

**Addis Ababa University
School of Graduate studies
School of Social Work**

**Intimate partner sexual violence and associated
problems among women living with HIV/AIDS:
The Case of Zewuditu Memorial Hospital Anti-
retroviral treatment (ART) center**



By

Memekia Gashaw Shibabaw

**A Thesis Submitted to the School of Social Work In Partial
Fulfillment of the Requirements for the Degree of Masters in
Social Work**

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Approved by the Examining Committee:

Name

Signature

Dr. Abebe Asfaw, PhD (Thesis Advisor)

(Examiner)

Dr. Mengistu Legesse (Examiner)

(Chairman)

Declaration

I declare that “Intimate partner sexual violence and associated problems among women living with HIV/AIDS: The Case of Zewuditu Memorial Hospital Anti-retroviral treatment (ART) center” is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other degree at any other institution.

