary. Your experiences could be beneficial to other women in Ethiopia. You may withdraw participation at any point, and that in the event of refusal/withdrawal of participation, the participants will not incur penalty or loss of treatment or another benefit to which they usually are entitled.

There are soft drinks like Coca-Cola, tea and coffee for your time but no other direct benefit to your participation, but many women have found it helpful to have the opportunity to talk.

I kindly let you know that all of the answers you provide me will be kept secret. The researcher will not keep the record of your name or address. We will record the audios, but all will have remained secret, and your names will no longer be mentioned at any documents. Any information from the participants like raw data will be stored securely and kept confidential. The publications that will arise from this study will exclude any information that will make it possible to identify the participants' name or identity. In case others enter the room, dummy questionnaires will be used.

Consent

I (-----) have been informed about the study entitled (Intimate partner violence against women living with and without HIV: Contexts and associated factors in Wolaita Zone, Ethiopia by Mr Mengistu Meskele Koyira.

I understand the purpose and procedures of the study.

I have been given an opportunity to answer questions about the study and have had answers to my satisfaction.

I declare that my participation in this study is entirely voluntary and that I may withdraw at any time without affecting any treatment or care that I would usually be entitled to.

I have been informed about any available compensation or medical treatment if an injury occurs to me as a result of study-related procedures.

If I have any further questions/concerns or queries related to the study, I understand that I may contact the researcher Mr Mengistu Meskele (+251913177996 or E-mail address: mengistu77@gmail.com).

If I have any questions or concerns about my rights as a study participant, or if I am concerned about an aspect of the study or the researchers, then I may contact:

BIOMEDICAL RESEARCH ETHICS ADMINISTRATION

Research Office, Westville Campus

Govan Mbeki Building

Private Bag X 54001

Durban

4000

KwaZulu-Natal, SOUTH AFRICA

Tel: 27 31 2604769 - Fax: 27 31 2604609

Email: [BREC@ukzn.ac.za](mailto: BREC@ukzn.ac.za)

Agree to audio recording Yes ----- No-----

Signature of participant Date

Witness name

1.-----

2.-----

Interviewer name

Questionnaire: FGD guide for women living with and without HIV

1. What problems have women experienced in health in your community? (**PROBE:** on violence, not on health.) What type of unwanted actions or behaviour do men do to their partners? **PROBE:** financially, emotionally, physically, sexually? **PROBE**
2. Can you give me examples of physical violence in your community? In your life?
3. When and where does physical violence occur? Has it had a great effect on your physical well-being? In what ways?
4. How has it affected your feelings about yourself?
5. Are women forced to have sex with their partner/husband? Under what circumstances? Can you give examples of sexual violence in your community? In your life?
6. When and where does sexual violence occur? Who usually decides how, when and how often to have sex between partners? Do men force their partners to have sex even if they do not want to? Are women abused for testing for HIV?
7. Who are the perpetrators? For physical/sexual violence (**PROBE:** Your husband/ family member, people you know/don't know.) What happens to the perpetrators?
8. What are the problems that women face after an attack? (**PROBE:** physical, psychological, social problems.)
9. How do survivors of physical/sexual violence cope after the attack? Where do women get help (report) if they are abused by their partners?
10. Has it made it difficult for you to meet friends or relatives? How?
11. What are community responses when physical or sexual violence occurs? What is done to prevent violence?
12. What is done to help survivors? How could these efforts be improved? Do women's support networks exist to help survivors?
13. What social and legal services exist to help address these problems? (**PROBE:** health, police, legal counselling, social counselling.) Who provides these services? How could these efforts be improved?
14. Has the problem of physical/sexual violence got worse, better, or stayed the same?
15. Is there anything that religious leaders can do to prevent physical or sexual violence? Is there anything women leaders can do to prevent sexual violence?

Questions for people living with HIV

16. Do you think it is suitable for a woman to inform her partner about her HIV test results? Why do you say so? **PROBE:** Why do some women fail to collect their HIV test results?
- a. Fail to join PMTCT/ART programme?
 - b. What makes some women decide to accept the test?
17. What is the best time/opportunity to inform the male partner?
18. How would you inform partner if you wanted to?
19. How do you think a husband/partner might react after you tell him your status (that you are HIV positive)?
20. Who else do you think women inform about their HIV status?
21. What do you think happens to a woman who makes her status known to her partner? **PROBE:** several actions and behaviours. What do you think happens when women tell other people about their status?
22. What could happen to a woman after she discloses her HIV test results to a husband/partner?
23. How involved are men in the ART programme? Are men supportive of women to test during pregnancy and at other times?

Appendix 10: Information sheet, consent form and questionnaire (In-depth-interview for the service provider)

Information Sheet and Consent to Participate in Research

Date:-----

How are you? My name is ----- / I am Mengistu Meskele Koyira, a PhD student at the University of KwaZulu-Natal (UKZN), and former staff of Wolaita Sodo University, my contact address is (+251913177996 or E-mail address: mengistu77@gmail.com). You are being invited to consider participating in a study that involves research in **“Intimate partner violence against women living with and without HIV: Contexts and associated factors in Wolaita Zone, Ethiopia”**. The aim and purpose of this research is to learn about women’s health and life experiences and to generate local evidence. The study is expected to enrol up to 25 interviewees, but it depends on the information we get. We will conduct similar other interviews in the nine health facilities in Wolaita Zone. It will involve the following procedures. We are going to interview you, record the audio and take notes. The duration of your participation, if you choose to enrol and remain in the study, is expected to be 45 minutes.

The study may involve the following risks and/or discomforts. By participating in this research project, you may have minimum discomfort to disclose your painful experience, though, many women have found it helpful to have the opportunity to talk. We will also refer to psychological intervention or a counselling service at a healthcare facility in case you get discomfort. We (the research assistant) will also provide counselling at the end of the interview. The study will help to generate local evidence to assist with the initiation and implementation of programmes to address intimate partner violence against women.

This study has been ethically reviewed and approved by the UKZN Biomedical Research Ethics Committee (approval number-----).

In the event of any problems or concerns/questions you may contact the researcher Mr Mengistu Meskele (at +251913177996 or E-mail address: mengistu77@gmail.com) or the UKZN Biomedical Research Ethics Committee, contact details as follows:

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Research Office, Westville Campus

Govan Mbeki Building

Private Bag X 54001

Durban

4000

KwaZulu-Natal, SOUTH AFRICA

Tel: 27 31 2604769 - Fax: 27 31 2604609, Email: BREC@ukzn.ac.za

Your participation in this research is entirely voluntary. Your experiences could be beneficial to other women in Ethiopia. You may withdraw from participation at any point, and in the event of refusal/withdrawal of participation, the participants will not incur penalty or loss of treatment or another benefit to which they are normally entitled. There is no direct benefit to your participation, but many women have found it helpful to have the opportunity to talk.

I kindly let you know that all of the answers you provide me will be kept secret. The researcher will not keep the record of your name or address. We will record the audios, but all will remain secret, and your names will not be mentioned in any documents. Any information from the participants like raw data will be stored securely and kept confidential. The publications that arise from this study will exclude any information that will make it possible to identify the participants' name or identity. In case others enter the room during the interview, dummy questionnaires will be used.

Consent

I (-----) have been informed about the study entitled **Intimate partner violence against women living with and without HIV: Contexts and associated factors in Wolaita Zone, Ethiopia** by Mr Mengistu Meskele Koyira.

I understand the purpose and procedures of the study.

I have been given an opportunity to answer questions about the study and have had answers to my satisfaction.

I declare that my participation in this study is entirely voluntary and that I may withdraw at any time without affecting any treatment or care that I would usually be entitled to.

I have been informed about any available compensation or medical treatment if an injury occurs to me as a result of study-related procedures.

If I have any further questions/concerns or queries related to the study I understand that I may contact the researcher Mr Mengistu Meskele (+251913177996 or E-mail address: mengistu77@gmail.com).

If I have any questions or concerns about my rights as a study participant, or if I am concerned about an aspect of the study or the researchers, then I may contact:

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Govan Mbeki Building

Private Bag X 54001
Durban
4000

KwaZulu-Natal, SOUTH AFRICA

Tel: 27 31 2604769 - Fax: 27 31 2604609

Email: PREC@ukzn.ac.za

Agree to audio recording Yes ----- No-----

Signature of participant Date

Witness name

1.-----

2.-----

Interviewer name

Questionnaire: Semi-structured in-depth-interview questions for a service provider

1. What is your role or responsibility in this facility?
2. What are the most frequent reasons women give for coming to the office/emergency room?
3. Are cases of family or intimate partner violence seen? What are the most common types of abuse that you identify? Do you think it is good to screen for violence?
4. Do you and your staff members routinely ask questions to determine whether the patient might be a victim of family violence? Why? How? What instruments do you use? How often?
5. What tests or examinations do you routinely perform when a woman indicates that she has been the victim of violence? How do you decide which tests to perform?
6. What are the challenges for screening for abuse?
7. Were you trained to screen for abuse? How do you recognize that they are abused?
8. What types of abuse do you detect?
9. Do women disclose, without being asked, the abuse they experienced?
10. What form of education would you need regarding violence against women? How do you handle them? Do you detect them on your own or do women report them to you?

11. What is the procedure for obtaining an official report from the medical examiner?
12. How many people with this type of problem does your institution serve per month? Do you have a way of keeping records on cases? Is there a form and procedure for recording them? Can you explain it to me? (Request a copy of the record form, referral slips, and any other documents that may exist.)
13. Do you or your staff provide follow-up care to women who have been victims of family violence? Are there mechanisms for referring them to other institutions? Do you think the record-keeping system is adequate to identify women affected by family violence, refer them to the appropriate services, and provide timely follow-up services?
14. Have you ever come into contact with cases of family violence among your clients? Can you tell me how these experiences originated, what you did, and what the client did?
15. Do you know of other organizations or persons in this community that work on family violence issues? Who are they? What is your relationship with them? Is there coordination with other institutions to address the needs of abused women?
16. What changes in legislation, policy, or staffing would facilitate your work?
17. What changes in the behaviours or attitudes of the person with whom you work would facilitate your work?
18. Do you think the partner violence can interfere with the treatment and care of ART drugs?
How?
19. Do you encourage women to disclose their HIV test results to their partners? Do they disclose? After how long? With what results? Do you think their partners know their results? Do you think they know their partner's results?
20. How do you think a husband/partner might react after women tells him her status (that she is HIV-positive)?

Thank you!

Appendix 11. Quantitative study information sheet, consent form and questionnaire for women
Information Sheet and Consent to Participate in Research

Date: -----

How are you? My name is ----- I provide the information about the researcher Mr. Mengistu Meskele Koyira, a PhD student at the University of KwaZulu-Natal (UKZN), and former staff of Wolaita Sodo University, his contact address is +251913177996 or E-mail address: mengistu77@gmail.com. You are being invited to consider participating in a study that involves research in “Intimate partner violence against women living with and without HIV: Contexts and associated factors in Wolaita Zone, Ethiopia”. The aim and purpose of this research is to learn about women’s health and life experiences and to generate local evidence. The study is expected to enrol 816 participants. We will conduct this study in the nine health facilities in Wolaita Zone. It will involve the following procedures. We are going to ask you questions on women’s health and life experience. All answers that you may provide me are acceptable. The duration of your participation, if you choose to enrol and remain in the study, is expected to be 45 minutes.

The study may involve the following risks and/or discomforts. By participating in this research project, you may have minimum discomfort to disclose your painful experience, though, many women have found it helpful to have the opportunity to talk. We will also refer to psychological intervention or a counselling service at a healthcare facility in case you get discomfort. We (the research assistant) will also provide counselling at the end of the interview. The study helps to generate local evidence to assist with the initiation and implementation of programmes to address intimate partner violence against women.

This study has been ethically reviewed and approved by the UKZN Biomedical Research Ethics Committee (approval number-----).

In the event of any problems or concerns/questions you may contact the researcher Mr Mengistu Meskele (at +251913177996 or E-mail address: mengistu77@gmail.com) or the UKZN Biomedical Research Ethics Committee, contact details as follows:

Biomedical Research Ethics Administration

Research Office, Westville Campus

Govan Mbeki Building

Private Bag X 54001

Durban

4000

KwaZulu-Natal, SOUTH AFRICA

Tel: 27 31 2604769 - Fax: 27 31 2604609

Email: [BREC@ukzn.ac.za](mailto: BREC@ukzn.ac.za)

Your participation in this research is completely voluntary. Your experiences could be very helpful to other women in Ethiopia. You may withdraw from participation at any point, and in the event of refusal/withdrawal of participation the participants will not incur penalty or loss of treatment or another benefit to which they are normally entitled. There is no direct benefit to your participation, but many women have found it helpful to have the opportunity to talk.

I kindly let you know that all of the answers you provide me will be kept secret. The researcher will not keep a record of your name or address. Any information from the participants like raw data will be stored securely and kept confidential. The publications that arise from this study will exclude any information that will make it possible to identify the participants' name or identity. In case others enter the room during the interview, dummy questionnaires will be used.

CONSENT

I (-----) have been informed about the study entitled Intimate partner violence against women living with and without HIV: Contexts and associated factors in Wolaita Zone, Ethiopia by Mr Mengistu Meskele Koyira.

I understand the purpose and procedures of the study.

I have been given an opportunity to answer questions about the study and have had answers to my satisfaction.

I declare that my participation in this study is entirely voluntary and that I may withdraw at any time without affecting any treatment or care that I would usually be entitled to.

I have been informed about any available compensation or medical treatment if an injury occurs to me as a result of study-related procedures. If I have any further questions/concerns or queries related to the study I understand that I may contact the researcher Mr Mengistu Meskele (+251913177996 or E-mail address: mengistu77@gmail.com).

If I have any questions or concerns about my rights as a study participant, or if I am concerned about an aspect of the study or the researchers, then I may contact:

Biomedical Research Ethics Administration

Research Office, Westville Campus

Govan Mbeki Building

Private Bag X 54001

Durban

4000

KwaZulu-Natal, SOUTH AFRICA

Tel: 27 31 2604769 - Fax: 27 31 2604609

Email: PREC@ukzn.ac.za

Signature of participant

Date

Witness name

1.-----

2.-----

3. Interviewer name -----

Section I: Quantitative data for a quantitative study: Socio-demographic and economic characteristics

No	Questions	Response	Skip
	Client HIV status	1. ART client 2. HIV-negative women	
S1	How old are you now?	Age in completed years-----	
S2	What is your residence type?	1. Urban 2. Rural	
S3	What is your current marital status?	1. Currently married/living with man 2. Living with man not married 3. Currently having a regular partner living apart 4. Not currently married or living with a man	GoS7 GoS7 GoS7
S4	Have you ever been married or lived with a male partner?	1. Yes, married 2. Yes, lived with a man, but never married 3. No	
S5	Did the last partnership with a man end in divorce or separation, or did your husband partner die?	Divorced1 Separated/broken up 2 Widowed/partner died3	Go S7
S6	Was the divorce/separation initiated by you, by your husband/partner, or did you both decide that you should separate?	Respondent.....1 Husband/partner2 Both (respondent and partner)3 Other:4	
S7	How many times in your life have you been married and/or lived together with a man?	Number of times married/lived together ----- Refused/no answer -----8	

S8	Does/did your husband/partner have any other wives while being married (having a relationship) with you?	Yes.....1 No.....2 Don't know/don't remember.....3 Refused/no answer 4	
S9	How many wives/partners does/did he have (including yourself)?	Number of wives Refused/no answer8	
S10	Are/were you the first, second..... wife/partner?	Number/position [][] Refused/no answer8	
S11	Did you choose your current/most recent husband, did someone else choose him for you, or did he choose you? IF SHE DID NOT CHOOSE HERSELF, PROBE: Who chose your current/most recent husband/partner for you?	Both chose1 Respondent chose.....2 Respondent's family chose3 Partner chose4 Partner's family chose..... 5 Church.....6 Don't know/don't remember7	
S12	Before the marriage with your current/most recent husband, were you asked whether you wanted to marry him or not?	Yes1 No.....2 Don't know/don't remember...3 Refused/no answer.....4	
S13	Did your marriage involve bride price payment?	Yes/dowry1 Yes/bride price.....2 No3 Don't know/don't remember..4	
S14	Has all of the bride price been paid, or does some part still remain to be paid?	1. All paid 2. Partially paid 3. None paid 4. Don't know/don't remember	
S15	What is the size of your household?	-----	
S16	What is your religion?	1. Orthodox 2. Muslim 3. Protestant 4. Catholic 5. Traditional 6. Apostolic 7. Other, specify	
S17	What is your ethnicity?	1. Wolaita 4. Gurage 2. Amara 5. Oromo 3. Dawuro 6. Other/specify---	

S18	What is your occupation? (Women)?	1. Housewife 2. Trader 3. Student 4. Government/NGO employee 5. Daily laborer 6. Other, specify-----	
S19	What is your husband's occupation?	1. Farmer 2. Government employee 3. Merchant 4. Daily laborer 5. NGO 6. Other/specify	
S20	Have you ever attended formal school?	1. Yes 2. No	If no go S22
S21	What is the highest grade you have completed?	Grade completed.....	
S22	Has your husband attended formal education?	Yes.....1 No.....2	"no" GO S24
S23	What is your husband's highest grade he has completed?	Formal grade completed-----	
S24	What is your monthly income?	Ethiopian Birr: -----	
S25	Does your household have a functioning: [Write '1' if Yes & '0' if No] W1. Television ___ W2. Radio ___ W3. Satellite dish ___ W4. Mobile phone ___ W5. Cell phone (home) ___ W6. Table ___ W7. Chair [] 8. Bed/cotton/spring/mattress/ 9. Electric Mitad ___ W10. Bicycle ___ W11. Motor bicycle /Bajaji ___ W12. Refrigerator ___ W13. Electricity 14. Tractor/car 15. Farm land/town land 16. 'Enjera Mitad' (Wood) 17. Electric stove []		

Section II. Thinking about your (current or recent) husband/partner, would you say it is generally true that he... (Decision making subscale)

S.No	Questioner	Y es	No	DK
D27	Tries to keep you from seeing your friends?	1	2	8

D28	Tries to restrict contact with your family of birth?	1	2	8
D29	Insists on knowing where you are at all times?	1	2	8
D30	Ignores you and treats you indifferently?	1	2	8
D31	Gets angry if you speak with another man?	1	2	8
D32	Is often suspicious that you are unfaithful?	1	2	8
D33	Expects you to ask his permission before seeking healthcare for yourself?	1	2	8

Section III: The next questions are about things that happen to many women, and that your **current partner, or any other partner** may have done to you. Has your current husband or partner or any other partner ever... **(Emotional violence)**

S.N	Questions (Physical violence) Has he or any other partner ever...	A) If		B) Has		C) In the past 12			D) Before the past		
		Yes	No	Yes	No	One	Few	Many	One	Few	Many
P38	Slapped you or thrown something at you that could hurt you?	1	2	1	2	1	2	3	1	2	3
P39	Pushed you or shoved you or pulled your hair?	1	2	1	2	1	2	3	1	2	3
P40	Hit you with his fist or with something else that could hurt you?	1	2	1	2	1	2	3	1	2	3
P41	Kicked you, dragged you or beat you up?	1	2	1	2	1	2	3	1	2	3
P42	Choked or burnt you on purpose?	1	2	1	2	1	2	3	1	2	3
P43	Threatened to use or actually used a gun, knife or other weapon against you?	1	2	1	2	1	2	3	1	2	3

S.N.	Questions	A) If Yes continue with B. If NO skip to next item		B) Has this happened in the past 12 months? (If Yes ask C only. If No ask D only)		C) In the past 12 months would you say that this has happened once, a few times or many times? (After answering C, go to next item)			D) Before the past 12 months would you say that this has happened once, a few times or many times?		
		Y es	N o	Y es	No	O ne	F ew	Ma ny	On e	F ew	M any
E34	Insulted you or made you feel bad about yourself?	1	2	1	2	1	2	3	1	2	3
E35	Belittled or humiliated you in front of other people?	1	2	1	2	1	2	3	1	2	3
E36	Done things to scare or intimidate you on purpose (e.g. by the way he looked at you, by yelling and smashing things)?	1	2	1	2	1	2	3	1	2	3
E37	Threatened to hurt you or someone you care about?	1	2	1	2	1	2	3	1	2	3

S.N	(Sexual violence) Has he or any other partner ever...	A) If Yes continue with B. If No skip to next item		B) Has this happened in the past 12 months? (If Yes ask C only. If No ask D only)		C) In the past 12 months would you say that this has happened once, a few times or many times? (After answering C, go to next item)			D) Before the past 12 months would you say that this has happened once, a few times or many times?		
		Yes	No	Yes	No	One	Few	Many	One	Few	Many
S44	Did your current husband/partner or any other partner ever physically force you to have sexual intercourse when you did not want to?	1	2	1	2	1	2	3	1	2	3
S45	Did you ever have sexual intercourse you did not want to because you were afraid of what your partner or any other partner might do?	1	2	1	2	1	2	3	1	2	3
S46	Did your partner or any other partner ever force you to do something sexual that you found degrading or humiliating?	1	2	1	2	1	2	3	1	2	3

S.N.				
P47	Verify whether answered yes to any question on physical violence. See Question Number P38-S43.	1. Yes, physical violence 2. No, physical violence		
S48	Verify whether answered yes to any question on sexual violence. See Question S44-S46	1. Yes, sexual violence 2. No sexual violence		
I49	Have you ever been pregnant?	1. Yes 2. No		If 2 Go to I52
I50	You said that you have been pregnant: TOTAL number of times. Was there ever a time when you were slapped, hit or beaten by (any of) your husband/partner(s) whilst you were pregnant?	1. Yes 2. No 3. Don't know/don't remember 4. Refused/no answer		If 2,3,4 Go to I53
I51	Did you miscarry as a result of violence?	1. Yes 2. No		
I52	Have you ever been injured (physical harm, including cuts, sprains, burns, broken bones or broken teeth) as a result of these acts by (any of) your husband/partner(s)? Please think of the acts that we talked about before.	1. Cuts, punctures, bites 2. Scratches, abrasion, bruises 3. Sprains, dislocations 4. Burns 5. Penetrating injury, deep cuts, gashes 6. Broken eardrum, eye injuries 7. Fractures, broken bones 8. Broken teeth 9. Others	Y es 1 1 1 1 1 1 1 1	No 2 2 2 2 2 2 2 2 2
I53	In your life, how many times were you injured by (any of) your husband/partner(s)? Would you say once or twice, several times or many times?	1. Once/twice 2. Several (3-5) times 3. Many (more than 5) times 4. Don't know/don't remember 5. Refused/no answer		
I54	Has this happened in the past 12 months?	1. Yes 2. No 3. Don't know/don't remember 4. Refused/no answer		
I55	Did you receive healthcare for your injury?	1. Yes, sometimes 2. Yes, always 3. No		
I56	Have you ever tried to seek help?	1. Yes		2. No

I57	Who did you tell about this behaviour of your partner (physical violence)?	No one.....1 Friends.....2 Parents.....3 Brother or sister.....4 Uncle or aunt.....5 Husband/partner's family.....6 Children7 Neighbours..... 8 Police9 Doctor/health worker.....10 Religious leader.....11 Counsellor12 NGO/Women's organisation13 Local leader.....14 Law organisation.....15 Other (specify): _____16
I58	Did anyone try to help you? Who tried to help you? MARK ALL MENTIONED PROBE: Who else?	No one.....1 Friends.....2 Parents.....3 Brother or sister.....4 Uncle or aunt.....5 Husband/partner's family.....6 Children7 Neighbours..... 8 Police9 Doctor/health worker.....10 Religious leader.....11 Counsellor12 NGO/Women's organisation.....13 Local leader.....14 Law organisation.....15 Other (specify): _____16

W59	During the times that you were hit, did you ever fight back physically or defend yourself? 1.Yes 2.No IF YES: How often? Would you say once or twice, several times or most of the time?	<ol style="list-style-type: none"> 1. Once or twice 2. Many times/most of the time 3. Don't know/don't remember 4. Refused/no answer
W	Have you ever hit or physically mistreated your husband/partner	

60	when he was not hitting or physically mistreating you? 1. Yes 2. No IF YES: How often? Would you say once or twice, several times or many times?	1. Once or twice 2. Many times 3. Don't know/don't remember 4. Refused/no answer
----	---	---

Section III: Lifetime experience of violence from relatives, other people that they know, and/or from strangers.

S.No.	Question		Ask only for those marked. How many times did this happen?		
			Once or twice	A few times	Many times
L61	<p>Since the age of 15, has anyone (FOR WOMEN WITH CURRENT OR PAST PARTNER) other than your partner/husband) ever beaten or physically mistreated you in any way?</p> <p>1. Yes 2. No</p> <p>IF YES: Who did this to you? PROBE: How about a relative? How about someone at school or work? How about a friend or neighbour? A stranger or anyone else?</p>	1. No one	1	2	3
		2. Father	1	2	3
		3. Stepfather	1	2	3
		4. Other male family member	1	2	3
		5. Female family member	1	2	3
		6. Teacher	1	2	3
		7. Police/soldier	1	2	3
		8. Male friend of family	1	2	3
		9. Female friend of family	1	2	3
		10. Boyfriend	1	2	3
		11. Stranger	1	2	3
		12. Someone at work	1	2	3
		13. Priest/religious	1	2	3
		14. Leader	1	2	3

S. No.	Question		How old were you during the incident?	How old was this person during the incident?	Ask only for those marked. How many times did this happen?		
					Once or twice	A few times	Many times
L62	Before the age of 15 , do you	1. No one			1	2	3

<p>remember if anyone in your family ever touched you sexually, or made you do something sexual that you didn't want to?</p> <p>1. Yes 2. No</p> <p>IF YES: Who did this to you? IF YES OR NO</p> <p>CONTINUE:</p> <p>How about someone at school?</p> <p>How about a friend or neighbour?</p> <p>Has anyone else done this to you?</p> <p>IF YES: Who did this to you?</p>	2. Father			1	2	3
	3. Stepfather			1	2	3
	4. Other male family member			1	2	3
	5. Female family member			1	2	3
	6. Teacher			1	2	3
	7. Police/soldier			1	2	3
	8. Male friend of family			1	2	3
	9. Female friend of family			1	2	3
	10. Boyfriend			1	2	3
	11. Stranger			1	2	3
	12. Someone at work			1	2	3
	13. Priest/religious			1	2	3
	14. Leader			1	2	3

S.N.	Characteristics	Response	Skip
L63	What did you do in your relationship when you encountered physical and or sexual violence?	1. Leave relationship temporarily 2. Leave relationship permanently 3. I didn't encounter violence 4. Other	
L64	What are the consequences of violence in your life?	1. Non-applicable 2. Self-humiliation 3. Problems in health and treatment 4. Social discrimination 5. Low access to basic needs	
H65	Does/Did your partner drink alcohol?	1. Yes 2. No	If 2 L69
H66	How often does(did) he get drunk? Often, only sometimes, or never?	1. Every day or nearly every day 2. Once or twice a week 3. 1 to 3 times in a month 4. Rarely 5. Don't know/don't remember 6. Refused/no answer	

S.N	Questions	Response	Res pon se		
H68	In the past 12 months, have you ever experienced any of the following problems, related to HIS drinking? a) money problems b) health problems c) conflict with family or friends d) problems with authorities (bar owner/police, etc.) x) other, specify				
			Yes	No	
		A) Money problems	1	2	
		B) Health problems	1	2	
		C) Conflict with family Or friends	1	2	
	D) Problems with authorities	1	2		
	E) Other:	1	2		
L69	Just now we talked about problems that may have bothered you in the past four weeks. I would like to ask you now: In your life, have you ever thought about ending your life?	Yes1 No.....2 Don't know/don't remember3 Refused/no answer4			
L70	Have you ever tried to take your own life?	Yes1 No2 Don't know/don't remember.....3			

		Refused/no answer.....4	
H71	Have you ever asked your current/most recent partner to use a condom?	Yes.....1 No2 Don't know/don't remember.....3 Refused/no answer.....4	
H72	Has your current/most recent husband/partner ever refused to use a condom?	Yes..... 1 No 2 Don't know/don't remember.....3 Refused/no answer.....4	If 1 Go L7 4
H73	In what ways did he let you know that he disapproved of using a condom? MARK ALL THAT APPLY	Told me he did not approve A Shouted/got angry B Threatened to beat me C Threatened to leave/throw me out of homeD Beat me/physically assaulted me.....E Took or destroyed methodF Accused me of being unfaithful/not a good woman..... G Laughed at me/not take me seriously .. H Said it is not necessaryI Other X	
L74	Now I would like to ask you about your first sexual intercourse. At what age were you when you first had sexual intercourse?	Completed years-----	
L75	Which of the following statements most closely describe your experiences the first time you had sexual intercourse? I was willing; I was persuaded; I was tricked; I was forced; I was raped	I was willing.....1 I was persuaded.....2 I was tricked.....3 I was forced4 I was raped.....5	
L76	Who was this with?	Husband/partner.....1 Boyfriend.....2 Teacher.....3 Father/family member.....4 Man from school/area.....5 Friend of the family.....6 Relative.....7 Stranger/unknown person.....8 Others..... 9	
L77	How old was he when you had sexual intercourse with him? Would you say he was.....	Year [][] Younger than me.....1 Same age with me.....2 1-2 years older than me.....3 3-5 years older than me.....4 5-10 years older than me.....5 More than 10 years older than me...6	

		Refused/no answer9	
L78	The number of sexual partners women have had differs a lot from person to person. Some women report having had one sex partner, some two or more, and still others report many, even 50 or more. In your life how many different men have you had sex with? IF NEEDED, PROBE: More or less; I do not need to know the exact number.	Partners [][] Don't know/don't remember.....1 Refused/no answer.....2	
L79	When you were a child, was your mother hit by your father (or her husband or boyfriend)?	Yes.....1 No.....2 Parents did not live together.....3 Don't know/don't remember.....4 Refused/no answer5	
L80	As a child, did you see or hear this violence?	Yes.....1 No.....2 Don't know/don't remember.....3 Refused/no answer.....4	
H81	As far as you know, was your (most recent) partner's mother hit or beaten by her husband?	Yes.....1 No2 Parents did not live together3 Don't know/don't remember4 Refused/no answer5	
H82	Did your (most recent) husband/partner see or hear this violence?	Yes.....1 No.....2 Don't know/don't remember.....3 Refused/no answer4	
H83	As far as you know, was your current/most recent husband/partner beaten regularly by someone in his family?	Yes.....1 No.....2 Don't know/don't remember....3 Refused/no answer.....4	
H84	Since you have known him, has he ever been involved in a physical fight with another man?	Yes1 No2 Don't know /don't remember.....3 Refused/no answer 4	
<p>SECTION IV: ATTITUDES TOWARDS PARTNER BEATING</p> <p>In this community and elsewhere, people have different ideas about families and what is acceptable behaviour for men and women in the home. I am going to read to you a list of statements, and I would like you to tell me whether you generally agree or disagree with the statement. There are no right or wrong answers.</p>			
A85	In your opinion, does a man have a good reason to hit/beat his wife if:		Yes No DK

	a) She does not complete her household work to his satisfaction b) She disobeys him c) She refuses to have sexual relations with him d) She asks him whether he has other girlfriends e) He suspects that she is unfaithful f) He finds out that she has been unfaithful	A) household B) disobeys C) no sex D) girlfriends E) suspects F) unfaithful	1 1 1 1 1 1	2 2 2 2 2 2	3 3 3 3 3 3	
A86	In your opinion, can a married woman refuse to have sex with her husband if: a) She doesn't want to b) He is drunk c) She is sick d) He mistreats her e) She suspects he has extra-marital sexual relations with another woman f) She suspects her husband has an STI/HIV	A) not want B) drunk C) sick D) mistreats E) suspects extra-marital sex F) suspects/knows STI/HIV	1 1 1 1 1 1	2 2 2 2 2 2	3 3 3 3 3 3	
RESPONDENT AND HER PARTNER						
H87	In general, do (did) you and your (current or most recent) husband/partner discuss the following topics together: a) Things that have happened to him in the day b) Things that happen to you during the day c) Your worries or feelings d) His worries or feelings	A) his day B) your day C) your worries D) his worries	Yes 1 1 1 1	No 2 2 2 2	DN 3 3 3 3	
H88	In general, do (did) you and your (current or most recent) husband/partner discuss together how you should have sex, when, how often?	Rarely1 Sometimes.....2 Often.....3 Don't discuss.....4 Refused/no answer.....5				
H89	In your relationship with your (current or most recent) husband/partner, how often would you say that you quarrelled? Would you say rarely, sometimes or often?	Rarely.....1 Sometimes.....2 Often.....3 Don't know/don't remember.....4 Refused/no answer.....5 Didn't quarrel at all ----- -6				
L90	Did you test for HIV?	Yes.....1 No.....2 Refused/no answer3				
ASK HIV positive only. GO to question L98 if women is HIV negative						
H91	Did you tell your husband or partner about your HIV test result?	Yes.....1 No.....2 Refused/no answer3				If 1 Go L9 3

L92	Are you planning to tell your husband/partner about your HIV test result?	Yes.....1 No.....2 Refused/no answer3	
L93	How long did it take you to disclose your HIV test results to your husband/partner?	Within three days.....1 Within a week2 Within a month3 Within three months4 Within six months5 Over six months.....6	
L94	What was his reaction after telling him or after he knew your HIV status?	Helped me.....1 Shouted at me.....2 Supported me.....3 Violence.....4 Emotional violence.....5 Thought about his HIV status6 Asked about my sexual history.....7 Consulted the doctor/nurse.....8 Threatened to beat me.....9 Threatened rejecting me.....10 Rejected me.....11 Withdrew sexual intercourse.....12 Took other sexual partners.....13 I don't know.....14 Was happy.....15 Other.....16	
L95	Do you think your relationship with your partner changed for the better or for the worse or did not change after telling him your HIV status?	Better.....1 Worse.....2 Nothing changed.....3	
L96	Did you tell any other person about your HIV status?	Yes.....1 No.....2 Refused/no answer.....9	
L97	What type of support did you receive from him/her?	Counselling.....1 Money.....2 Information.....3 Medicines/drugs.....4 Other.....5 Nothing.....6	
SECTION V: COMPLETION OF INTERVIEW			
L98	We have now finished the interview. Do you have any comments, or is there anything else you would like? ----- -----		
L99	I have asked you about many difficult things. How has talking about these things made you feel? WRITE DOWN ANY SPECIFIC RESPONSE GIVEN BY RESPONDENT _____	Good/better.....1 Bad/worse2 Same/no difference..... 3	
Finish			

Thank you very much for your participation!

Appendix 12: Local language (Wolaia Donna) questionnaires

Gujuwa 1: Oduwa Worakata, maayetuwanne pillgetta oyyishasearch (Maccasara loyittidi oyichiyo oyisha)

Oduwa Worakata, maayetuwanne pillgetta oyyishasearch

Gaallassa: -----

Ayimala loo dēetti?, Tasuntayyi -----Tanni mantta Koyira Maskale Mangistuyi kwuwaZulu- Natalle universitiyanni doctoretta tamariyage kassi kasse Wolayita Soddo universitiyanni luxisiyaga ottiyo pilgettawu qofa shakanawu yaasi.. Ha manta gayyitanawu koyikko , entte demanawu sikiyya payidoyi (+251913177996 woyikko emelle: mengistu77@gmail.com). Entenna haa pillgetta yagnidoo gishawu bonchuwanni shobetidetta “ Haa pilligettasika kusha qoffayi “Nu Topianni Wolayita Zonniyan garsanni bari matta laggiyappe Echi Ayibiyara de'yanne Echi Ayibiyara bayinna macaa assa gakkia shoochiya meeziyanne, aarra gaayitidabatubba ”

Ha pillgettawu huppe hallchooyi maccassa payattettanne ettu duussa meeziya tamarrannee qasika ettu heeran hannetiabba errannassa .

Haagamalla 25 oyisha nuni oyichanna. Wolaitta Zonniyanni uddupuni payattetta naagiyo kettatun oyichettes. Heegeka hagappe kaaliya marranni pollettessi. Nuni entenna oyisha oyichanna, eente cengursaka dukkana, qoofa qasuwa worakatannika xafanna. Entte ha pillgettan ishi gikko , haaga wursanayiyo 45 daqiqqa ekkes.

Haa pilgettassi haaggappe kaaliya kohoyi woyike injetenabbay de'annawu danddayees. Entte haa pilgettani gellidi, enttena gakkida qohuwa shakiyo wodde amarida injetenabbayi siyettanna dandaayees. Hegga gidikonne, darro macaassasi wozannaba laggiyara shakiyogge loo'o qaadda. Onni erri entte kaasse adhiida itta meeziya nuuyiyo odishshin yibbatsiyabbi dee'ikonne zooriyanni maadannasinne intte miyyianni eqanasi payattetta naagiya keetawu yeddana. Nunnika nubaggarra haa oyishsha oggi maakidi enttena zooranna. Ha pilgettaayika maadiyogge bari matta lagiyappe gakiya shochiya haanotasi nu heera hanotta demanasinne halcuwa poliyaa getusi qoppa imannasa.

Haa pilgettay UKZN assa boollani ossettiya pilgetta matta maabbarayi zaari xellidinne ottana maala maatta imidossona (Maayuwa payidoyi:-----).

Gelladanni mettoyi de'ikko woyikko oyishayi de'ikko haa pilgetta ottiyagga maanta Meskele Mengistu silkiya payiduwani (+251913177996 Woyiko imelliya : mengistu77@gmail.com) UKZN assa boollani ottiyo pillgetta maabara demiyogge haagappe garissara de'es.

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Haa pillgettanni entte gellanage entte shenne. Toppiyanni de 'iya maacassawu entte meeze keehippe go 'es. Haa pilgetta oyichishinni ayi woodiyanika agagana gikko dandayassa. Aggo gishawu neenni kasse go 'ettiyobbatuppe attiyabbikka woyikko gaakiya qoheettikka baawa.

Haa pilligetta qooppa shaakko giishshawu aayibbinne emettiyabi baawa. Giddoshine daroo machasayi bantta ullubba baa lagiyaara hassayannawu lo 'o qaada demessi.

Taani entteyo boonchuwanni ersiyooqge dee 'ikko entte taasi oddobba ubba kossanni naaganna. Entte heerayinne entte suntayi haa duqittiyabatu giddo oyikkettiddi uttenaga pillgetta ottiya manttawayi erssessi. Nunni entta cengurssa duqannashinni ubbayika xuuranni oyiiqettesi. Entte suntayika ayii mazinggabba bollanikka xafettenna. Ha entteppe nuni ekkiddi xaafiddo qooffa ubbayi xuuranni oyiqettiddi ossinne yootetena. Haa pillgettappe kiiyidi attamettiyabba entte sunnta qoncissenna. Nunni enttenna ooyisha ooyichishin assi geelikko , harra cimiyobba haassayidi baallettanna.

Maayetuwa

Taanni (-----) Mantta Koyira Meskele Mengistu ottiyo "Nu Topianni Wolayita Zonniyan garsanni bari matta laggiyappe Echi Ayibiyara de 'iyanne Echi Ayibiiyara bayinna macaa assa gakkiiya shoochiya meeziyanne, aarra gaayitidabatubba" pillgettababba siyassi.

Ha piilgetta halchuwakka akeekkassi.

Tassi gellibeyinnabayi de 'ikokka taanna koshshiyagga oyichadda erannawu kaddayi immettissi.

Taanni qooncissiyogge , haa ooyishanni beetidogge mulerrakka ta sheeniyanna. Haa pilgetta oyichishinni ayi woodiyanika agagana dandaayayissi.

Aggo gishawu taanna kasse go'ettiyo xaaliya ehuwappe woyikko bonchuwappe attiyabbikka baawa.

Haa pilgeettara gaayittidaganni taanna gaakiyaa qoohoyi de'ikko , hee baalassi kooshiyaa kaassa qaanxiyogga wooyikko xaaletiyogga do'iyabba siiyassi.

Geelladanni mettoyi de'ikko woyikko oyishayi de'ikko haa pilgeetta ottiyagga maanta Meskele Mengistu silkiya payiduwani (+2519131 77996 Woyiko imelliya : mengistu77@gmail.com)

Qaasikka taayio jujo ooyiishayi piilggiya maanttawa booli de'ikko haagaappe kaalliyaa xooqassa ooyichannagge qoonceettis.

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Ceengursa Duqaanawu mayidetti

Eee ----- Akkayi-----

Parama

Gaalassa

Markattu Suntta

1.-----

2.-----

Oyichiya Izawa Suntta

Maaccassara maara haassayio oyishsha

Maaccassara maara haassayio oyishsha

1. Enttebappe guutta eranawu dandaayiyaana? Entte kalaamiya timihittiya taamaridetti?

- A. Entte de'iyossai aawanne?
- B. Enttiyo naatti de'?
- C. Daalassa mulliyanni ayi ottetti?
- D. Ayyibba ottiyogge entena ufaayissi?

2. Entte keetawabba taasi anne yoottitte? Kooyiro waannidi gayittidette? Awudde geelettidetti?
 - a. Eii (entte keetawayi) ayyi otti?
3. Entte keetawara de'īya meetoyi (oshshayi) awude doomide? Hee ooshayikka woqu wodiyaakaanawu takkide?
 - a. Haa ooshashayi aggidi lo'ido woode woyikko yaa daariddo woode de'ī?
4. Entte mootta gaarssani maaccassa bollani gaakiya shoochachayi woyickko tooshe dee'ī? Entte de'uwannishin?

Boollani gaakiya shoochayi wooyikko tooshe awude gaaki?
5. Entte heeranni maattuma gaatotettara gayittidabanni maccassa gaakiya meettuwasī leemisoo de'ī? Nee sheenpwanni? Maattuma gaatotettara gayittidabanni maccassa gakiya meettuwasī awuudde awudenne awaanni maattuma gaatotettara gayittidabanni maccassa gaakiya meettuwasī merettiyi ?
6. Hee meetuwa gaatiyayi oonne? Bollan wooyikko maattuma gaakettani gaakiyabawu (Piilgitte: Nee keetawayi/ nee keetta assee, nee erriyo assee/ eerikki). Hee meetuwa gaatida izaawa boolli aayibbe haanidee?
7. Hee shochai gakisiminni maaccassa booli gaakida koohoyi ayibee? (**Piilgitte:** Boolla , huuphiya, taa maabarara gaayituwa gaayitottetta boolaani)
8. Boolla tooshiyappe attida maaccassayi hee meetuwappe atti simiidi baanttana waanidi zaaridi looyittiyonna?
9. Entte deerettettayi maaccassa boolla nniinne maattumattetta gayitottanni gaakiyabatunni meetuwa boollani immiyo zaaroyi ayibbe? Tooshiya xaayisannayo ayiibi ossetidee?
10. Haa meetuwaapee attidaageta maaddanawu ayyibbi oosetide? Heegeka wattiyakko lo'anne? Maaccassa maadidi ootiya maabarayi hee meetuwappe attidagetta maadanawu de'ī?
11. Haa yohuwaa xellannanne maadanna Derettetta woyikko kaawuwa hiigiya de'ī? (Piilgitte: Paayattetta, poollisiya, hiigiya zoore, dorrettetta zoore) Haa haagazuwa oonne immiyayi? Haa haagazoyi waatiyakko lo'anne?
12. Bollanni gaakiya metoyi/ Maattuma boollanni gaakiya meetoyi kaaseppe yaa ittidi bii, loo'ī, woyikko kaasegadanikka de'ī enntte wollaita woikko entte de'īyossa kaakossappe?
13. Nee boolla payattetawu wolkama metuwa meldhi? Ayyiba ogiiyarra?
14. Neennattetta nee qoofiyode waatiddi qoohi?
15. Nee qoopyodde nee naatu bolli qoohuwa gaattide? Aayimalla ogiyanni?
16. Heegekka qaasii nee keetawu nee imiyobbawunne nee osuwa bollani meetuwa gaattide?
17. He qoohoyi neenni nee laagiya woyiko nee dabbuwa be'ennamala degidde? Waattiddi?

18. Hee meettuwa neenni haara laagiyara haassayaaddi? Etti neessi ayyi maalla maalsiyya zaaridonna?
- Neeyiyo etti daaroba ottana maalla neenni koyidobi de'i?
 - Ayiibi ayyibbi neenna maadanawu dandayi?
19. Neebba nenni guuye xeeliyowode haara maaccasayo ayimalla zooriya immayi
20. Haaga maala meetwawa baari azinara doomidada oonne?

Hiviyarra de 'iya assa oyichiyo oyisha

21. Nenni qoopiwode maccassa bantta bollanni HIVE de 'iyoga ba keetawassi yottiyoge lo'o? Ayisi? Piilga.
22. Ayisi issi issi macaassayi HIViyaa wuxettiya ekkanna ixixsi gii ?
- Ayissi PMTCT/ART programmeya go'ettawu ixixsi?
 - Haaratta qassi ayissi wuxetiya ekkanna wossanniyonna?
23. Attumassawu yoottanawu lo'o wode awude?
24. How would you inform him if you wanted to?
25. Nee bollanni HIVE de 'iyagga siyi simidi Ne keettawa ayi maalsiya zaari?)
26. Bantta bollani HIVE de 'iyoga oyiyo yottiyonna?
27. Macaasiya barri wuxettiya yotta simmini i keetawappe ayibi hannanawu dandayi? Daro eshshatta piilga!
28. Maacassayi harra assasi odiodde gaakiyabbayi ayiibbe?
29. Attumassayi ART programmiyanni gelli? Maacassayi shaaharanni de'ishini attumassayi etti maramarettanawu maddiyonna?

Entte saatiya yarshshido gishawu Galatayisi!

Gujuwa 2: Oduwa Worakata, maayetuwanne pillgetta oyyishasearch (Echiayibiyara de 'iranne de'enna macassa ciittan oyichiyo oyisha)

Gaallassa: -----

Oduwa Worakata, maayetuwanne pillgetta oyyishasearch

Date: -----

Ayimala loo'oo de' eetti?, Tasuntayyi -----Tanni mantta Koyira Maskale Mangistuyi kwuwaZulu- Natalle universitiyanni doctoretta tamariyage kassi kasse Wolayita Soddo universitiyanni luxisiyaga ottiyo pilgettawu qofa shakanawu yaasi.. Ha manta gayyitanawu koyikko , entte demanawu sikiyya payidoyi (+2519131'996 woyikko imelle: mengistu"@gmail.com). Entenna haa pillgetta yagnidoo gishawu bonchuwanni shobetidetta " Haa pilligettasika kusha qoffayi "Nu

Topianni Wolayita Zonniyan garsanni bari matta laggiyappe Echi Ayibiyara de "yanne Echi Ayibiiyara bayinna macaa assa gakkiiya shoochiya meeziyanne, aarra gaayitidabatubba "

Ha pillgettawu huppe hallchooyi maccassa payattettanne ettu duussa meeziya tamarrannee qasika ettu heeran hannetiabba errannassa .

Haagamalla ooyishha 4 (oyidu) ciittanni Wolaitta Zonniyanni uddupuni payattetta naagiyo kettatun oyichettes. Heegeka hagappe kaaliya marranni pollettessi. Nuni enttena oyisha oyichanna, eente cengursaka dukkana, qoofa qasuwa worakatannika xafanna. Entte ha pillgettan ishi gikko , haaga wursanayiyo 55 daqiqqa ekkes.

Haa pilgettassi haaggappe kaaliya kohoyi woyike injetenabbay de "annawu danddayees. Entte haa pilgettani gellidi, enttena gakkida qohuwa shakiyo wodde amarida injetenabbayi siyettanna dandaayees. Hegga gidikonne, darro macaassasi wozannaba laggiyara shakiyogge loo "o qaadda. Onni erri entte kaasse adhiida itta meeziya nuuyiyo odishshin yibbatsiyabbi dee "ikonke zooriyanni maadannasinne intte miiyyianni eqanasi payattetta naagiya keetawu yeddana. Nunnika nubaggarra haa oyishsha oggi maakidi enttena zooranna. Ha pilgettaayika maadiyoge bari matta lagiyappe gakiya shochiya haanotasi nu heera hanotta demanasinne halcuwa poliyaa getusi qoppa imannasa.

Haa pilgettay UKZN assa boollani ossettiya pilgetta matta maabbarayi zaari xellidinne ottana maala maatta imidossona (Maayuwa payidoi:-----).

Gelladanni mettoyi de "ikko woyikko oyishayi de "ikko haa pilgetta ottiyagga maanta Meskele Mengistu silkiya payiduwani (+2519131 996 Woyiko imelliya : mengistu "@gmail.com) UKZN assa boollani ottiyo pillgetta maabara demiyogee Haagappe garissara de "es.

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Haa pillgettanni entte gellanage entte shenne. Toppiyanni de 'iya maacassawu entte meeze keehippe go 'es. Haa pilgetta oyichishinni ayi woodiyanika agagana gikko dandayassa. Aggo gishawu neenni kasse go 'ettiyoobbatuppe attiyabbikka woyikko gaakiya qoheettikka baawa.

Haa pilligetta qooppa shaakko giishshawu aayibbinne emettiyabi baawa. Giddoshine daroo machasayi bantta ullubba baa lagiyaara hassayannawu lo 'o qaada demessi.

Taani entteyo boonchuwanni ersiyooogge dee 'ikko entte taasi oddobba ubba kossanni naaganna..Entte heerayinne entte suntayi haa duqittiyabatu giddo oyikkettiddi uttenaga pillgetta ottiya manttawayi erssessi. Nunni entta cengurssa duqannashinni ubbayika xuuranni oyiiqettesi. .Entte sunttayika ayii maziggabba bollanikka xafetenna. Ha entteppe nuni ekkiddi xaafiddo qooffa ubbayi xuuranni oyiqettiddi ossinne yootetena. Haa pillgettappe kiiyidi attamettiyabba entte suntta qoncissenna. Nunni enttenna ooyisha ooyichishin assi geelikko , harra cimiyobba haassayidi baallettanna.

2.1.Maayetuwa

Taanni (-----) Mantta Koyira Meskele Mengistu ottiyo "Nu Topianni Wolayita Zonniyan garsanni bari matta laggiyappe Echi Ayibiyara de 'iyanne Echi Ayibiiyara bayinna macaa assa gakkiiya shoochiya meeziyanne, aarra gaayitidabatubba" pillgettababba siyassi.

Ha piilgetta halchuwakka akeekkassi.

Tassi gellibeyinnabayi de 'ikokka taanna koshshiyagga oyichadda erannawu kaddayi immettissi.

Taanni qooncissiyogge , haa ooyishanni beetidogge mulerrakka ta sheeniyanna. Haa pilgetta oyichishinni ayi woodiyanika agagana dandaayayissi.

Aggo gishawu taanna kasse go "ettiyo xaliya ehuwappe woyikko bonchuwappe attiyabbikka baawa.

Haa pilgeettara gaayittidaganni taanna gaakiyaa qoohoyi de "ikko , hee baalassi kooshiyaa kaassa qaaxiyogga wooyikko xaaletiyogga do "iyabba siiyassi.

Geelladanni mettoyi de "ikko woyikko oyishayi de "ikko haa pilgeetta ottiyagga maanta Meskele Mengistu silkiya payiduwani (+2519131 996 Woyiko imelliya : mengistu"@gmail.com)

Qaasikka taayiyu jujo ooyiishayi piilggiiya maanttawa boolli de "ikko haagaappe kaalliya xooqassa ooyichannagge qoonceettis.

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Ceengursa Duqaanawu mayidetti Eee ----- Akkayi-----

Parama Gaalassa

Markattu Suntta

1.-----

2.-----

Oyichiya Izawa Suntta -----

2.3. Oyiisha: Hiviyara de'iyanne HIViya bayina macassa cittan pilgiyo pilgetta

Hentte moottani maaccassayi etta paayattetta bollani de'iya meeze ayibbe? (Pilligitte: ooshsha bollani , payaattetta bollanna gidenna)

1. Entte heerann de'iya bollanni gaakiya shoochayo leemisuwa imuttetti? Entte sheempuwa boollannishin? Boollanni gaakiya shoochai aawuddenne aawani gaakki? Heegge entte paayattetta boollanni etteyiyo meetuwa gaatti? Ayimalla ogiyaani?
2. Nenni nebba qoppiyo wode ayiibba qoohuwa gaatti?
3. Entte derriya garssani mattuma gayitottettani gakkiya meetoyi de'ī? Ne shempuwa bollannishin? Awudenne awanni maatumma gaayitottettani gaakiya osha qohoyi gaki?
4. Hee qohuwa gattiya onne? Bolla woyiko mattuma gayitottentan gayitiya qohuwawu (Pilligitte: Ne keetawayi/ ne keetta assay, ne eriyo assae/ neenni erenna assee). He qohuwa gattida assa bollani ayibe gaakayi?
5. He shochai gakki simini maacassa gaakida mettoyi ayibe? (Pilligitte: Bolla, onnattettani, heera gayitottettani .)
6. Haa shochappe attida maaccassayi waaniddi danawu daanddayiddonna?
7. Heegekka nee laggiya woyikko dabuwaara gayittenne mala metto gidide? maaniddi?
8. Entte deerre haa bolla woyiko matuma gayitotetta ppe gakkiya qohuusi immio zaaroyi ayibbe? Haa qoohuwa xayisanawu aayibbi ossetannawu kooshshi?
9. Haa qoohuwappe attida assa maaddanna ayibba ottanna kooshshi? Waattiyakko haa baaxxe lo'anna daandayi? Maaccassa maadiya maabarayi haa qoohuwappe attida assa asshanu de'ī?
10. Haa yohuwaa xellannanne maadanna Derettetta woyikko kaawuwa hiigiya de'ī? (Pilligitte: Paayattetta, poollisiya, hiigiya zoore, dorrettetta zooree) Haa haagazuwa oonne immiyayi? Haa haagazoyi waattiyakko lo'anne?
11. Bollanni gaakiya metoyi/ Maatuma boollanni gaakiya meetoyi kaaseppe yaa ittidi bii, loo'ī, woyikko kaasegadanikka de'ī?
12. Bollanni gaakiya metoyi/ Maatuma boollanni gaakiya meetoyi teqannawu haayimanotiya kalletiyagetti maadanna daandayibi dee'ī?
13. Maaccassa kaallettiyagetti Maatuma boollanni gaakiya meetoyi teqannawu ayibbako ottanawu dandayinna?

HIV de'īyo assa oyichiyo oyishatta

14. Nenni qoopiwode maccassa bantta bollanni HIVe de'iyoga ba keetawassi yottiyoge lo'o? Ayisi? Piilga.
15. Issi issi assay ayissi bantta Hiviiya wuxettiya siyannawu ixxi?

- a. PMTCT/ART programmemiya ixxiyonna?
 - b. Ayiibbe issi issi assatti bantta wuxxettiya siyanamalla ottiyagge?
16. Attumma assassin yottannawu lo"o wode awude?
 17. Assai yottanawu koyikko wattada yottayi?
 18. Nenni HIVe deyyogaa yoota simiyori ne keetawa ayi maalla amaliya beesii?
 19. Macaassa harra assawu ossi yottanawu koyiyonna?
 20. Nenni qoppiyode maccasayi baanta HIViya wuxeetiya yootisimiyori gaakiyabbi ayibbe?
Daaro eeshatta piilga! Qassi maacassayi haara assassin yooti simiyori gaakiyabbi ayibbe?
 21. Qassi maccassayi barri HIViya wuxeetiya bantta azinawu/ laagiyawu yootiyode gaakiyabbi ayiibe?
 22. Atumassay ART Programmeyanni gelliyona/maadiyonna? Maccassa shaaharani de7iyode attumassa etti maramarettanawu maadiyonna?

Gallattettes!

Gujuwa 3: Oduwa Worakata, maayetuwanne pillgetta oyyishatta (paayattetta naaggiya hiilanchaturraa loyittidi haassayiyo oyisha)

3.1. Oduwa Worakata, maayetuwanne pillgetta oyyishasearch

Gaalassa:-----

Ayimala loo de'eetti?, Tasuntayyi -----Tanni mantta Koyira Maskale Mangistuyi kwuwaZulu-Natalle universitiyanni doctoretta tamariyage kassi kasse Wolayita Soddo universitiyanni luxisiyaga ottiyo pilgettawu qofa shakanawu yaasi.. Ha manta gayyittanawu koyikko , entte demanawu sikiyya payidoyi (+2519131'996 woyikko imelle: mengistu"@gmail.com). Entenna haa pillgetta yagnidoo gishawu bonchuwanni shobetidetta “ Haa pilligettasika kusha qoffayi “Nu Topianni Wolayita Zonniyan garsanni bari matta laggiyappe Echi Ayibiyara de 7ianne Echi Ayibiiyara bayinna macaa assa gakkia shoochiya meeziyanne, aarra gaayitidabatubba ”

Ha pillgettawu huppe hallchooyi maccassa payattettanne ettu duussa meeziya tamarrannee qasika ettu heeran hannetiabba errannassa .

Haagamalla 25 oyisha nuni oyichanna. Wolaitta Zonniyanni uddupuni payattetta naagiyo kettatun oyichettes. Heegeka hagappe kaaliya marranni pollettesi. Nuni entenna oyisha oyichanna, eentte

cengursaka dukkana, qoofa qasuwa worakatannika xafanna. Entte ha pillgettan ishi gikko , haaga wursanayiyo 45 daqiqqa ekkes.

Haa pilgettassi haaggappe kaaliya kohoyi woyike injetenabbay de"annawu danddayees. Entte haa pilgettani gellidi, enttena gakkida qohuwa shakiyo wodde amarida injetenabbayi siyettanna dandaayees. Hegga gidikonne, darro macaassasi wozannaba laggiyara shakiyogge loo"o qaadda. Onni erri entte kaasse adhiida itta meeziya nuuyiyo odishshin yibbatsiyabbi dee"ikonne zooriyanni maadannasinne intte miiyianni eqanasi payattetta naagiya keetawu yeddana. Nunnika nubaggarra haa oyishsha oggi maakidi enttena zooranna. Ha pilgettaayika maadiyoge bari matta lagiyappe gakiya shochiya haanotasi nu heera hanotta demanasinne halcuwa poliyaa getusi qoppa imannasa.

Haa pilgettay UKZN assa boollani ossettiya pilgetta matta maabbarayi zaari xellidinne ottana maala maatta imidossona (Maayuwa payidoi:-----).

Gelladanni mettoyi de"ikko woyikko oyishayi de"ikko haa pilgetta ottiyagga maanta Meskele Mengistu silkiya payiduwani (+2519131'996 Woyiko imelliya : mengistu"@gmail.com) UKZN assa bollani ottiyo pillgetta maabara demiyogee Haagappe garissara de"es.

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Haa pillgettanni entte gellanage entte shenne. Toppiyanni de"iya maacassawu entte meeze keehippe go"es. Haa pilgetta oyichishinni ayi woodiyanika agagana gikko dandayassa. Aggo gishawu neenni kasse go"ettiyobbatuppe attiyabbikka woyikko gaakiya qoheettikka baawa.

Haa pilligetta qooppa shaakko giishshawu aayibbinne emettiyabi baawa. Giddoshine daroo machasayi bantta ullubba baa lagiyaara hassayannawu lo"o qaada demessi.

Taani entteyo boonchuwanni ersiyooqge dee ikko entte taasi oddobba ubba kossanni naaganna..Entte heerayinne entte suntayi haa duqittiyabatu giddo oyikkettiddi uttenaga pillgetta ottiya manttawayi erssessi. Nunni entta cengurssa duqannashinni ubbayika xuuranni oyiiqettesi. .Entte sunntayika ayii maziggabba bollanikka xafettenna. Ha entteppe nuni ekkiddi xaafiddo qooffa ubbayi xuuranni oyiqettiddi ossinne yootetena. Haa pillgettappe kiiyidi attamettiyabba entte sunnta qoncissenna. Nunni enttenna ooyisha ooyichishin assi geelikko , harra cimiyobba haassayidi baallettanna.

3.2. Maayetuwa

Taanni (-----) Mantta Koyira Meskele Mengistu ottiyo “**Nu Topianni Wolayita Zonniyan garsanni bari matta laggiyappe ‘Echi Ayibiyara de’yanne Echi Ayibiiyara bayinna macaa assa gakkiiya shoochiya meeziyanne, aarra gaayitidabatubba’** pillgettababba siyassi.

Ha piilgetta halchuwakka akeekkassi.

Tassi gellibeyinnabayi de ikokka taanna koshshiyagga oyichadda erannawu kaddayi immettissi.

Taanni qooncissiyogge , haa ooyishanni beetidogge mulerrakka ta sheeniyanna. Haa pilgetta oyichishinni ayi woodiyanika agagana dandaayayissi.

Aggo gishawu taanna kasse go'ettiyo xaaliya ehuwappe woyikko bonchuwappe attiya qohoyi baawa.

Haa pilgeettara gaayittidaganni taanna gaakiyaa qoohoyi de ikko , hee baalassi kooshiyaa kaassa qaanxiyogga wooyikko xaaletiyogga do iyabba siiyassi.

Geelladanni mettoyi de ikko woyikko oyishayi de ikko haa pilgetta ottiyagga maanta Meskele Mengistu silkiya payiduwani (+2519131 996 Woyiko imelliya : mengistu"@gmail.com)

Qaasikka taayiyo jujo ooyiishayi piilggiya maanttawa boolli de ikko haagaappe kaalliyaa xooqassa ooyichannagge qoonceettis.

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Ceengursa Duqaanawu mayidetti Eee ----- Akkayi-----

Parama Gaalassa

Markattu Suntta

1.-----

2.-----

Oyichiya Izawa Suntta

3.3. Oyiishsha: Payaattetta haagaazuwa imiyagetura haasayio oyisha

1. Haa ottiyo keettanni entteyo de'iyaa bayirattettayi ayibbe?
2. Haa entte payattetta naagiyo keetta maacchasa yiyi gaasoyi ayiibe?
3. Keetta assappe woyikko maatta laggiyappe gaakiya shoochiyabba gaasuwara yiyabi de'i? Waanna huppe gaaso ayibbe?
4. Enttannara issippe ottiya ossanchatti maaccassa keetta assappe shootiyoba gaakidakonnee ubba wodee oyiichiyonna?
5. Maacchassayi entteyo hee qohoyi gaakiddoga yoottiyode ubba gaallasi ayi malla mirmarra ottetti? Ayi mirmarra ottanakonne onne wosaanniya immiya?
6. Ha attumassape maacassa gakiya shoocha maramarannawu xuubbe ayibe?
7. Nenni attumassape maacssa gakiyaa shoocha luuxetta eekadi? Maccassa shochettidoga qassi ayibinni errayi?
8. Ayi ayi malla atumassape qakiya qohuwa piilgaddi ?
9. Maccassayi bantanna gakidabba oyichennani yoottiyonna?
10. Keeta assappe gaakiya qohuwassi ayimalla timihirtira imiyakoo lo'0? Heega wattidi oyiqiyo? Hega nenni oyichaye maccassa yootti?
11. Higaawe masiraja paayattetta osanchappe ekkanna de'iya maarayi ayibbe?

12. Issi agginna gaarssanni intte osso keetta heega maalla mettoyi gaakido apunni assa akkami? Entteyo heega maala maraja oyiqiyo maara de`i? Entte hee maharaja oyiqanaw go`ettiyo forime woikko mazingabba de`i? Heegga tayo qooncissannawu dandayetti?
(Koppe de`ikko oyichite, reffere ootiyo woraqatayi de`i, woyikko haara maazgabbayi de`ikko)
13. Entte gidinikka enttannara ottiyagetti haa toshettayi gaakido maaccassassi ubba gaalla kaallidi Haagazyonna? Ettaka haarra paayattetta naagiyo keetakko yeeddiyo huunettayi de`i? Entte maazgabba oyiiqettayi keetta assappe meetoyi gaakido maaccassa elle shshaakidi eraannaw maadi, loo`o Haagazu ekiiyossa yeedannawu maadii, qaasikka woodiyara woodiyara gaakidi Haagazu immiyo haanoyi de`i?
- Bari maatta laagiyappe tooshee gaakiddo maacca assappe ekkiddo meeziya**
14. Entte Haagazyo entte danbagnatu garssappe keeta assappe gaakiya tooshe gaakido assara gayittidetti? Hee meeze awaappe dendidaakko erretti, entte ayi ottidakkonne qassi entte danbbagnatti ayii ottidakkonne?
15. keetta assappe gaakiya tooshe gaakido assaa kaapiya woyikko maadiya dirjitte haa entte heerani de`iyako erretti? Onne etti? Enttenara de`iya dabottettai ayibbe? Haa tooshhe gaakido assa maadanau entte haara osso keettara issippe mayettido hunnetayi de`i?
16. Ayi maalla lamme, polliciyanni, Haagazuwa immiya assatunni yiikko entte ossuwa loyittanawu daanddayi?
17. Ayi maalla esha lamme, enttenarra ottiyagetu bollani yikko ossuwa murutissanawu maaddi?
18. Entte qoopiyo wode haa tooshe maaccasayi ekiyo Haagazuwa bolli , woyikko ehi ayibiya xalliya xalletui Haagazuwanni metuwa ehaanawu daanddayi?Wattidi?
19. Entte maccasa banttana HIViyaa wuxeetiya haarawu yoottannawu zooretti ? Maccassayi yottiyonna? Appunni saatiyappe simini? Ayiiba wuxeetiya? Entte qoopyode attumassayi etta wuxeetiya eryi? (Maccasayishin ettaga eryi?
20. Attumassayi macaasayi bantta wuuxetiya yootisimini ayimaalla esha bessi (HIV bee nennanni de`iyogga) ?

Gallatayissi!

Oduwa Worakata, maayetuwanne pillgetta oyyishatta (Maacassa oyichiyo Oyyisha)

Oduwa Worakata, maayetuwanne pillgetta oyyishasearch

Gaalassa:-----

Ayimala loo de'eetti?, Tasuntayyi -----Tanni mantta Koyira Maskale Mangistuyi kwuwaZulu- Natalle universitiyanni doctoretta tamariyage kassi kasse Wolayita Soddo universitiyanni luxisiyaga ottiyo pillgettawu qofa shakanawu yaasi.. Ha manta gayyitanawu koyikko , entte demanawu sikiyya payidoyi (+2519131'996 woyikko imelle: mengistu"@gmail.com). Entenna haa pillgetta yagnidoo gishawu bonchuwanni shobetidetta "Haa pilligettasika kusha qoffayi "Nu Topianni Wolayita Zonniyan garsanni bari matta laggiiyappe Echi Ayibiyara de"iyanne Echi Ayibiiyara bayinna macaa assa gakkiiya shoochiya meeziyanne, aarra gaayitidabatubba "

Ha pillgettawu huppe hallchooyi maccassa payattettanne ettu duussa meeziya tamarrannee qasika ettu heeran hannetiabba errannassa .

Nunni mullera 816 oyishsha Wolaitta Zonniyanni uddupuni payattetta naagiyo kettatun de"iya maacassa oyichettes. Heegeka hagappe kaaliya marranni pollettessi. Nuni entenna oyisha oyichanna,entte suntta xappokko . Entte ha pillgettan ishi gikko , haaga wursanayiyo 25-30 daqiqqa ekkes.

Haa pilgettassi haaggappe kaaliya kohoyi woyike injetenabbay de"annawu danddayees. Entte haa pilgettani gellidi, enttena gakkida qohuwa shakiyo wodde amarida injetenabbayi siyettanna dandaayees. Hegga gidikonne, darro macaassasi wozannaba laggiiyara shakiyogge loo"o qaadda. Onni erri entte kaasse adhiida itta meeziya nuuyiyo odishshin yibbatsiyabbi dee"ikonne zooriyanni maadannasinne intte miiyiyanne eqanasi payattetta naagiya keetawu yeddana. Nunnika nubaggarra haa oyishsha oggi maakidi enttena zooranna. Ha pilgettaayika maadiyogge bari matta laggiiyappe gakiya shochiya haanotasi nu heera hanotta demanasinne halcuwa poliyaa getusi qoppa imannasa.

Haa pilgettay UKZN assa boollani ossettiya pilgetta matta maabbarayi zaari xellidinne ottana maala maatta imidossona (Maayuwa payidoyi:-----).

Gelladanni mettoyi de"ikko woyikko oyishayi de"ikko haa pilgetta ottiyagga maanta Meskele Mengistu silkiya payiduwani (+2519131'996 Woyiko imelliya : mengistu"@gmail.com) UKZN assa bollani ottiyo pillgetta maabara demiyogge Haagappe garissara de"es.

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Haa pillgettanni entte gellanage entte shenne. Toppiyanni de 'iya maacassawu entte meeze keehippe go 'es. Haa pilgetta oyichishinni ayi woodiyanika agagana gikko dandayassa. Aggo gishawu neenni kasse go "ettiyoobbatuppe attiyabbikka woyikko gaakiya qoheettikka baawa.

Haa pilligetta qooppa shaakko giishshawu aayibbinne emettiyabi baawa. Giddoshine daroo machasayi bantta ullubba baa lagiyaara hassayannawu lo 'o qaada demessi.

Taani entteyo boonchuwanni ersiyooqge dee 'ikko entte taasi oddobba ubba kossanni naaganna. Entte heerayinne entte suntayi haa duqittiyabatu giddo oyikkettiddi uttenaga pillgetta ottiya manttawayi erssessi. Nunni entta cengurssa duqannashinni ubbayika xuuranni oyiiqettesi. Entte sunttayika ayii maziggabba bollanikka xafettenna. Ha entteppe nuni ekkiddi xaafiddo qooffa ubbayi xuurranni oyiqettiddi ossinne yootetena. Haa pillgettappe kiiyidi attamettiyabba entte sunnta qoncissenna. Nunni enttenna ooyisha ooyichishin assi geelikko , harra cimiyobba haassayidi baallettanna.

Maayetuwa

Taanni (-----) Mantta Koyira Meskele Mengistu ottiyo **'Nu Topianni Wolayita Zonniyan garsanni bari matta laggiyappe 'Echi Ayibiyara de 'yanne Echi Ayibiiyara bayinna macaa assa gakkiya shoochiya meeziyanne, aarra gaayitidabatubba "** pillgettababba siyassi.

Ha piilgetta halchuwakka akeekkassi.

Tassi gellibeyinnabayi de 'ikokka taanna koshshiyagga oyichadda erannawu kaddayi immettissi. Taanni qooncissiyogge , haa ooyishanni beetidogge mulerrakka ta sheeniyanna.

Haa pilgetta oyichishinni ayi woodiyanika agagana dandaayayissi. Aggo gishawu taanna kasse go "ettiyo xaaliya ehuwappe woyikko bonchuwappe attiya qohoyi baawa.

Haa pilgeettara gaayittidaganni taanna gaakiyaa qoohoyi de 'ikko , hee baalassi kooshiyaa kaassa qaanxiyogga wooyikko xaaletiyogga do 'iyabba siiyassi.

Geelladanni mettoyi de`ikko woyikko oyishayi de`ikko haa pilgeetta ottiyagga maanta Meskele Mengistu silkiya payiduwani (+2519131 '996 Woyiko imelliya : mengistu"@gmail.com)

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Oyishetida assatu paarama

Date

Markatu paramm

Oyichiyaga suntan-----

Table 7. Wolaita Language Questionnaire. Kifiliya I. Essippettettanne yelletaba

Ma.P.	Oyiisha	Zaaruwa	Piiritte
	HIV pillgetta ayi malle?	1. ART talliya ekkiyaga 2. HIV bollanni bawa	
S1	Entte layitta appunne?	Kumeetta Laayittayi -----	
S2	Entte de 'iyossayi awee?	1.kaattama 2. Gaatariya	
S3	Haa 'i enttee geeluwa ekuwabbay ayimale??	1. Ha''I azina gelassid/ Azinara de 'ayissi → 2. Attumassara de 'ayis gelabeyikke → 3. Ha 'i ubbade tanara gayittiya attumayi desishini gelabeyikke → 4. Ha 'i wodiyen gellabeyikke / attumassara de7ike.	S7 S7 S7
S4	Haggappe kasse gelada woyikko attumassara de 'ada erayi?	4. Eee, gellasi 5. Eee, attumassara de 'asi , shin gellabeyikke 6. Kassi	
S5	Attumassara nessi wursettanni de 'iya gaytottettay birshettidetti, shaketidettiye , woyiko ne matta lagge hayiqide?	Birshettida.....1 Shakettida/Meqisi 2 7. Azinayi Haiqissi.....3	S7
S6	Ha birshetta koyiro qattidayi nenne, ne kettawayi woyikko na 'ayikka issippe mayettidetti?	Maccasiyo1 Keettawa2 Na 'ayikka issippe3 Harrayi :4	
S7	Ne de 'uwan azinna apputo gelladi/ woyiko attumassarra woqa de 'adi?	Gellidoga payidoyi/ Issippe de7idoge ----- Akkayi zaroyyi immikke-----8	
S8	Nennara benni entte gellatishin ne kettawassi harra maccasiya	Eee.....1 Kashi.....2	

	de"ayi?	Hassayikke.....3 Akkayi zaruwa immike4	
S9	Nennara datti ayyo appun macassa de "i?	Macca payidoyi Akkayi/Zarroyi bawa8	
S10	Nenni koyirro/na "anttoMacasse/ lagge?	Payiduwa/ daraja [][] Zaruwa ixissi8	
S11	Ha7i ne azinna nenni dooraddi, harra assayi neyo doridde, woyikko izawa doridde nenna? Nenni dorennabba gidikko , ha "i nne kettawa onni nessi dooride?	Na "ayikka issippe dorrida.....1 Maccasiya dorasu.....2 Maccase ketta assayi doorissi3 Kettawayi doorisi4 Azinna ketta assayi doorissi.....5 Wossiyo kettayi dorrisii.....6 Tanni erikke/ Akekike7	
S12	Haa kettawa gellanappe kasse /a "i matta kettawa gellanawu nenni oyichadi?	Eee.....1 Kashi.....2 Akekikike.....3 Zaruwa ixxisii.....4	
S13	Nee gellido ciiloshayi immettide?	Eee /cillosha1 Eee/ Maccasasi immiyo waga.....2 Akkayi3 Errike/Assayikke.....4	
S14	Maccassa ciiloshayi ubbayika qanxettide woyikko , sinttappe qanxettanawu de "iyabbayi ha "ikka de "i?	1.Ubbayikka qanxettissi 2 .Kibbayi qanxettissi 3 . Ayibbikka qanxettibenna 4 .Tanni erikke /Skakikke	
S15	Neesoni de "iyaa assa paayido wooqe?	-----	
S16	Entte haayimanotte ayibe?	1.Ortodokisiya 4. katolikiya 2.Issillama 5. Woogaa amanuwa 3.Protestantiya 6.Haara	
S17	Entte sheeshshaa ayibbe?	.Wolaita 4.Gurage 2.Amaara 5.Oromoo 3. Dawuro 6. Haara	

S18	Entte Osoyi ayiibe? (Maaccasasi)	1. So osuwa 2. Zal7ancha 3. Tamariya 4. Kaawuwa/Kaawo gidenna 5. Qaane osancha 6. Haara-----	
S19	Nee keettawa osso ayibe?	1. Goshshancha 2. Kawo osancha 3. Zaldhancha 4. Qanne Osancha 5. Kaawo Osuwappe kaare 6. Haara	
S20	Kaalame timihirtiya tamaradi?	0. -----Kashi 1.-----Eenno	Kaashi Giiko 111
S21	Entte wursido xooqa kiifille aapunne?	Wuursiddo kifiille.....	
S22	Nee keettawa kaalamiya timihitiya taamaride?	0. -----Kashi 1.-----Ee	If "no" GO to Q. 113
S23	Nee keetawa ogiido xooqa kiifille aapunne?	Wuursiddo xooqa kiifille-----	
S24	Entte ketta aginnanni demiyo mishayi/damoza woqqe ?	Toppiya birranni: -----	
S25	<p>Entte keettanni: [Xaappa '1' Liike gidikko & '0' Kaashi Giddiko]</p> <p>W1. Televission: __ W2. Radoniya: __ W3. Sattelayitte Diishiya: __ W4. Mobilliya silkiya: __ W5. Soo Silkiya: __ W6. Xarapheza: __ W7. Woonbara __ W8. Pirashiya/puttuwa/shubuwa pirashiya osettida aliga: __ </p> <p>W9. Korrintiya bashiya : __ W10.Biskilittiya: __ W11. Mottorira sakilliya/bajajiya W12. Pirijiya __ W13. Electirikiya __ W14.Tracteriyya/Makinna __ W15. Gosha bitta/Kattama bitta: __ W16.Budenna bashiya mittan kattiyaga: __ W17. Eletrikiya midija</p>		

Kiifiliya II. Ne a7i matta laggiya/azinnabba qoppiyode , hagape garssada de7iyabbayi tumme?

Ma.P	Oyiisha	A) Enno giddiko ‘B’ kko bitte.Akkayi giddikko kaaliyagakko bitte	B) Haage adhdhida 12 aginnattu gaarssani haanide?(Enno giidiko ‘C’ xalla oyichay. Akkayi giidiko ‘D’ xalla oyicha)	C)) Haaga adhdhida 12 aginnattu gaarssani haanidogge issitto, amarida wode, woyikko daarotto? (‘C’ zaaridi simiddi kaalliyagakko bitte)	D)12 aginaappe kaasse haagge haannidoyi issitoyi, amarida wode, Darro wode?
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Ma.P.	Oyiishaa	E ee	Kaas hi	Errikk e
D27	Nee laagiya woyikko daabuwa be "enna maalla diigess?	1	2	8
D28	Entteso keetta assaara(yeelidageturra) gaayittenna maalla teqees?	1	2	8
D29	Neeni ubba woodde de "iyosa eraanawu kooyesi?	1	2	8
D30	Neenna olligesi wooyikko dumma xeellessi?	1	2	8
D31	Haara attumassara hassayikko yiillottes?	1	2	8
D32	Amaannetaka giiddi ubbadde siiressi?	1	2	8
D33	Neehuppiyawu paayattetta demanayo baa sheeniya oyichaanaga kooyessi?	1	2	8

Kifiliya III: Haagappe kaalidi de "iyage daaro maaccassa bollanni ha " haziinnayi woyikko

		Ee	Aka yi	Ee	Akayi	Issitto	Amaratto	Daarot to	Issitt o	Am arat to	Daarot to
E34	Nenna caayidde woyikko neeyo ittaba siyettanadann ottide?										
E35	Harra assa sinttani kawushide?										
E36	Erriyidi issibbaa neenna yaashisanawu otti(Lem.Waasidi woyiko yashisiyidi neenna xeelidde) ?										
E37	Nenna woyikko neenni dichiyoba yashiside?										

	Oyisha Nee keettawayi woyikko nee haarra lagge....	A) Enno giddiko "B" kko bitte. Akkayi giddikko kaaliyagakko bitte		B) Haage adhdhida 12 aginnattu gaarssani haanide?(Enno giidiko "C" xalla oyichay. Akkayi giidiko "D" xalla oyicha)		C)) Haaga adhdhida 12 aginnattu gaarssani haanidogge issitto, amarida wode, woyikko daarotto? ("C" zaaridi simiddi kaalliyagakko biitte)			D)12 aginaappe kaasse haagge haannidoyi issitoyi, amarida wode, Darro wode?		
		Eee	Ak kayi	E ee	Akka yi	Iss itto	A mara tto	D aarot to	ss itt o	A mara tto	Daaro tto
P38	Issibanni neena shociide woyikko issibayi qohannamalla caadidde?										
P39	Suugidde woyikko huuphiya neegga daapidde?										
P40	Bubuxide woyiko nenna qoohiya haarabanni shocidde?										
P41	Neenna kaakidde, goochide woyikko shodhide?										
P42	Yiiloyide woyikko eriiyide neenna xugiide ?										
P43	Zayiiyani yashiside woyikko heega go"etidde, biilama woyikko harra maasariya neenna qoohannawu goo"ettide?										

S.N.	Oyisha Nee keettawa woyikko haara laage neenna ...	A) Enno giddiko ‘B’ kko bitte. Akkayi giddikko kaaliyagakko bitte		B) Haage adhdhida 12 aginnattu gaarssani haanide? (Enno giidiko 'C' xalla oyichay. Akkayi giidiko 'D' xalla oyicha)		C)) Haaga adhdhida 12 aginnattu gaarssani haanidogge issitto, amarida wode, woyikko daarotto? (‘C’ zaaridi simiddi kaaliyagakko biitte)			D)12 aginaappe kaasse haagge haannidoyi issitoyi, amarida wode, Darro wode?		
		Ee	A kayi	Ee	Akayi	I ssitto	A mara tto	Daaro tto	I ssitto	A mara tto	Daa rotto
S44	Ha'i nee keetawayi woyikko haara laage baa wolkanni sugidi neenni koyenna asho gayittotettassi wa'iside?	1	2	1	2	1	2	3	1	2	3
S45	Neenna nee keettawa woyikko harra lage neenni koyennanni de'ishinne yellatishin asho gaakketta neenara polliede?	1	2	1	2	1	2	3	1	2	3
S46	Ne kaaha bashibaani nee keetawa woyikko haara laage issiba asho gakettaba ssi wolkanttide?	1	2	1	2	1	2	3	1	2	3

Ma. P.	Oyiisha																																
P47	Bollanni gaakiya shochayi woyikko toshshee de 'iyakko shaakka? Osha payiduwa xeella 400-405.	1.Eee , bollanni gaakiya shochayi woyikko toshshee de 'es 2.Akkayi, bollanni gaakiya shochayi woyikko toshshee baawa.																															
S48	Ashuwa gayittottetani yiya toshe de 'ikko shaka? Osha payiduwa xeella 500-502	1.Eee, Ashuwa gayittottetani yiya toshe de 'es. 2. Akkayi, Ashuwa gayittottetani yiya toshe baawa.																															
I49	Abbe ixeeetta giidaara errayi?	1.Eee 2.Akkayi If 2 Go to I52																															
I50	Entte abbe ixeeetta gididi eriyoga odidetta. Abbe ixeeetta giddirashi nee keetawa shocidi woyiko tochchidi erri?	1.Eee 2.Akayi 3.Errikke /Haasayikke If 2,3,4 Go to I53 4.Ixxissi/Zaaroyi baawa																															
I51	Haa ne keetawa tochetappe dendidaganni bosheshettara erayi?	1.Eee 2.Akkayi																															
I52	Neeni haa nee maata keetawappee woyikko haara laagiyappee bolla shoetada, heegeka qanxeettata, xugeetada, meequetta woyikko achaa me'ada haa nunnii qomora haasayido gasuwappe dendidagan erayi?		<table border="1"> <thead> <tr> <th></th> <th>Eee</th> <th>Akay</th> </tr> </thead> <tbody> <tr> <td>A. Qanxoyi,cadettoyi,satayi</td> <td>1</td> <td>2</td> </tr> <tr> <td>B. Garettayi,uzuziyabbayi</td> <td>1</td> <td>2</td> </tr> <tr> <td>C. Burqe, Madhiyappe shodetidabayi</td> <td></td> <td>2</td> </tr> <tr> <td>D. xugettayi</td> <td>1</td> <td></td> </tr> <tr> <td>E. Gido gelida</td> <td>1</td> <td>2</td> </tr> <tr> <td>F. Me7ida hayittayi, ayifiya</td> <td>1</td> <td>2</td> </tr> <tr> <td>G. Meqoyi, meqetta meoyi</td> <td>1</td> <td>2</td> </tr> <tr> <td>H. Acha meoyi</td> <td>1</td> <td>2</td> </tr> <tr> <td>I. Harrabbayi</td> <td>1</td> <td>2</td> </tr> </tbody> </table>		Eee	Akay	A. Qanxoyi,cadettoyi,satayi	1	2	B. Garettayi,uzuziyabbayi	1	2	C. Burqe, Madhiyappe shodetidabayi		2	D. xugettayi	1		E. Gido gelida	1	2	F. Me7ida hayittayi, ayifiya	1	2	G. Meqoyi, meqetta meoyi	1	2	H. Acha meoyi	1	2	I. Harrabbayi	1	2
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H. Acha meoyi	1	2																															
I. Harrabbayi	1	2																															
I53	Nee de 'uwanni , nee keetappe woyiikko haara laagiyaappe woyiisa mansunxaaddi? Neenni heega issitto, naa 'utto woyikko daaroto gaayi ?	6. Issito/Naa7utto 7. Daaroto(3-5) wode 8. Keehipe daroto (5 moolla) 9. Taa errikke / Haasayikke 10. Ixxisi / Zaaroyi baawa.																															
I54	Has this happened in the past 12 months?	5. Eee 6. Akkayi 7. Taa errikke / Haasayikke 8. Ixxisi/ Zaaroyi baawa																															
I55	Hee neqohuwayo hakimya marpiya ekkadi?	1.Eee issitto issitto ekassi 2.Eee ubbattokka ekasi 3.Kashi ekabbeyike																															
I56	Hee quhuwasi assappe maduwa koyadda erayi?	1.Ee 2.Akayi																															

Maacassa bollanni gaakiya toshshiya

I57	Haa ne keettawayi nenna shociiyogaa oossi yottadi?	<p>Onninne maddibbena.....1 Lagettusi.....2 Yellidagetusi.....3 Ishasi / Micheesi.....4 Awwa michesi/Awa ishassi5 Azinna keetta assassi.....6 Natussi7 Shooruwassi.....8 Pollisiyaasi.....9 Hakimiyas/Payattetta nagiyagettusi.....10 Amanuwa kalletiyagetusi.....11 Zoriyagetusi.....12 Kawwo dirjittiya gidennagetussi/Maacassa mabarrassi.....13 Heera kalletiyagetusi 14 Higgiya mabbarawu15 Haaratusi(Qoncissa):_____16</p>
I58	Neenna maddida assi de 'i? Onne maddiddayi? Ubba zaruwakka malatta: Onne Haarrayi madiddayi?	<p>Onninne maddibbena.....1 Lagettusi.....2 Yellidagetusi.....3 Ishasi / Micheesi.....4 Awwa michesi/Awa ishassi5 Azinna keetta assassi.....6 Natussi7 Shooruwassi.....8 Pollisiyaasi.....9 Hakimiyas/Payattetta nagiyagettusi.....10 Amanuwa kalletiyagetusi.....11 Zoriyagetusi.....12 Kawwo dirjittiya gidennagetussi/Maacassa mabarrassi.....13 Heera kalletiyagetusi 14 Higgiya mabbarawu15 Haaratusi(Qoncissa):_____16</p>
W59	Neenni shoocettido wode neenna ashanau zaarada arra waretada woyikko nee huphiya ashioba ottaddi? 1.Eee 2.Akkayi Enno giidikko: Apputo? Neeni heega issito woyikko naa 'utto , daarotto wooyikko daaro woode?	<p>5. Issitto woyikko Naa 'utto 6. Daarotto /Keehippe daarotto , /daaro woodiyanna 7. Taa errikee / Akeekike 8. Ixxissi / Zaaroyi baawa</p>
W60	Neenni ne keetawa nenna	

bochena diishin aa ashuwa shochaddi, woyiko tochaddi? 1.Eee 2. Akkayi , Enno giidikko: Apputto? Neeni heega issito woyikko naa 'utto , daarotto wooyikko daaro woode?	5. Issitto woyikko Naa 'utto 6. Daarotto/Keehippe daarotto , /daaro woodiyanna 7. Taa errikee / Akeekike 8. Ixxissi / Zarro bawa
---	---

Kifiliya III: Maaccassa daabuwappe, haara etti eriyoo assappenne imaattappe gaakiya toshiya

MaP.	Oyiisha		Zarroyi immetidogaa kanchiya oyicha. Apputto heege annidde?		
			Issito Woyikko Naa 'utto	maaridda diyassa	Daarotto
L61	15 lavittappe siminni: Ayyi assa giidikkoka (Haa 'i woyikko kaasse aziinnara dee 'iya maaccasaayi: Nee keetawappe haarayi / laagiyyappe) nee boolla shochiciddi erri? 1.Eee 2. Akkayi, Eee giidikko : Onne heega nee bollani ottidde ? Piilgitte : Nee daboyishin? Nee taamariyosan woyikko ottiyossan de 'iyabbi? Laage woyikko shooroyi? Immattayi woyikko haara assayi?	1. Onnikka baawa	1	2	3
		2. Awaa	1	2	3
		3. Keetaye aziina	1	2	3
		4. Keetanni de 'iya haara attumassa	1	2	3
		5. Keetanni de 'iya maaccassa	1	2	3
		6. Teacher	1	2	3
		7. Police/ soldier	1	2	3
		8. Keetan de 'iya attuma laage	1	2	3
		9. Soonna de 'iyaa maacca laggiyo	1	2	3
		10. Attuma Laagiya	1	2	3
		11. Immatta	1	2	3
		12. Osso ketta de 'iya haara assa	1	2	3
		13. Keesiya/Hayimanotiyaga	1	2	3
		14. Kaaletiyaga	1	2	3

Maaccassa daabuwappe, haara etti eriyoo assappenne imaattappe gaakiya toshiya

Ma.P.	Oyisha		Heegga ottiyowode laayitta neeyo wooqe?	He ega ottiya izzawa qaasi appun n laayitte?	Zarroyi immetidogaa kanchiya oyicha. Apputto heege annidde?		
					I ssitto /Naa" utto	A mmari da wodiyawu	Daaro woodiyawu
L62	<p>15 layitappe kaasee, issi assinenna haa keettanni asho gayittettotawu bochidakonne haassayayi, woyikko nenni kooyennanni de 'ishinni asho gayittetta ottanawu issibba ottide?</p> <p>Eee giddikko: Onne heegga ottidagge nee bollanni? Eee ottis gikko oyisha dooma: Taamare keettanni de 'iya asse?</p> <p>Laagge woyikko shooro? Haara asse haaga nee boollanni ottiday? Eee giddikko: Who did this to you?</p>	1. Onnikka baawa			1	2	3
		2. waa			1	2	3
		3. Keetaye aziina			1	2	3
		4. Keetanni de 'iya haara attumassa			1	2	3
		5. Keetanni de 'iya maaccassa			1	2	3
		6. Teacher			1	2	3
		7. Police/ soldier			1	2	3
		8. Keetan de 'iya attuma laage			1	2	3
		9. Soonni de 'iyaa maacca laggiyo			1	2	3
		10. Attuma Laagiya			1	2	3
		11. Immatta			1	2	3
		12. Osso ketta de 'iya haara assa			1	2	3
		13. Keesiya/Hayimanotiya ga			1	2	3
		14. Kaaletiyaga			1	2	3

Ma.P.	Oyiisha	Zaaruuwa	Xaalitte
	Neenii azzinaappe gaakiya tooshiyabba ayiippiyanni bee 'addi woyikko markatadda errayi?	1. Eee 2. Akkayi	
L64	Neenna nee bollaa bollanni woyikko ashuwa bollanni gaakiya shochayi gaakiyode?	1. Higawe giddida maaduwa kooyadassa 2. Hiigawee giidenna maaduwa kooyaddassa	

H65	Nee keettawayi mattoyiya ushsha uyii?	1. Ee 2. Akayi	
H66	Awude awude ushsha uyii? Ubbade, issitto issito, mullekka uyyenna?	7. Ubbade 8. Saminttan issitto woyikko nautto 9. Agginappe 1-3 10. Issito issitto 11. Tanni erikke 12. Ixxissi	

S.N	Oyisha	Response	Res pon se															
H68	Ne kettawa ushara gayittidaganni hagappe kalliya abba mettoyi gaakidde? a) Mishsha mettoyi b) Payattetta mettoyi c) Keetta assara /laaggiyara oshayi d) Maattayi de 'iyogettura mettoyi (Uttelya gottatura/polissetura, h.h.m) x) Haarata, qooncissa	<table border="1"> <thead> <tr> <th></th> <th>Ee</th> <th>Akkayi</th> </tr> </thead> <tbody> <tr> <td>A)Miisha metuwa</td> <td>1</td> <td>2</td> </tr> <tr> <td>B) Payattetta metuwa</td> <td>1</td> <td>2</td> </tr> <tr> <td>C) Keetta assara/lagi iyara osha</td> <td>1</td> <td>2</td> </tr> <tr> <td>D) Maattayi de 'iyogettura mettoyi (Uttelya gottatura/polissetura, E) Harra</td> <td>1</td> <td>2</td> </tr> </tbody> </table>		Ee	Akkayi	A)Miisha metuwa	1	2	B) Payattetta metuwa	1	2	C) Keetta assara/lagi iyara osha	1	2	D) Maattayi de 'iyogettura mettoyi (Uttelya gottatura/polissetura, E) Harra	1	2	
	Ee	Akkayi																
A)Miisha metuwa	1	2																
B) Payattetta metuwa	1	2																
C) Keetta assara/lagi iyara osha	1	2																
D) Maattayi de 'iyogettura mettoyi (Uttelya gottatura/polissetura, E) Harra	1	2																
L69	Ha'i nenna kasse oyidu samminttatu garssani uni idabatta hassayana. Ha'i oyicha : Ne layittani ne shempuwa woranna gadda qooppada errayi ?	Eee.....1 Akkayi.....2 Akekikike3 Ixxisi/Zaaroyi bawa.....4																
L70	Nee shipiyo woorannawu mallada errayi??	Eee.....1 Akkayi2 Akekikike.....3 Ixxisi/Zaaroyi baawa.....4																
H71	Ne matta wode keetawa/laggiya kondomiya go'etossi gadda oyicha erayi?	Eee..... 1 Akayi..... ..2 Akekikike.....3																

		Ixxisi4	
H72	Ne matta wode keetawa/laggiya kondomiya go"ettikke gidde ixside?	Eee.....1 Akayi.....2 Akekke.....3 Ixxisi.....4	If 1 Go L7 4
H73	Kondomiya go"ettikke yagogga nessi ayibba oogiyanni yottide? Ubba zaaruwaka malatta	Go"ettikke yaggidi yottissi A Waasissi/Yillotisi B Shocannawu yashisisi C Yedanawu/keetappe karre yedanawu gissi D Tanna shocissi.....E Kondomiyo xayisis /ekkisiF Amannetakka yagidi motissi/Lo"o maccassa giidakka giisi..... G Ta bollanni micissi/sheneho giisi..... .. H Hegge maadenna giisiI Harrabba X	
L74	Tanni ha"i nenni kochoruwanni gayittiddo asho ngakettamba oyichanna. Koyiro neenni asho gayittottetta oottiyode nessi appunni layitte?	Kumetta layitta-----	
L75	Koyiro nenni asho gayitottetta ottiyode ayibbi nenna gaakide? Ta maattana; Tanna amanttissi; Tanni cimettasi; Tannaa wolkanttisi; tanna dafarissi	Hege ta sheenne.....1 Tanni amannettasi.....2 Tanni cimettasi.....3 Tanyo wolqamisi.....4 Tanni dafaretassi.....5	
L76	Heegge onnara haanide?	Keetawa/lagiyara.....1 Attuma siquwara.....2 Astamariyara.....3 Awara/Taa keetta assara.....4 Tamare keettan heeraattumassara.....5 Keetta assa laagiyara.....6 Taa dabuwaara.....7 Immattara/erenna assara.....8 Haarara..... 9	
L "	Neenni arra asho gayitottetta ottiyode assi appunn layitte? Nenni ayo	Layitta [][] Taappe daressi.....1 Tagga malla.....2 1-2 layitta tappe darressi.....3 3-5 layitta tappe daressi.....4 5-10 layitta taappe daressi.....5 10 layitta taappe dareesi.....6 Zaaruwa ixxisi.....9	

L78	Macca aassassi asho gaytottettasi de"iya atumassa qodayi issuwappe issuwanni dumattessi . Issi issi assassin issi laggeHaarassi qassi 2 woyikko arroyi, harrassi qassi daroyi, ubbaka 50 nne heegappe dariyaga. Nessi layittani qassi ayikkenna assa asho gayttetetta ottadi? Koshiyabba gidiko pilga: Darooye gutte; Tanni like payiduwa koyikke.	Lagettu payidoyi..... [][] Akekikke.....1 Ixxisi/ Zaaroyi bawaa2	
L79	Nee na"attetta wode, ne ayiyya nne awanni sho"ettade?	Eee..... ..1 Akkayi..... ...2 Yellidagetti issippe de"okonna.....3 Errikke.....4 Ixxissi.....5	
L80	Na"attettani , haa tochetta be"addi?	Eee.....1 Akkayi.....2 Tanni erikke.....3 Ixxissi/Zaaroyi baawa.....4	
H81	Nenni eriyode ne azinna ayiya ba keettawanni sho"ettade?	Eee.....1 Akkayi2 Yellidagetti issippe de"okonna.....3 Akekikke..... ..4 Ixxassi/Zaaroyi baawa.....5	
H82	Nee matta azinnayi/ lagge haa toshiya be"idde?	Eee.....1 Akkayi.....2 Akkekike.....3 Zaaroyi bawaa.....4	
H83	Nenni eriyode nne matta keettawa/lagge ubba wodde onnanninne ba keetta assappe shoettidi erri?	Eee.....1 Akayi.....2 Akkekike.....3 Ixxisi/Zaaroyi bawaa.....4	
H84	Nenni eriwodiyappe dommidi ne keetaway harra assara warettidi eriyee?	Eee.....1 Akayi2 Erikke/Akekike.....3 Ixis/Zaaroyi baawaa..... 4	

	Kiffiliya IV: Barri kettayiyo shochanawu de 'iya				
	Ha mabarran gidi harrani assassin bari so assassin duma duma qofayi de 'es. Qassika maccassawukka attumassau wogga gidiya eshayi de '3ss. He qooppa qashuwa taani nessi nababanna.Hegga qassi nenni maayettiyaakonne maayettenako yootassa. Heegasika like woyikko like gidenna zaaroyi baawa.				
A85	Nee qoofanni , Keetawa barri maccasiyo shocannayiyo lo "oo gassoyi daannawu dandayi? a)Barri keetawa ufayisiyattuan soo ossuwa oottada wursana xaayiko? b) Barri keetawassi azazetanna xayiko c) Asho gayittetawu ixissi giiko d) Assi gela 'o laagge de 'iyakonne oyichiko? e) Keetawa barikettayio amannetuku giidi siriko. f) Keetayiya amannettenaga I demiyabba giidiko	A) Soo keetta B) Azaazettennani xaayiko C) Ashuwa gaayitottetta ixixikko D) Gela 'o laagiya E) Siiriko F) Amannettenna	Yes 1 1 1 1 1	No 2 2 2 2 2	DK 3 3 3 3 3
A86	Nee qoofani, Geellida macassayi bari keetawassi asho gayitottetta ixnanawu dandayiyo ogge : a) Maacassiya koyennani xaayikko b) Izawi usha uyiabba giidiko c) Keetayiya uyiabba giidiko d) Keetawayi o toochiko e) Keetawasi harra Haara corra maccssa lagge de 7esi gada siiriko f) Baari keetawassi basho gayittetappe oyikiya sakoyi/ HIV de 'essi gaada siiriko	A) Koyennani xaayiko B) Usha uyiiko C) Saaketiko D) Toocho E) haara maccassa siriko F) HIViya siiriko	1 1 1 1 1 1	2 2 2 2 2 2	3 3 3 3 3 3
Zariyagga nne I keetawaa					
H87	Nenninne ne keetawayi haagappe kaaliya huphe yohuwabba issippe haasayidetti: a) Galla galla hannettidabatun b) Galla ne bollanni hannidabatunni c) Nenna mettidabatunni d) A meettidabatunni	a) Kettawa gallassan b) Nee gallassan c) Ne mettuwanni d) A mettuwanni	1 1 1 1	2 2 2 2	3 3 3 3
H88	Nenninne ne matta wode keetawayi haagappe asho gayitottetta wattidi ottannako, awude ottannako, apputte ottanako hassayidi eretti?	Ayininko.....1 Issitto issitto.....2 Ubatto.....3 Hassayidi erreko.....4 Ixxisi/Zaaroyi bawa.....5			
H89	Ne matta wode azinnara de 'iya gayitottetanni, arra wooqa wodiya warettidetti?	Ayininko.....1			

	Hinno ayiniko ayiniko wode gayiye, issitto issitto woyike ubbade?	Issitto issitto.....2 Ubatto.....3 Hassayidi erreko.....4 Ixxisi/Zaaroyi bawa.....5 Warrettidi erokko----- -----6	
L90	HIV maramarettadi?	Eee.....1 No.....2 Zaarua ixixisi.....3	
HIV de iyo assa kanchiya oyicha. Oyishsha L98 baa maccassayi HIVE bayinabba giidiko			
H91	HIViya wuxettiya ne kettawassi /laagiyassi yootadi?	Eee.....1 Akayi.....2 Ixxisi/Zaroyi bawa.....3	If 1 Go L9 3
L92	Ne keetawayoo/laagiyayo nee HIVibiya wuxettiya yottannawu halchayida de7ayi ?	Eee.....1 Akayi.....2 Ixxisi/zaroyi bawa.....3	
L93	Ne keetawassi/laagiyassi nee HIV iya wuxettiya qoncissada yootannawu woqa wodiya ekidde?	Heezu gallassa gidoni.....1 Issi samitta garsan.....2 Issi agginna,,,,,..... 3 Heezu agginna ,,,,,4 Ussupunni agginna.....5 Ussupun agginappe bolla.....6	
L94	HIV wuxettiya siyiddi makki simiddi nee keetawa /matta lagge besido eshayi ayi malle?	Tanna maddisi.....1 Ta bollanni wassisi.....2 Tanna zempissisi.....3 Tochisi/sho 'isi.....4 Kawusha toshiya.....5 Barri HIV tamarissisi6 Ta asho gayitottetta tarikiya oyichisi.....7 Hakimiya/nursiya zoretta	

		oyichisi.....8 Shocannawu yashisisi.....9 Ollidi aggiggannawu yashisisi.....10 Tanna olliddi aggiyaagissi.....11 Asho gayittetetta aggiyagissi.....12 Harra maccassa ekkissi.....13 Taani erike.....14 Iuppayittissi.....15 Harrabba.....16	
L95	Neeni qoopiyodde arranne nee keetawarra de'iya gaayittottetta kasegappe HIV wuxettiya yotta siminni lo'uwawu lamettideye ettawu lamettide?	Lo'uwawu.....1 Iittawu.....2 Ayibbawunne laamettibenna.....3	
L96	Nee HIV wuxettiya harra assawu yootadi?	Eee.....1 Akkayi.....2 Zaaroyi ixxisi.....9	
L97	Ettappe aymalla maaduwa demaddi?	Zorriya.....1 Miisha.....2 Maraja.....3 Xaaliya/kiininiya.....4 Haarabba.....5 Ayibbakka demabbeyikke.....6	
Kiffiliya Uddufunna V: Oyisha wursetta			
L98	Ha 'i ninni oyisha wurssida. Nenni immiyo qooqi haari de 'i, gujannawu koyiyobbi haarabbi de 'i? ----- ----- -----		
L99	Keehippe mettya oyishatta oyichassi. Ha oyishatunni neessi siyettidabbi ayibbe.....? Oyishettiya izawi imido zaaruwa mulliyakka xaappa? <hr/> Wurssa	Lo'o.....1 Iitta/lo'enna2 Issi malla/Dummabi bawa 3	

Ha oyiisha zaaranawu beettido giishawu keehippe Gaalatosi !

Appendix 13: Amharic questionnaire

ስለእናቶች ጤና መጠይቅ: ጤና ይስጥልኝ? ስሜ ----- ይባላል። እኛ በወላይታ ዞን ላይ ስለ እናቶች ጤና እና የሕይወት ተሞክሯቸውን ለመመርመር የዳሰሳ ጥናት እያካሄድን እንገኛለን። እርስዎ በዚህ ጥናት ለመሳተፍ እንደ ሎቶሪ ዕጣ በዕድል ተመርጠዋል።እርስዎ የሚሰጡኝ መረጃ በሙሉ በሚስጥር እንደሚያዝ ለማረጋገጥ እፈላጊለሁ። የእርስዎ ስም በምንም ተዓምር በተመራማሪ አይያዝም / አይመዘገቡም። በማንኛውም ሰዓት መጠይቁን / ውይይቱን ለማቋረጥ ሙሉ መብት አለዎት። በተጨማሪም ማንኛውንም ለመመለስ የማፈልገትን መጠይቅ የመዘለል መብት አለዎት። አንዳንድ መጠይቆች ትንሽ ልክብዱ ይችላሉ።

የምርምሩ ዋና ዓላማ እና ጥቅም : እናቶች ላይ ከትዳር አጋር / ጓደኛ የሚደርስ ትንኮሳ/ ግጭትና ከግጭቱ ጋር ተያያዥ ያላቸውን ነገሮች ለመፈተሽ እና የአከባቢውን መረጃ ለማደራጀት ከትዳር አጋር / ጓደኛ የሚደርስ ትንኮሳ/ ግጭት ለመከላከል የሚሠራውን ፕሮግራሞች ይረዳ ዘንድ ነው። በምርምሩ መሳተፍ ለተሳታፊዎች ቀጥተኛ የሆነ ጥቅም አያስገኝም። ቢሆንም ለተሳታፊዎች የቀሰላቸውን ታርክ ለመወያየት ምቹ ዕድል ይፈጥራል።

የምርምሩ ጉዳት : በዚህ ምርምር ፕሮጀክት መሳተፍ የሚያሳምምዎትን የትንኮሳ ልምድ ማካፈሉ ምቹ ላይሆን ይችላል። በጣም ትንሽ የሚንገምተው ጉዳት ሊኖረው ይችላል።

አድራሻ እና ጥያቄ : ጥያቄ ካሎት ልጠይቁኝ ይችላሉ። ተጨማሪ መረጃ ካስፈለገት ወይም ከጥናቱ ለመውጣት ከፈለጉ የምርምሩን ባለበት አቶ መንግሥቱ መስቀሌ በስልክ ቁጥር (+251913177996 ወይም በኢ-ሜል አድራሻ: mengistu77@gmail.com) ደውለው ማናገር ይችላሉ። Biomedical Research Ethics Administration: Email: BREC@ukzn.ac.za Tel: 27 31 2604769 - Fax: 27 31 2604609.

የስምምነት ቅጽ: በዚህ ጥናት የመሳተፍ ውሳኔ የእርስዎ ነው።እታች ያለው ፈርማዎት ይህንን የስምምነት ቅጽ ማንበብን ወይም ሌላ ሰው እንዳይበብሉት እና በዚህ ጥናት ለመሳተፍ መወሰንዎን ያሳያል።ወደፊት ጥናቱን ለማቋረጥ ከፈለጉ በቀላሉ ያሳውቁኝና በየትኛውም ጊዜ ማቋረጥ ይችላሉ። ይህንን መጠይቅ ለማጠናቀቅ 25- 30 ደቂቃ ልፈጅ ይችላል።ጥያቄውን ለመጠየቅ ይስማማሉ? ከተሰማሙ ብቻ ይጠይቁ:

የተሳታፊው ፊርማ ቀን

የምስክር ፊርማ

1. -----

.....

2. -----

የመረጃ ሰብሳቢ ስምና ፊርማ

S7	ስንት ጊዜ አግብተዋል / ከወንድ ጋር ፍሩዋል?	የጋብቻ ቁጥር ----- ፈቃደኛ አለመሆን፤መልስ የለም..... 8	
S8	ከእርስዎ ጋር ግንኙነት ስያደርግ ባለቤትዎ ሌላ ምስት አለዉ?	1. አዎን 2. አይደለም 3. አላውቅም ; አላስታውስም 4. ፈቃደኛ አለመሆን	2, 3, 4 ከሆነወደ 11ይህዱ
S9	ከእርስዎ ጭምር ባለቤትዎ ስንት ምስቶች አሉት?	የምስቶች ብዛት:- ----- ፈቃደኛ አለመሆን.....8	
S10	እርስዎ አሁን/ ድሮ ስንተኛ ምስት ነበሩ? የመጀመሪያ፤ሁለተኛ ወይም.....ስንት	ደረጃ በቁጥር፤- ----- ፈቃደኛ አይደለም ፤ መልስ የለም.....8	
S11	ያሁኑን ባለቤቶን ለማግባት ማን መረጠ ?	1. ሁለታችን መረጥን 2. ተሳታፊ/ እኔ 3. የእኔ ቤተሰብ መረጠ 4. ቤተክርስቲያን 5. ባለቤቴ መረጠ 6. አላውቅም 7. ፈቃደኛ አይደለም	
S12	ያሁኑን ጋብቻ ከመፈጸማችሁ በፊት ካሁኑ ወይም ከቅርብ ጊዜ የጋብቻ አጋርዎን ለማግባት እንደሚፈልጉ ጠይቀዋል?	1. አዎን 2. አይደለም 3. አላውቅም/ አላስታውስም 4. ፈቃደኛ አይደለም/ መልስ የለም	
S13	የእርስዎ ጋብቻ የጥሎሽ ክፊያ ያካተቴ ነበር?	1. አዎን/ ለባል የተሰጠ 2. አዎን / ለሴት የተሰጠ 3. አይደለም 4. አላውቅም	3, 4 ከሆነ ወደ 15 ይህዱ
S14	ሁሉም ጥሎሽ ተከፍሏል ወይም ገና ልከፈል የቀረ አለ?	1. ሁሉም ተከፍሏል 2. በከፍል ተከፍሏል 3 . ምንም አልተከፈለም 4. አላውቅም	
S15	የቤተሰብ ብዛት ስንት ነዉ?	----- ---	
S16	ሐይማኖትዎ ምንድን ነዉ?	1. ኦርቶዶክስ 2. ሙስልም 3. ፕሮተስታንት 4. ካቶልክ 5. ባህላዊ 6. ሐዋሪያት 7. ሌላ ካለ ይገለጽ	
S17	ብሔሮ ምንድን ነዉ?	1. ወላይታ 2. አማራ 3. ዳዉሮ 4. ጉራጌ	

		5. አርጥ 6. . ሌላ ካለ ይገለጽ --	
S18	ሥራዎ ምንድን ነው? (ለሌት)	1. የቤት እጫበት 2. ነጋዴ 3. ተማሪ 4. የመንግሥት / መግሥታዊ ባልሆነ ድርጅት ሠራተኛ 5. ቀን ሠራተኛ 6. ሌላ ካለ ይገለጽ --	
S19	የባለቤትዎ ሥራ ምንድን ነው?	1. ገበሬ 2. የመንግሥት ሠራተኛ 3. ነጋዴ 4. ቀን ሠራተኛ 5. መግሥታዊ ባልሆነ ድርጅት ሠራተኛ 6. ሌላ	
S20	መደበኛ ትምህርት ተከታትለዋል?	1. አዎን 2. አይደለም → 2 ከሆነ ወደ 22 ይህዱ	
S21	የጠናቀቁት ከፍተኛ ክፍል ስንት ነው?	የጠናቀቁት ክፍል.	
S22	ባለቤትዎ መደበኛ ትምህርት ተከታትለዋል?	1. አዎን 2. አይደለም → 2 ከሆነ ወደ 23 ይህዱ	
S23	ባለቤትዎ የጠናቀቀው ከፍተኛ ክፍል ስንት ነው?	የጠናቀቀው መደበኛ ክፍል.	
S24	ወራዊ ገቢ ምን ያህል ነው?	በኢትዮጵያ ብር: ----- -----	
S25	<p>በቤትዎ ውስጥ የሚሠሩ አለ: [አዎን ከሆነ '1' አይደለም ከሆነ '0' ጻፍ.]</p> <p>W1. ተሌቭዥን: ___ W2. ሬድዮ: ___ W3. ሳተላይት ዲሽ: ___ W4. ሞባይል ስልክ: ___ </p> <p>W5. የቤት ስልክ [] W6. ጠረጴዛ [] W7. ወንበር [] W8. አልጋ / የጥጥ/ እስፎንጅ/ ስፍርንግ []</p> <p>W9. ኤሌክትሪክ ምጣድ: ___ W10. ብስክሌት: ___ W11. ሞቶር ሳይክል/ ባጃጅ: ___ W12. ፍራጅ: ___ </p> <p>W13. ኤሌክትሪክ ስቲ/ መብራት [] W14. ትራክተር/ መኪና ___ 15. የእርሻ መሬት/ የከተማ መሬት []</p>		

]	W16. የእንጀራ ምጣድ(የማገዶ) [] W 17 ኤሌክትሪክ ስቶቭ/ ምድጃ []
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ክፈል 2: ስያህቡ ያሁኑ ወይም የቅርብ ጊዜ ባለቤት/ ዳደኛዎት የሚከተለው ሃሳብ ባጠቃላይ እዉነት ነው ብለው ያሰባሉ ? **(ዉሳነ የመወሰን ያለዉ ሙብት)**

S. No	መጠይቅ	አ ዎን	አይደለ ም	አለዉ ቅም
D27	ዳደኛዎትን እንዳያዩ / እንዳይጎበኙ ለማድረግ ይሞክራል?	1	2	8
D28	ወላጅ ቤተሰብ ጋር እንዳትገናኝ ለመቆጣጠር ይሞክራል?	1	2	8
D29	ሁል ጊዜ የምትዉልበትን/ የምትገኝበትን ለማወቅ ይፈልጋል?	1	2	8
D30	እርስዎን ለሰው ከሚያደርገው በልዩነት ይጎዳል ወይም እርስዎን ይረሳል ?	1	2	8
D31	ከሌላ ወንድ ጋር ካወሩ ይቆጣል?	1	2	8
D32	ታማኝ አይደለሽም ብሎ ሁል ጊዜ ይጠራጠራል?	1	2	8
D33	የህክምና አገልግሎት ለማግኘት የእሱን ፈቃድ እንዲታገኝ ይፈልጋል?	1	2	8

የሚከተለው ጥያቄ ለብዙ እናቶች የሚከሰትና የእርስዎ ያሁኑ የትዳር ጓደኛ ወይም ሌላ ጓደኛ በእርስዎ ላይ ስላደረሰው ነገር ነው። የእርስዎ ያሁኑ የትዳር ጓደኛ ወይም ሌላ ጓደኛ በየትኛውም ጊዜ፤

S. N.	ጥያቄ እርሱ ወይም ሌላ ጓደኛ.... አካላዊ ጥቃት ከሚከተለው አድርሷል?	A) አዎን ከሆነ “B” ይቀጥሉ። አይደለም ከሆነ ወደሚቀጥለው ይሂዱ		B) ይህ ባለፉት 12 ወራት ውስጥ ተከስቷል? (አዎን ከሆነ “C” ብቻ ይጠይቁ. አይደለም ከሆነ “D” ን ብቻ ይጠይቁ)		C) ባለፉት 12 ወራት ውስጥ ይህ የተከሰተው አንዴ ፤ ጥቂት፤ ወይም ብዙ ጊዜ ነው? (Cን ከመለሱ ወደ ሚቀጥለው ይሂዱ)			D) ከ12 ወራት በፊት ይህ የተከሰተው አንዴ ፤ ጥቂት፤ ወይም ብዙ ጊዜ ነው?		
		አዎን	አይደለም	አዎን	አይደለም	አንዴ	ጥቂት	ብዙ	አንዴ	ጥቂት	ብዙ
P38	መትቶሻል ወይም እርስዎ ላይ የወረወሩት ነገር ጉዳት አድርሷል?	1	2	1	2	1		3	1	2	3
P39	ገፍቷል ወይም ፀጉር ጎትቷል?	1	2	1	2	1		3	1	2	3
P40	በቡጢ / በቦክስ መቷል ወይም በሌላ ነገር ጎድቷል?	1	2	1	2	1		3	1	2	3
P41	በእርግጫ መቷል፤ ጎትቷል ወይም መቷል?	1	2	1	2	1		3	1	2	3
P42	በሚያቃጥል ነገር ሰውነቶን ሆን ብሎ አቃጥሏል?	1	2	1	2	1		3	1	2	3
P43	መሣሪያ(ጠመንጃ፤ ሹጉጥ ወዘተ እጠቀማለሁ ብሎ አስፈራርቷል፤ ወይም መሣሪያውን፤ ቢላዋን፤	1	20፩	1	2	1		3	1	2	3

ወይንም ሌላ መሣሪያን እርስዎን ለመጉዳት ተጠቅሟል?

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S. N.	ጥያቄ ስሜታዊ ጥቃት/ ስነልቦናዊ	A) አዎን ከሆነ“B”ይቀጥሉ። አይደለም ከሆነ ወደሚቀጥለው ይሂዱ		B) ይህ ባለፉት 12 ወራት ውስጥ ተከስቷል? (አዎን ከሆነ “C” ብቻ ይጠይቁ፡ አይደለም ከሆነ “D” ን ብቻ ይጠይቁ)		C) ባለፉት 12 ወራት ውስጥ ይህ የተከሰተው አንዴ ፤ ጥቂት፤ ወይም ብዙ ጊዜ ነው? (Cን ከመለሱ ወደሚቀጥለው ይሂዱ)			D) ከ12 ወራት በፊት ይህ የተከሰተው አንዴ ፤ ጥቂት፤ ወይም ብዙ ጊዜ ነው?		
		አዎን	አይደለም	አዎን	አይደለም	አንዴ	ጥቂት	ብዙ ጊዜ	አንዴ	ጥቂት	ብዙ ጊዜ
E34	እርስዎን ተሳታፊ ወይም ስለእርስዎ መጥፎ እንዲሰማዎት አድርጓል?	1	2	1	2	1	2	3	1		3
E35	በሰው ፊት አንቋሽጂል/ ዝቅ አድርጓል?	1	2	1	2	1	2	3	1		3
E36	ሆን ብሎ በነገሮች ማስፈራራት (ለምሳሌ ወደ አንቺ በማየት፤ ዕቃዎችን በማጮህ?)	1	2	1	2	1	2	3	1		3
E37	እርስዎን ወይም እርስዎ የሚሰሩለትን ሰው ለመጉዳት ማስፈራራት?	1	2	1	2	1	2	3	1		3

ተ. ቁ	ጥያቄ እርሱ ወይም ሌላ ዳደኛ.... ስለ ወስባዊ ጥቃት ከሚከተለው?	A) አዎን ከሆነ “B” ይቀጥሉ። አይደለም ከሆነ ወደሚቀጥለው ይሂዱ		B) ይህ ባለፉት 12 ወራት ውስጥ ተከስቷል? (አዎን ከሆነ “C” ብቻ ይጠይቁ. አይደለም ከሆነ “D” ን ብቻ ይጠይቁ)		C) ባለፉት 12 ወራት ውስጥ ይህ የተከሰተው አንዴ ፤ ጥቂት፤ ወይም ብዙ ጊዜ ነው? (Cን ከመለሱ ወደ ሚቀጥለው ይሂዱ)			D) ከ12 ወራት በፊት ይህ የተከሰተው አንዴ ፤ ጥቂት፤ ወይም ብዙ ጊዜ ነው?		
		አዎን	አይደለም	አዎን	አይደለም	አንዴ	ጥቂት	ብዙ ጊዜ	አንዴ		ብዙ ጊዜ
S44	እርስዎ ሳይፈልጉ የሁኑ ትዳር አጋርዎ ፤ ዳደኛዎ፤ ወይም ማንኛውም ሌላ አጋርዎ የግብረ-ሥጋ ግንኙነት እንዲያደርጉ በአካላዊ(በኃይል) አስገድዷል?	1	2	1	2	1	2	3	1		3
S45	አጋርዎ ወይም ሌላ ዳደኛ ስለሚያደርጉት ነገር እየፈሩ ነገር ግን ሳይፈልጉ የግብረ-ሥጋ ግንኙነት ፈጽሟል?	1	2	1	2	1	2	3	1		3
S46	አጋርዎ ወይም ሌላ ዳደኛ በኃይል አስገድዶ ፆታዊ ግንኙነት መፈጸሙ ስብዕናዎን/ ሞራሉን የነካበት ሁኔታ አለ?	1	2	1	2	1	2	3	1		3

ተ. ቁ	መጠይቅ			
P47	በአካላዊ ትንኮሳ የተጠየቁ ማንኛውንም ጥያቄዎች አዎን መሆናቸውን አረጋግጥ? የጥያቄ ቁጥር P38- P43 ተመልከት.	3. አዎን፤አካላዊ ትንኮሳ አለ 4. አካላዊ ትንኮሳ የለም		
S48	ፆታዊ ትንኮሳ የተጠየቁ ማንኛውንም ጥያቄዎች አዎን መሆናቸውን አረጋግጥ? የጥያቄ ቁጥር S44- S46 ተመልከት.	3. አዎን ፆታዊ ትንኮሳ አለ 4. ፆታዊ ትንኮሳ የለም		
I49	ነፍሱ ጡር ሆነው ያዉቃሉ?	1. አዎን 2. አይደለም 2 ከሆነ ወደ 52 ይህዱ		
I50	ነፍሱ ጡር እንደነበሩ ነግረዉኛል : : ምናልባት በዛን ጊዜ በአጋሮ ወይም በማንኛውም ጓደኛ የተመቱበት/ የተደበደቡበት ጊዜ ነበረዎት ?	1. አዎን 2. አይደለም → 2, 3, 4 ከሆነ ወደ 52 ይህዱ 3. አላዉቁም/ አላስታዉስም 4. ለመመለስ ፈቃደኛ አልሆኑም/ መልስ የለም		
I51	በደረሰዉ አካላዊ ትንኮሳ የተነሳ ዉርጃ አጋጥሟል ?	1. አዎን 2. አይደለም		
52	አካላዊ ጉዳት፤ስንጥቅ፤ጭረት ፤ወለምታ፤ቃጠሎ ወይም የአጥንት ስብራት ከትዳር አጋርዎ ፤ ጓደኛዎ፤ወይም ማንኛውም ሌላ አጋርዎ ከዚህ ከፍ ብሎ በተነጋገርናቸዉ ጉዳዮች ምክንያት ደርሶበት ያዉቃል? 1. አዎን 2. አይደለም አይደለም ከሆነ ወደ 53 ይህዱ	አዎን	አይደለም	
		1. የተቆረጠበት፤የተበሳ ቁስል፡ ንክሻ	1	2
		2. የተቧቸጨረ፤መገሽለጥ፤ መላላጥ	1	2
		3. ወለምታ፤ ዉልቃት	1	2
		4. ቃጠሎ	1	2
		5. የተበሳ ቁስል፤ በጥልቅ	1	2
		6. የተቆረጠበት፤መድማት		
		7. የተጎዳ የጅሮ ፋምቡር፤የዓይን ቁስል	1	2
		8. ስብራት፤የአጥንት ስብራት	1	2
		9. የጥርስ ስብራት	1	2
10. ሌላ				
I53	በሕይወትዎ ከትዳር አጋርዎ ፤ ጓደኛዎ፤ወይም ማንኛውም ሌላ አጋርዎ ምን ያህል ጊዜ ቆስለዋል/ ተጎድተዋል? ምን ያህል ጊዜ?	11. ምንም → 1, እና 5 ከሆነ ወደ 59 ይህዱ 12. አንዴ/ ሁለቱ 13. ብዙ ጊዜ (3- 5) ጊዜ 14. ብዙ (ከ5 በላይ) ጊዜ 15. አላዉቁም/ አላስታዉስም → 5 ከሆነ ወደ 59 ይህዱ 16. ለመመለስ ፈቃደኛ አልሆኑም/ መልስ የለም		
I54	ይህ ባለፉት 12 ወራት ዉስጥ ተከስቷል ?	1. አዎን 2. አይደለም 3. አላዉቅም/ አላስታዉስም 4. ለመመለስ ፈቃደኛ አልሆኑም/ መልስ የለም		
I55	ስለዚህ ጉዳት የጤና አገልግሎት አግኝቷል ?	1. አዎን 2. አይደለም		
I56	ስለዚህ ጉዳት እርዳታ ለማግኘት ፈልጎ ነበር?	1. አዎን 2. አልፈለጉም		
I57	ይህንን የባለቤትዎን አካላዊ	1. ለማንም አልነገርኩም 2. ለጓደኛ 3. ለቤተሰብ		

	የትንኮሳ ባህሪን ለማን ነገሩ ?	3. ለወንድም ወይም ለእህት 6. ለባል/ ለወላጅ ቤቴሰብ 7. ለልጆች 8. ለጎረቤት 9. ለፖሊስ 10. ለዶ/ር/ ጤና ባለሙያ 11. ለሃይማኖት መሪዎች 12. ለአማካሪዎች 13. ለ NGO/ ለሴቶች ማህበር 14. ለመንደር መሪዎች 15. ለህግ ማህበር 16. ለሌላ	5. አጎት አክስት
I58	ለመርዳት የሞከረ ሰው ነበር?	1. የላም 4. ለወንድም ወይም ለእህት 6. ለባል/ ለወላጅ ቤቴሰብ 7. ለልጆች 8. ለጎረቤት 9. ለፖሊስ 10. ለዶ/ር/ ጤና ባለሙያ 11. የሃይማኖት መሪዎች 12. ለአማካሪዎች 13. ለ NGO ለሴቶች ማህበር 14. ለመንደር መሪዎች 15. ለህግ ማህበር 16. ለሌላ	3. ለቤተሰብ 5. አጎት አክስት

አካላዊ ትንኮሳ የደረሰችዉ ሴቶች

W59	ድብዳቤ በደረሰብዎት ጊዜ መልሰዉ በእሱ ላይ አካላዊ ድብዳቤ አድርጓል ወይም እራስዎን ተከላክለዋል? 1. አዎን 2. አይደለም አዎን ከሆነ ምን ያህል ጊዜ?	9. አንዴ ወይም ሁለት 10. ብዙ ጊዜ / አብዛኛዉ ጊዜ 11. አላዉቅም / አላስታዉስም 12. አንቢ / መልስ የለኝም
W60	ባለቤትዎ እርስዎን ሳይመታ እርስዎ የእሱን አካል መትተዉ ወይም ተችተዉ ያዉቃሉ? 1. አዎን 2. አይደለም አዎን ከሆነ ምን ያህል ጊዜ ?	1. አንዴ ወይም ሁለት 2. ብዙ ጊዜ / አብዛኛዉ ጊዜ 3. አላዉቅም / / አላስታዉስም 4. አንቢ / መልስ የለኝም

ክፍል: የሕይወት ዘመን የትንኮሳ ልምድ ከዘመድ፣ከሌላ ከሚያዉቁት ሕዝብ፤ እና/ ወይም ከእንግዳ

S.No.	ጥያቄ	የተከበቡትን ብቻ ጠይቅ ምን ያክል ጊዜ ነዉ ይህ የተከሰተዉ?			
		አንዴ ወይም ሁለት	ጥቅት ጊዜ	አብዛኛዉ ጊዜ	
W61	ከ15 ዓመት በኋላ ያሁኑ ወይም የድሮ ዳደኛ፤ ወይም ከባለቤት ጋር አካል ለሆነ የደበደቤ ወይም በሌላ ነገር የመታሸ ሰው አለ? 1. አዎን 2. አይደለም , አዎን ከሆነ ማን አደረገ? ፈትሽ: ዘመድስ እንዴት ነዉ? ትምህርት ቤት ወይም ሥራ ላይ ያለዉ ሰውስ? ዳደኛ ወይም ጎረቤት? እንግዳ ወይም ሌላ ማንኛዉም ሰው?	1. ማንም	1	2	3
		2. አባት	1	2	3
		3. የእንጀራ አባት	1	2	3
		4. ሌላ ወንድ የቤት አባል	1	2	3
		5. ሴት የቤት አባል	1	2	3
		6. አስተማሪ	1	2	3
		7. ፖሊስ/ ወታደር	1	2	3

		8. የቤተሰብ ወንድ ጓደኛ	1	2	3
		9. የቤተሰብ ሴት ጓደኛ	1	2	3
		10. የወንድ ጓደኛ	1	2	3
		11. እንግዳ	1	2	3
		12. በሥራ ላይ ያለው ሰው	1	2	3
		13. ቄስ/ የሐይማኖት	1	2	3
		14. መሪ	1	2	3

ክፍል3: ከዘመድ፣ከሚያወቁት ሌላ ሰው፤ ወይም ከእንግዳ በሕይወት ዘመን የሚደርስ ትንኮሳ

S. No.	ጥያቄ	ማን ነው ያደረገው?	የተከበቡትን ብቻ ጠይቅ ምን ያክል ጊዜ ነው ይህ የተከሰተው?		
			አንዴ / ሁለቴ	ጥቅት ጊዜ	አብዛኛው ጊዜ
S62	<p>ከ15 ዓመት በፊት ከቤተሰብ አባላት ማናቸውም ለግብረ-ሥጋ ግንኙነት እርስዎን ነክቷል ወይም እርስዎ ባይፈልጉም የግብረ-ሥጋ ግንኙነት እንዲያደርጉ አድርጓል?</p> <p>1. አዎን 2. አይደለም</p> <p>አዎን ከሆነ: ማን ነው ያደረገው? አዎን ከሆነ ወይም አይደለም ከሆነም ይቀጥሉ:</p> <p>በትምህርት ቤት አንዴት ነው? ጓደኛ ወይም ጎረቤት እንዴት ነው? ማንኛውም ሰው በእርስዎ ላይ ይህንን አድርጓል? አዎን ከሆነ: ማንኛው ያደረገው?</p>	1. ማንም	1	2	3
		2. አባት	1	2	3
		3. የእንጅራ አባት	1	2	3
		4. ሌላ ወንድ የቤተሰብ አባል	1	2	3
		5. ሴት የቤተሰብ አባል	1	2	3
		6. አስተማሪ	1	2	3
		7. ፖሊስ/ ወታደር	1	2	3
		8. ወንድ የቤተሰብ ጓደኛ	1	2	3
		9. ሴት የቤተሰብ ጓደኛ	1	2	3
		10. ወንድ ጓደኛ	1	2	3
		11. እንግዳ	1	2	3
		12. በሥራ ላይ ያለው ሰው	1	2	3
		13. ቄስ/ የሐይማኖት	1	2	3
		14. መሪ	1	2	3

S. N.	ጥያቄ	መልስ	ዝላል
L63	አካላዊ ወይም ፆታዊ ጥቃት ባጋጠሞት ጊዜ የሁለታችሁ ግንኙነት ምን ሆነ?	<ol style="list-style-type: none"> 1. በጊዜያዊነት ግንኙነቱን አቋሚያለሁ 2. በቋሚነት ግንኙነቱን አቋሚያለሁ 3. ጥቃት አላጋጠመኝም 4. ሌላ 	3 Go H65
L64	አካላዊ ወይም ፆታዊ ጥቃት ያስከተለው ዉጤት ምንድን ነው?	<ol style="list-style-type: none"> 1. ምንም 2. እራስህን መጉዳት/ ማዋረድ 3. የጤናና ህክምና ችግር 4. ከህብረተሰብ መገለል 5. ለመሠረታዊ ፍላጎቶች መድረሱ መቀነስ 	
H65	አሁን ወይም በፊት ባለቤትዎ አልከል ይጠጣል?	3. አዎን 2. አይደለም	2 ከሆነ ወደ 69 ይህዱ
H66	ምን ያህል ጊዜ ነው አልከል የሚጠጣው?	<ol style="list-style-type: none"> 5. ሁል ቀን ወይም ለሁል ቀን ተቀራራቢ 6. በሳምንት አንዴ / ሁለቱ 7. በወር 1-3 ጊዜ 8. አልፎ አልፎ 5 አላወቅም/ አላስታወስም 6. ፈቃደኛ አይደለሁም/ መልስ የለኝም 	

H68	ባለፉት 12 ወራት ውስጥ የባለቤትዎ አልከል መጠጣት ጋር በተያያዘ ያጋጠመዎት ችግር ከሚከተለው የትኛው ነው?		አዎን	አይደለም
		A) የገንዘብ ችግር	1	2
		B) የጤና ችግር	1	2
		C) ከቤተሰብ እና ዳደኛ ጋር ፀብ	1	2
		D) ከታላቋዎች ጋር ችግር (የሆተል ባለቤት/ ፖሊስ ወዘተ,)	1	2
	E) ችግር የለም F. ሌላ ይገለጽ	1	2	
L69	ባለፉት አራት ወራት ውስጥ ራስዎን ለማጥፋት አስባዎት ያወቃሉ?	<ol style="list-style-type: none"> 1. አዎን 2. አይደለም 3. አላወቅም 4. ፈቃደኛ አይደለሁም/ መልስ የለኝም 		
	ራስዎን ለማጥፋት ምክረው ያወቃሉ?	<ol style="list-style-type: none"> 1. አዎን 2. አይደለም 3. አላወቅም 		

L70		4 . ፈቃደኛ አይደለሁም/ መልስ የለኝም	
H71	ያሁኑን ወይም የቅርብ ጊዜ ዳደኛዎትን/ ባለቤቶን ኮንዶም እንዲጠቀም ጠይቀው ያዉቃሉ?	1 . አዎን 2. አይደለም 3 . አላውቅም 4 . ፈቃደኛ አይደለሁም/ መልስ የለኝም	
H72	ያሁኑ ወይም የቅርብ ጊዜ ዳደኛዎ/ ባለቤትዎ ኮንዶም ለመጠቀም እንቢ ብሉ ያዉቃል?	1 . አዎን 2. አይደለም 3 . አላውቅም 4 . ፈቃደኛ አይደለሁም/ መልስ የለኝም 2- 4ኪሆነ ወደ 74 ይህዱ	
H73	በምን ዓይነት መንገድ ነው ኮንዶምን ለመጠቀም እንቢ ማለቱን የገለጸው? ሁሉንም ምላሾች ያክብቡ	A ጮኹብኝ/ ተቆጣኝ B ለመምታት አስፈራራኝ C ከቤት ለማዉጣት አስፈራራኝ. D መታኝ/ አካሌን ተነከሰኝ..... E ኮንዶሙን አጠፋ F ታማኝ እንዳልሆንኩኝ ከሰሰኝ/ ጥሩ ሴት እንዳልሆንኩኝ. . G ሳቀብኝ/ በጥሩ አላየኝም..... H አስፈላጊ እንዳልሆነ ነገረኝ. I ሌላ X	
L74	አሁን ስለመጀመሪያ ጊዜ ስለፈጸሙት ግብረ- ሥጋ ግንኙነት ልጠይቆት። በምን ዕድሜ/ መቼ የግብረ- ሥጋ ግንኙነት ጀመሩ?	ዕድሜ በሙሉ ዓመት፡- - - - - - - - - -	
L75	ከሚከተለው የትኛው ነው እርስዎ በመጀመሪያ ጊዜ የግብረ- ሥጋ ግንኙነት ስያደርጉ የተፈጸመውን ድርጊት የሚገልጸው?	1 . እኔ ፈቃደኛ ነበርኩ 2. አሳምነውኝ ነበር 3 . ተታልዬ ነው 4. ተገድጄ ነበር 5. ተደፍሪያለሁ	
L76	ይኼ የሆነው ከማን ጋር ነበር?	1. ባል 2. ወንድ ዳደኛ 3. አስተማሪ 4. አባት/ ቤተሰብ አባል 5. የትምህርት ቤት ወንድ/ የአከባቢ 6. የዳደኛ ቤተሰብ 7. ዘመድ 8. እንግዳ/ የማይታወቅ ሰው 9. ሌላ	
L77	እርስዎ ከዛ ሰው ጋር የግብረ- ሥጋ ግንኙነት ስፈጽሙ ለእሱ/ ለሃ ሰው ስንት ዓመት ነበር?	በዓመት - - - - - - - - - - A. ከእኔ በዕድሜ ያንሳል B. ተመሳሳይ ዕድሜ ነበርን C. 1- 2 ዓመት ይበልጠኝ ነበር D. 3- 5 ዓመት ይበልጠኝ ነበር E. 5- 10 ዓመት ይበልጠኝ ነበር	

		F. ከ10 ዓመት በላይ ይበልጠኝ ነበር G. ፈቃደኛ አይደለም/ መልስ የለኝም		
L78	ለእናቶች ያሉዋቸው የግብር- ሥጋ ግንኙነት ዳደኛ ከአንዱ ወደ ሌላው እናት በጣም ይለያያል። አንዳንዶች እናት አንድ ዳደኛ ፤ለሌላ 2 ወይም ከዛ በላይ፤ ለሌላ ደግሞ ብዙ እንዳዉም ከ 50 በላይ፡ በአይወትዎ ምን ያክል ከተለያዩ ወንዶች ጋር ነዉ ግንኙነት ያደረጉት? ፈትሽ: ብዙ ነዉ ወይም ጥቂት; እቅጩን አይደለም ለማዎቅ የሚፈላገዉ.	ዳደኞች ብዛት አላዉቅም/ አላስታዉስም..... 1 ፈቃደኛ አይደለም/ መልስ የለም..... 2		
L79	ህፃን በነበሩ ጊዜ እናትዎ በአባትዎ ወይም በራስዎ ወንድ ዳደኛ ተመትተዉ ነበር?	1. አዎን 2. አይደለም 3. ወላጆች በአንድነት አይኖሩም 4. አላዉቅም 5. ፈቃደኛ አይደለሁም/ መልስ የለንም		
L80	ህፃን በነበሩ ጊዜ ይህንን ትንኮሳ አይተዉ ወይም ሰምተዉ ነበር?	1. አዎን 2. አይደለም 3. አላዉቅም 4. ፈቃደኛ አይደለሁም/ መልስ የለኝም		
H81	የባለቤትዎ እናት በራሳቸዉ ባል ተመትተዉ ያዉቃሉ?	1. አዎን 2. አይደለም 3. ወላጆች በአንድነት አይኖሩም 4. አላዉቅም 5. ፈቃደኛ አይደለሁም/ መልስ የለንም		
H82	የቅርብ ጊዜ ባለቤትዎ/ ዳደኛ ይህንን ጥቃት አይቶ ወይም ሰምቶ ያዉቃል?	1. አዎን 2. አይደለም 3. አላዉቅም 4. ፈቃደኛ አይደለሁም/ መልስ የለኝም		
H83	የእርስዎ ያሁኑ ባለቤትዎ / የቅርብ ጊዜ ወንድ ዳደኛ በቤተሰቡ/ ወላጅ ድብደባ ይደርስበት ነበር ወይ?	1. አዎን 2. አይደለም 3. አላዉቅም 4. ፈቃደኛ አይደለሁም/ መልስ የለኝም		
H84	ባለቤቶች ከሌላ ወንድ ጋር አካላዊ ድብደባ ወስጥ ተሳትፎ / ተደባድቦ ያዉቅ ነበር?	1. አዎን 2. አይደለም 3 አላዉቅም 4. ፈቃደኛ አይደለሁም/ መልስ የለኝም		
A85	ክፍል 4: የባለቤት መደብደብ ዝንባሌ የሚከተሉትን ዓረፍተ ነገሮች አነብሎታለሁ። ከወንድ ባህሪ ባለቤታቸዉን ለመምታት ጥሩ ምክንያት ልኖረዉ የሚችለዉ ከሚከተለዉ በየትኛዉ ነዉ? መስማማት አለመስማማቶን የእርስዎን ሀሳብ ይንገሩ ?			
		Ye s	No	D N
	A) የቤት ሥራዋን እሱን በሚያረካ መልኩ ሠርታ ካላጠናቀቀች ለመምታት ጥሩ ምክንያት ነዉ።	1	2	3
	B) እሱን ካልታዘዘች ለመምታት ጥሩ ምክንያት ነዉ።	1	2	3
	C) እሱ ጋር የግብር- ሥጋ ግንኙነት እንቢ ካለች ለመምታት ጥሩ ምክንያት ነዉ።	1	2	3
	D) ሌላ የሴት ዳደኛ እንዳለዉ ከጠየቀች ለመምታት ጥሩ ምክንያት ነዉ።	1	2	3
	E) እሱ ታማኝ አይደለሽም ብሎ ከጠረጠራት ለመምታት ጥሩ ምክንያት ነዉ።	1	2	3
	F) ታማኝ አለመሆኑዋን ካረጋገጠ ለመምታት ጥሩ ምክንያት ነዉ።	1	2	3

A86	ያገቡ እናቶች ለባለቤታቸው የግብረ-ሥጋ ግንኙነት እንቢ ለማለት ከሚከተለው የትኛውን ይችላሉ?			
	a) ባለቤቷ ካላፈለገች የግብረ-ሥጋ ግንኙነት እንቢ ለማለት ትችላለች።	1	2	3
	b) ባሏ መጠጥ ከጠጣ የግብረ-ሥጋ ግንኙነት እንቢ ለማለት ትችላለች።	1	2	3
	c) እሷ ከታመመች የግብረ-ሥጋ ግንኙነት እንቢ ለማለት ትችላለች።	1	2	3
	d) ባሏ ካላከበራት/ ካንቋሸሻት የግብረ-ሥጋ ግንኙነት እንቢ ለማለት ትችላለች።	1	2	3
	e) ከጋብቻ ውጭ ሌላ ሴት ጓደኛ መኖሩን ከጠረጠረች የግብረ-ሥጋ ግንኙነት እንቢ ለማለት ትችላለች።	1	2	3
	f) ባለቤቷ አባላዘር በሽታ/ ኤች ኤችይቭ ካለበት የግብረ-ሥጋ ግንኙነት እንቢ ለማለት ትችላለች።	1	2	3
ተሳታፊዎና ባለቤቷ				
H87	ባጠቃላይ ያሁኑ ባል / የቅርብ ጊዜ ወንድ ጓደኛ የሚከተሉትን ርዕሶች ተወያይተው ያዉቃሉ፡	Yes	No	D N
	a) ስለእሱ ቀን ዉሎ ሁኔታ	1	2	3
	b) ስለ አንቺ ቀን ዉሎ ሁኔታ	1	2	3
	c) ስለአንቺ ጭንቀት ወይም ስሜት	1	2	3
	d) ስለ እሱ ጭንቀት ወይም ስሜት	1	2	3
H88	ባጠቃላይ ያሁኑ ባል / የቅርብ ጊዜ ወንድ ጓደኛ ግብረ-ሥጋ ግንኙነት እንዴት ማድረግ እንዳለባችሁ ተወያይተው ያዉቃሉ፤ ምን ያህል ጊዜ?	1. አልፎ አልፎ 2. አንዳንዴ 3. ሁል ጊዜ 4. አንወያይም 5. ፈቃደኛ አይደለሁም/ መልስ የለም		
H89	ያሁኑ ባል / የቅርብ ጊዜ ወንድ ጓደኛ ጋር በነበራችሁ ግንኙነት ምን ያህል ጊዜ ነዉ የተደባደባችሁት?	1. አልፎ አልፎ 2. አንዳንዴ 3. ሁልጊዜ (ብዙ ጊዜ) 4. አላዉቅም / አላስታዉስም 5. ፈቃደኛ አይደለሁም 6. አልተደባደብንም		
L90	ኤች አይቭ ተመርምረዋል?	1. አዎን 2. አይደለም 3. ፈቃደኛ አይደለሁም/ መልስ የለም		
ደንበኛዉ ኤች አይቭ ፖዜቲቭ ከሆነ ብቻ ይጠይቁ። ከኤች አይቭ ነፃ ከሆነ ወደ ጥያቄ 98 ይህዱ።				
H91	ስለኤች አይቭ ምርመራ ዉጤት ለባለቤትዎ ነግረዋል?	1. አዎን 2. አይደለም <u>አዎን ከሆነ ወደ 93 ይህዱ</u> 3. ፈቃደኛ አይደለሁም/ መልስ የለም		
L92	ስለኤች አይቭ ምርመራ ዉጤት ለባለቤትዎ ለመንገር እያቀዱ ነዉ?	1. አዎን 2. አይደለም <u>1, 2, 3 ወደ 96 ይህዱ</u> 3. ፈቃደኛ አይደለሁም/ መልስ የለም		
L93	ስለኤች አይቭ ምርመራ ዉጤት ለባለቤትዎ ለመንገር ምን ያክል ጊዜ ፈጀዎት?	1. ሦስት ቀናት 2. አንድ ሳምንት 3. አንድ ወር 4. 3 ሳምንታት 5. 6 ሳምንት 6. ከ 6 ሳምንት በላይ		
L94	ባለቤትዎ የእርስዎን ኤች አይቭ ምርመራ ዉጤት ከሰማ በኋላ ያሳየዉ ምላሽ እንዴት ነበር?	1. እርዳታ ሰጠኝ 2. ጮኸብኝ 3. ደገፈኝ		

		4. ጥቃት ፈጸሞብኝ 5. ስነልቦናዊ ጥቃት አደረሰብኝ 6. ስለራሱ ኤች አይቭ አስተማረኝ 7. ስለግብረሥጋ ሕወቴን ታርክ ጠየቀኝ 8. ዶ/ር/ ነርስ አማካሪቸው 9. ለመምታት አስፈራራኝ 10. ለመተዉ አስፈራራኝ 11. ተወኝ 12. ግብረ-ሥጋ ግንኙነት ተወኝ 13. ሌላ ግብረ-ሥጋ አጋር ወሰደ 14. አላዉቅም 15. ደስተኛ ነዉ 16. ሌላ.....	
L95	ከባለቤቶች ጋር ያለዉ ግንኙነት የኤች አይቭ ዉጤት ከገለጹ በኋላ ወደ ጥሩ ተቀየረ ወይስ ወደ መጥፎ?	1. ጥሩ 2. መጥፎ 3. ምንም የተቀየረ ነገር 4. የለም	
L96	ስለኤች አይቭ ዉጤቶን ለሌላ ሰዉ ነግረዉ ነበር?	1. አዎን 2. አይደለም 3. ፈቃደኛ አይደለሁም/ መልስ የለም	2 ወደ 98
L97	ከነገረዎት ሰዉ ምን አይነት እርዳታ አግኝተዉ ነበር?	1. ምክር አገልግሎት 2. ገንዘብ 3. መረጃ 4. ሕክምና/ መድኃኒት 5. ሌላ 6. ምንም	
L98	ክፍል 5: አሁን መጠይቁን ጨርሰናል። ምንአልባት ተጨማሪ አስተያየት ካሎት? ----- -----		
L99	በጣም ከባድ ጥያቄዎችን ጠይቅያለሁ። ይህንን መነጋገራችን ምን እንዲሰማዎት አደረገ? ምላሹን ይጻፉ? 1. ጥሩ/ መልካም 2. መጥፎ/ ጥሩ ያልሆነ 3. ተመሳሳይ/ ልዩነት የለም <p style="text-align: center;">አመሰግናለሁ!</p>		

ጥያቄ I : በጥልቀት የሚጠየቁ መጠይቆች (In-depth-Interview)

ጤና ይስጥልኝ? ስሜ ----- ይባላል። እኛ በወላይታ ዞን ላይ ስለ እናቶች ጤና እና የሕይወት ተሞክሯቸውን ለመማር የዳሰሳ ጥናት እያካሄድን እንኖላለን። እርስዎ በዚህ ጥናት ለመሳተፍ እንደ ሎቶሪ ዕጣ በዕድል ተመርጠዋል። እርስዎ የሚሰጡኝ መረጃ በሙሉ በሚስጥር እንደሚያዝ ለማረጋገጥ እፈላጋለሁ። የእርስዎ ስም ወይም የድምጽዎ ቂጂዎት በምንም ተዓምር በተመራማሪ አይያዝም / አይመዘገቡም።

በማንኛውም ሰዓት መጠይቁን / ወይም ለማቋረጥ ሙሉ መብት አለዎት። በተጨማሪም ማንኛውንም ለመመለስ የሚፈልጉትን መጠይቅ የመዝለል መብት አለዎት። እርስዎ የሚሰጡኝ ማንኛውም መልስ ተቀባይነት አለው። ይህ ማለት የሚሰጡኝ መልስ ትክክል ነው ወይም ስህተት ነው ማለት አይደለም። አንዳንድ መጠይቆች ትንሽ ልክብዱ ይችላሉ። ነገር ግን ብዙ ሴቶች ችግራቸውን ለማወራረት እንደ ምቹ አጋጣሚ እንደሆነ ነው የሚናገሩት። ከእርስዎ ጭምር ለሁሉም ሰው በዚህ ዳሰሳ ጥናት መሳተፍ ሙሉ በሙሉ በፈቃዳቸው የሚከውን ስሆን እርስዎ በዚህ ጥናት መሳተፍ በኢትዮጵያ ላይ ሌሎች እናቶች ጠቃሚ ነው። ጥያቄ አለዎት?

ይህንን መጠይቅ ለማጠናቀቅ 45 ደቂቃ ልፈጅ ይችላል። ጥያቄዎን ለመጠየቅ ይስማማሉ?

የተጠያቂ ለመጠየቅ ያለው ስምምነት

1. አልስማማም። ተሳታፊውን ያመስግኑ
 2. እስማማለሁ
- አሁን ከእርስዎ ጋር ለመነጋገር ጥሩ ሰዓት ነው?

እርስዎ እና እኔ በግል ክፍል እንነጋገራለን። ይህንን ክፍል ወደወታደራዊ ወይም እርስዎ የሚመርጡበት ሌላ ክፍል ካሌ እንሂድ? -----

የሚከተለውን የስምምነት ቅጽ ጠያቂዉ ይሙሉ

በዳሰሳዉ ለመሳተፍ ከዚህ በላይ የተፃፈዉን የስምምነት ሂደት ማንበቤን አረጋግጣለሁ።

ፊርማ: _____

Qualitative study section for women: Semi-structured questionnaire for an in-depth interview

1. ስለ እርስዎ ትንሽ ለማወቅ እፈልጋለሁ? መደበኛ ትምህርት ተከታትለዋል?
 - i . የመኖሪያ አድራሻ የት ነው?
 - ii . ልጅ አለዎት?
 - iii . ቀንን እንዴት ያሳልፋሉ?
 - iv . ምን መሥራት ያስደስቶታል?
2. ስለ ባለቤትዎ ልነግሩኝ ይችላሉ? መጀመሪያ እንዴት ተገናኙ? መቼ ነው የተጋቡት?
 1. ባለቤትዎ ምን ይሠራል?
 3. ከባለቤትዎ ጋር ያለው ችግር መቼ ነው የጀመረው? ይህ ችግር ምን ያህል ጊዜ ቆይቷል?
 1. ይህ ችግር የተሻሻለበት ወይም የባሰበት ጊዜ አለ?
 4. በእርስዎ ማህበረሰብ ከባል ጋር የሚደረግ አካላዊ ብጥብጥ/ ሁከት/ ግጭት ምሳሌ ካለ ሊነግሩኝ ይችላሉ? በርስዎ ሕይወትስ? አካላዊ ብጥብጥ/ ሁከት/ ግጭት መቼና የት ተከሰተ?
 5. ሴቶች በባለቤታቸው/ በጓደኛቸው ግብረ-ሥጋ ግንኙነት ለመፈጸም ይገደዳሉ? በምን ዓይነት ሁኔታ? በሁለታችሁ መሃል ማን ነው የግብረ-ሥጋ ግንኙነት እንዴት፤መቼ እና ምን ያህል ጊዜ ለመፈጸም የሚወስነው ማን ነው? ወንዶች ሴቶች የግብረ-ሥጋ ግንኙነት ባይፈልጉም እንዲያደርጉ ያስገድዳሉ? በእርስዎ ማህበረሰብ ከባል ጋር የሚደረግ ፆታዊ ብጥብጥ/ ሁከት/ ግጭት ምሳሌ ካለ ሊነግሩኝ ይችላሉ? በርስዎ ሕይወትስ? ፆታዊ ብጥብጥ/ ሁከት/ ግጭት መቼና የት ተከሰተ?
 6. ጥቃት ፈጻሚ ማን ነው? ፆታዊ ወይም አካላዊ ብጥብጥ/ ሁከት/ ግጭት (ፈትሽ: ባለቤትዎ/ የቤተሰብ አባላት, እርስዎ የሚያወቁት ሰው/ እርስዎ የማያወቁት ሰው.) ጥቃት ፈጻሚ ላይ የተወሰደው ነገር ምንድን ነው?
 7. ሴቶች ከጥቃት በኋላ የሚያጋጥማቸው ችግር ምንድን ነው? (ፈትሽ: አካላዊ, ስነ- ልቦናዊ, ማህበራዊ?
 8. ከአካላዊ ብጥብጥ/ ሁከት/ ግጭት አደጋ የተረፉት እንዴት ሆነው መቋቋም ይችላሉ?
 9. ከፆታዊ ብጥብጥ/ ሁከት/ ግጭት አደጋ የተረፉት እንዴት ሆነው መቋቋም ይችላሉ?
 10. የአካላዊ ወይም ፆታዊ ብጥብጥ/ ሁከት/ ግጭት በሚያጋጥምበት ጊዜ የማሕበረሰቡ ምላሽ ምንድን ነው? ብጥብጡን/ ሁከቱን/ ግጭቱን ለመከላከል ምን ተደረገ?
 11. ከችግሩ የተረፉትን ለመርዳት ምን ተደረገ? ይህን ጥረት ምን ቢደረግ ነው የሚናሻሻለው? ከጥቃት የተረፉትን ለመርዳት የእናቶች ድጋፊ ነትወርክ አለ?
 12. ይህንን ችግር ለመቅረፍ ምን ማህበራዊና ህጋዊ አገልግሎት አለ? (ፈትሽ: ጤና, ፖሊስ, ህጋዊ ምክር፤ ማህበራዊ ምክክር) ይህንን አገልግሎት የሚሰጠው ማን ነው? ይህ ጥረት እንዴት ሊሻሻል ችላለል?

- 13 እርስዎ ወላይታ ከመጡ በኋላ አካላዊ/ ጾታዊ ጥቃት ችግር ተባብሷል ፤ ተሻሻሏል፤ ወይም እንደነበር ነው?
- 14 አካላዊ/ ጾታዊ ጥቃት በእርስዎ አካላዊ ጤንነት ላይ ጉዳት ነበረው? በምን ዓይነት መንገድ?
- 15 ይህ እንዴት እርስዎ ለራስዎት በሚሰጠው ግምት ላይ ጉዳት አለው?
- 16 ስያስብዎ ይህ በልጆችዎ ላይ አስተዋጽዖ/ ጉዳት ነበረው? በምን ዓይነት መንገድ?
- 17 ይህ ጥቃት ለቤተሰብዎ የሚሰጡበትን በመከላከል ወይም ወደ ሥራ እንዳይሄዱ ጉዳት ነበረው?
- 18 ይህ ጥቃት ጓደኛዎን ወይም ዘመዶዎን እንዳይጎበኝ/ እንዳይገናኙ አስቸግሯል? እንዴት?
- 19 የእርስዎን ችግር ከሌላ ሰው ጋር ተወያይተው ያዉቃሉ? ምን ምላሽ ሰጡ?
- 1. ሌሎች ሰዎች ሊያደርጉላቸው የሚወዱት ተጨማሪ ነገር ነበረዎት?
- 2. ምን ተጨማሪ ነገር ቢያደርጉላቸው ይረዳዎት ነበር?
- 20 ወደ እርስዎ ሁኔታ መለስ ይበሉና ለሌሎች ሴቶች የሚሰጡት ምክር ካሉ?
- 21 እነማን ሴቶች ናቸው ይንን መሰል ችግሮችን ከባላቸው ጋር የጀመሩት?

ከኤች አይቭ ጋር ከሚኖሩ ሰዎች የተዘጋጀ መጠይቅ

- 22 እርስዎ ስያስቡ አንድ እናት የኤች አይቭ ምርመራ ውጤቱዋን ለባለቤትዋ መንገር ጥሩ ነው? ይህን ለምን አሉ? ፈትሽ
- 22. አንዳንድ ሴቶች የኤች አይቭ ውጤታቸውን ለመወሰድ ችለው የሚሉት ለምን ይመስላቸዋል?
 - a. PMTCT/ ART ፕሮግራም ለመቀላቀል እንቢ የሚሉት ለምንድን ነው? b. አንዳንድ ሴቶች ውጤታቸውን ለመቀበል እንዲወስኑ የሚያግዘው ነገሮች ምንድን ነው ?
- 23. ሴቶች ለወንድ ጓደኛ/ ባለቤት ውጤታቸውን ለመንገር ምቹ ጊዜ መቼ ነው?
- 24. እርስዎ ለወንድ ጓደኛ/ ባለቤት ለመንገር ከፈለጉ እንዴት ያስረዳሉ?
- 25. ኤች አይቭ በደም ውስጥ እንዳለበት ለባለቤት / ጓደኛ ከተናገሩ በኋላ የሚያሳዩው ነገር ምንድን ነው ?
- 26. ለሌላ ለማን ነው ሴቶች ስለ ኤች አይቭ ውጤታቸውን ለመንገር የሚፈልጉት ?
- 27. ኤች አይቭ በደም ውስጥ እንዳለበት ለባለቤት / ጓደኛ ከተናገሩ በኋላ ምን ልክሰት ይችላል? ፈትሽ በርካታ ባህሪያት/ ምላሽ!
- 28. ሴቶች ኤች አይቭ በደም ውስጥ እንዳለባቸው ለሌሎች ሰዎች ከተናገሩ ምን ልክሰት ይችላል?
- 29. በ ART ፕሮግራም ወንዶች እንዴት ተሳትፏቸዋል ? ወንዶች ሴቶችን በእርግዝና ጊዜያቸው ወቅት ኤች አይቭ እንዲመረምሩ ያበረታታሉ?

ስለሰጡን ጊዜ አመሰግናለሁ!

Annex II: Questionnaires for Focus Group Discussion

ጤና ይስጥልኝ? ስሜ ----- ይባላል። እኛ በወላይታ ዞን ላይ ስለ እናቶች ጤና እና የሕይወት ተሞክሯቸውን ለመማር የዳሰሳ ጥናት እያካሄድን እንገኛለን። እርስዎ በዚህ ጥናት ለመሳተፍ እንደ ሎቶሪ ዕጣ በዕድል ተመርጠዋል። እርስዎ የሚሰጡኝ መረጃ በሙሉ በሚስጥር እንደሚያዝ ለማረጋገጥ እፈላጋለሁ። የእርስዎ ስም ወይም የድምጽዎ ቂጂዎች በምንም ተዓምር በተመራማሪ አይያዝም / አይመዘገቡም። በማንኛውም ሰዓት መጠይቁን / ውይይቱን ለማቋረጥ ሙሉ መብት አለዎት። በተጨማሪም ማንኛውንም ለመመለስ የማፈልገትን መጠይቅ የመዝለል መብት አለዎት። እርስዎ የሚሰጡኝ ማንኛውም መልስ ተቀባይነት አለው። ይህ ማለት የሚሰጡኝ መልስ ትክክል ነዉ ወይም ስህተት ነዉ ማለት አይደለም። አንዳንድ መጠይቆች ትንሽ ልክብዱ ይችላሉ። ነገር ግን ብዙ ሴቶች ችግራቸውን ለማውራት እንደ ምቹ አጋጣሚ እንደሆነ ነዉ የሚናገሩት። ከእርስዎ ጭምር ለሁሉም ሰዉ በዚህ ዳሰሳ ጥናት መሳተፍ ሙሉ በሙሉ በፈቃዳቸዉ የሚከወን ስሆን እርስዎ በዚህ ጥናት መሳተፍ በኢትዮጵያ ላሉ ሌሎች እናቶች ጠቃሚ ነዉ። ጥያቄ አለዎት?

ይህንን መጠይቅ ለማጠናቀቅ 45 ደቂቃ ልፈጅ ይችላል። ጥያቄዉን ለመጠየቅ ይስማማሉ?

የተጠያቂ ለመጠየቅ ያለዉ ስምምነት

1. አልስማማም። ተሳታፊዉን ያመስግኑ
2. እስማማለሁ

አሁን ከእርስዎ ጋር ለመነጋገር ጥሩ ሰዓት ነዉ?

እርስዎ እና እኔ በግል ክፍል እንነጋገራለን። ይህንን ክፍል ወደወታል ወይም እርስዎ የሚመርጡበት ሌላ ክፍል ካሌ እንሂድ? -----

የሚከተለዉን የስምምነት ቅጽ ጠያቂዉ ይሙላ

በዳሰሳዉ ለመሳተፍ ከዚህ በላይ የተፃፈዉን የስምምነት ሂደት ማንበቤን አረጋግጣለሁ።

ፊርማ: _____

Discussion guide

1. በእርስዎ ማህበረተሰብ እናቶችን ያጋጠመዉ የጤና ችግር ምንድን ነዉ? (ፈትሽ፡ በብጥብጥ/ በሁከት/ በግጭት, በጤና / በበሽታ አይደለም) ወንዶች ምን ዓይነት ያልተፈለገ ባሕሪ ወይም ድርጊት በበለቤታቸዉ ላይ ልፈጽሙ ይችላል? ፈትሽ ገንዘብ ነክ፤ ኢኮኖሚ፤ አካላዊ፤ ግብረ-ሥጋዊ?

2. በእርስዎ ማሕበረተሰብ ስለ አካላዊ ብጥብጥ/ ሁከት/ ግጭት, ምሳሌ ሊነግሩኝ ይችላሉ? በእርስዎ ሕይወት? መቼና የት ነዉ አካላዊ ብጥብጥ/ ሁከት/ ግጭት, የተከሰተዉ? ይህ ችግር በእርስዎ አካላዊ ደህንነት ላይ ትላቅ አሉታዊ ተጽኖ አለዉ? በምን ዓይነት መንገድ?
 3. ይህ እንዴት እርስዎ ስለእራስዎ ያለዉን አመለካከት (feeling): ወይም ግምት ሊጎዳ ቻለ?
 4. በማሕበረሰብዎ ያለዉ ፆታዊ ትንኮሳ ምሳሌ ሊሰጡኝ ይችላሉ? በእርስዎ ሕይወትስ? መቼና የት ነዉ ፆታዊ ትንኮሳ የተከሰተዉ?
 5. ትንኮሳዉን ያደረሰዉ ማን ነዉ? ለአካላዊ/ ፆታዊ ትንኮሳ (**ፈትሽ**: የእርስዎ ባለቤት/ የቤተሰብ አባላት፤ እርስዎ የሚያወቁት ግለሰብ ወይም የማያወቁት ግለሰብ) ጥቃት ባደረሰዉ ግለሰብ ላይ የተወሰደዉ እርምጃ ምንድን ነዉ?
 6. ሴቶች በባለቤታቸዉ/ በጓደኛቸዉ ግብረ-ሥጋ ግንኙነት ለመፈጸም ይገደዳሉ? በምን ዓይነት ሁኔታ? በሁለታቸሁ መሃል ማን ነዉ የግብረ-ሥጋ ግንኙነት እንዴት፤መቼ እና ምን ያህል ጊዜ መፈጸም እንዳለበት የሚወስነዉ ? ወንዶች ሴቶች የግብረ-ሥጋ ግንኙነት ባይፈልጉም እንዲያደርጉ ያስገድዳሉ? ይህ ጥቃት ወይም ችግር ከተከሰተ በኋላ በሴቶች ላይ የተከሰተዉ ችግር ምንድን ነዉ? (**ፈትሽ**: አካላዊ፤ ስለ-ልቦናዊ፤ማኅበራዊ ችግሮች)
 7. ከአካላዊ/ ፆታዊ ጥቃት የተረፉት እንዴት ሆነዉ መቋቋም ይችላሉ?
 8. ይህ ጥቃት ጓደኛዎን ወይም ዘመዶዎን እንዳይጎበኝ/ እንዳይገናኙ አስቸግሯል? እንዴት?
 9. ይህንን ችግር ለመቅረፍ የእርስዎ ማህበረተሰብ ምላሽ ምንድን? ሴቶች እርዳታ የሚያገኙት ወይም ሪፖርት የሚያደርጉት የት/ ከየት ነዉ ? ትንኮሳዉን ለመከላከል ምን መደረግ አለበት?
 10. ከጥቃቱ የተረፉትን ለመርዳት የተደረገ ነገር ምንድን ነዉ? ይህ ጥረት እንዴት ቢያደርግ ነዉ? ከጥቃቱ የተረፉትን ለማሻሻል ይረዳ ዘንድ የሴቶች ድጋፍ ነትወርክ አለ?
 11. ይህንን ችግር ለመቅረፍ ምን ማህበራዊና ህጋዊ አገልግሎት አለ? (**ፈትሽ**: ጤና, ፖሊስ, ህጋዊ ምክር፤ ማህበራዊ ምክክር) ይህንን አገልግሎት የሚሰጠዉ ማንዉ? ይህ ጥረት እንዴት ሊሻሻል ችላላል?
 12. አካላዊ ወይም ፆታዊ ትንኮሳ ችግር ተባብሷል ፤ተሻሻሏል ወይም ባለበት ቆይቷል?
 13. የኃይማኖት አባቶች አካላዊ ወይም ፆታዊ ትንኮሳን ለመከላከል መፍትሄ ለማጣታት ይችላሉ?
 14. ፆታዊ ትንኮሳ ከመከላከል አንፃር ሴቶች መሪ ሊያደርጉት የሚችሉት ነገር ይኖራል?
- ኮኤች አይቭ ጋር ከሚኖሩ ሰዎች የተዘጋጀ መጠይቅ**
15. እርስዎ ስያስቡ አንድ እናት የኤች አይቭ ምርመራ ዉጤቱዋን ለባለቤትዋ መንገር ጥሩ ነዉ? ይህን ለምን አሉ? ፈትሽ
 16. አንዳንድ ሴቶች የኤች አይቭ ዉጤታቸዉን ለመዉሰድ ችለ የሚሉት ለምን ይመስለዎታል?

a. PMTCT/ART ፕሮግራም ለመቀላቀል እንቢ የሚሉት ለምንድን ነው? b. አንዳንድ ሴቶች ውጤታቸውን ለመቀበል እንዲወስኑ የሚያግዘው ነገሮች ምንድን ነው ?

17. ሴቶች ለወንድ ጓደኛ/ ባለቤት ውጤታቸውን ለመንገር ምቹ ጊዜ መቼ ነው?

18. እርስዎ ለወንድ ጓደኛ/ ባለቤት ለመንገር ከፈለጉ እንዴት ያስረዳሉ?

19. ኤች ኦይቭ በደም ውስጥ እንዳለበት ለባለቤት / ጓደኛ ከተናገሩ በኋላ የሚያሳዩው ነገር ምንድን ነው ?

20. ለሌላ ለማን ነው ሴቶች ስለ ኤች ኦይቭ ውጤታቸውን ለመንገር የሚፈልጉት ?

21. ኤች ኦይቭ በደም ውስጥ እንዳለበት ለባለቤት / ጓደኛ ከተናገሩ በኋላ ምን ልክሰት ይችላል?

ፈስሽ በርካታ ባህሪያት/ ምላሽ!

22. ሴቶች ኤች ኦይቭ በደም ውስጥ እንዳለባቸው ለሌሎች ሰዎች ከተናገሩ ምን ልክሰት ይችላል?

23. በ ART ፕሮግራም ወንዶች እንዴት ተሳትፏቸዋል ? ወንዶች ሴቶችን በእርግዝና ጊዜያቸው ወቅት ኤች ኦይቭ እንዲመረምሩ ያበረታታሉ?

አመሰግናለሁ!

Semi-structured questionnaire for service provider (In-depth interview)

ጤና ይስጥልኝ? ስሜ ----- ይባላል። እኛ በወላይታ ዞን ላይ ስለ እናቶች ጤና እና የሕይወት ተሞክሯቸውን ለመመርመር የዳሰሳ ጥናት እያካሄድን እንገኛለን። እርስዎ በዚህ ጥናት ለመሳተፍ እንደ ሎቶሪ ዕጣ በዕድል ተመርጠዋል።እርስዎ የሚሰጡኝ መረጃ በሙሉ በሚስጥር እንደሚያዝ ለማረጋገጥ እፈላጋለሁ። የእርስዎ ስም ወይም የድምጽዎ ቂጂዎች በምንም ተዓምር በተመራማሪ አይያዝም / አይመዘገቡም። በማንኛውም ሰዓት መጠይቁን / ወይይቱን ለማቋረጥ ሙሉ መብት አለዎት። በተጨማሪም ማንኛውንም ለመመለስ የማፈልገትን መጠይቅ የመዘለል መብት አለዎት። እርስዎ የሚሰጡኝ ማንኛውም መልስ ተቀባይነት አለው።ይህ ማለት የሚሰጡኝ መልስ ትክክል ነው ወይም ስህተት ነው ማለት አይደለም። አንዳንድ መጠይቆች ትንሽ ልክብዱ ይችላሉ። ነገር ግን ብዙ ሴቶች ችግራቸውን ለማወራረት እንደ ምቹ አጋጣሚ እንደሆነ ነው የሚናገሩት። ከእርስዎ ጭምር ለሁሉም ሰው በዚህ ዳሰሳ ጥናት መሳተፍ ሙሉ በሙሉ በፈቃዳቸው የሚከወን ስሆን እርስዎ በዚህ ጥናት መሳተፍ በኢትዮጵያ ላሉ ሌሎች እናቶች ጠቃሚ ነው። ጥያቄ አለዎት?

ይህንን መጠይቅ ለማጠናቀቅ 40 ደቂቃ ልፈጅ ይችላል።ጥያቄዎን ለመጠየቅ ይስማማሉ?

የተጠያቂ ለመጠየቅ ያለው ስምምነት

- 1. አልስማማም። ተሳታፊውን ያመስግኑ
- 2. እስማማለሁ

አሁን ከእርስዎ ጋር ለመነጋገር ጥሩ ሰዓት ነው?

እርስዎ እና እኔ በግል ክፍል እንነጋገራለን።ይህንን ክፍል ወደወታደራ ወይም እርስዎ የሚመርጡበት ሌላ ክፍል ካሌ እንሂድ? -----

የሚከተለውን የስምምነት ቅጽ ጠያቂው ይሙሉ

በዳሰሳዎ ለመሳተፍ ከዚህ በላይ የተፃፈውን የስምምነት ሂደት ማንበቤን አረጋግጣለሁ።

ፊርማ: _____

- 1. በዚህ ተቋም የእርስዎ ኃላፊነት ምንድን ነው?
- 2. ሴቶች ወደ ቢሯችሁ ወይም ድንገተኛ ክፍል የሚመጡበት ዋና ምክንት ምንድን ነው?
- 3. የቤተሰብ ወይም የትዳር አጋር ትንኮሳ ኬዝ ታይቶ ያወቃል?
- 4. ደንበኞች የቤተሰብ ትንኮሳ መድረሳቸውን ለማረጋገጥ የእርስዎ ሥራ ባልደረቦች በየጊዜው ይጠይቃሉ?

5. ሴቶች ትንኮሳ መድረሳቸውን ሪፖርት በሚያደርጉበት ጊዜ ምን ዓይነት ምርመራ ታደርጋላችሁ? ምርመራውን አማራጭ እንዴት ትወስናላችሁ?
6. ሴቶች ትንኮሳ ምርመራ ለማካሄድ የሚያጋጥመው ችግር ምንድን ነው ?
7. የሴቶች ጾታዊ / አካላዊ ጥቃት ለመከላከል ሥልጠና ወስደዋል?
8. የትኛውን ዓይነት የሴቶች ጾታዊ / አካላዊ ጥቃት መርምረው/ አግኝተው ያውቃሉ ?
9. ሴቶች የደረሰባቸውን ጥቃት ሳይጠየቁ ለባለሙያ ይናገራሉ?
10. ምን ዓይነት ትምህርት ብሰጣቸው ጥሩ ነው ብለው ያምናሉ? ትምህርቱን እንዴት አገኛችሁ? እነዚህን ትምህርቶች ሴቶች ሪፖርት ያደርጋሉ ወይም እርስዎ አግኝተዋል?
11. ህጋዊ የምርመራ ሪፖርት ካከመው ሐኪም ለማግኘት ምን ዓይነት ሂደት ትከተላላችሁ?
12. የእርስዎ ተቋም በየወሩ ምን ያህል ይህን መሰል ችግር ላሌባቸውን ሰዎች አገልግሎት ይሰጣል? ይህንን ኬዝ መዝገብ የመያዝ ነገር አለ? እነዚህን ለመመዝገብ ቅጽና የመመዝገቢያ ህደት አለ ? ለእኔ ሊያብራሩልኝ ይችላሉ?
(የመመዝገቢያ ቅጽ ኮፒ ይጠይቁ, ርፌራል ወረቀት፤ , ሌላ የሚያግዝ ዶክሜንት ካሌ)
13. እርስዎ ወይም የእርስዎ ስታፍ የቤተሰብ ብጥብጥ/ ሁከት/ ግጭት ለደረሰባቸው ሴቶች ክትትላዊ እንክብካቤ ይሰጣሉ? ችግር ያጠማቸውን ሰዎች ወደ ሌላ ተቋም ሪፈር የሚታደርጉበት መንገድ አለ? ሲያስቡ የመረጃ አያያዝ ሁኔታችሁ በቤተሰብ ትንኮሳ የተጎዱትን ለመለየት፤ ተገቢ አገልግሎት ወዳለበት ሪፈር ለማድረግ፤ ጊዜያዊ ክትትላዊ ድጋፍ ለመስጠት በቂ ነው ብለው ያስባሉ?

ከቅርብ ትዳር አጋር ትንኮሳ ካጋጠማቸው ሴቶች ተሞክሮ

14. የቤተሰብ ትንኮሳ ያጋጠማቸው ደንበኞች / በሽተኞችን አግኝተው ያቁቃሉ?
ይህ ልምድ ከየት እንደመጣና እርስዎ ምን እንዳደረጉ እንደሁም ደንበኛው ምን እንዳደረገ ይነግራሉ?
15. እርስዎ የሚያውቁት በዚህ ማሕበረሰብ ውስጥ የቤተሰብ ብጥብጥ/ ሁከት/ ግጭት ለደረሰባቸው ሴቶች ላይ የሚሠራ ተቋም ወይም ግለሰብ አለ? አነሳን ናቸው? እርስዎ ከእነርሱ ጋር ያለው ግንኙነት ምንድን ነው?
16. በቤተሰብ ትንኮሳ የተጠቁትን ሴቶች ፍላጎት ለማሟላት ከሌሎች ተቋም ጋር ያለው ቅንጅት አለ?
17. ምን ዓይነት የህግ ፤የፖሊሲ ወይም የስታፍ ለውጥ ቢናመጣ ነው ሥራውን የሚያሳልጠው?
18. ከእርስዎ ጋር ሚሠሩትን ባልደረቦችን ባህሪ ወይም ዝንባሌያቸውን ምን ቢሆን ነው ሥራውን የሚሳልጠው?
19. ስያስቡ የትዳር አጋር / ጓደኛ ትንኮሳ የፀረ- ኤችአይቭ ህክምናና እንክብካቤ ላይ ጣልቃ/ ችግር አለው? እንዴት?

20. እርስዎ ስያስቦ ሴቶች ኤች አይቭ በደማቸው መኖራቸውን ለባለቤታቸው ከተናገሩ ምን ዓይነት ምላሽ ይሰጣል ብለው ያስባሉ?

አመሰግናለሁ!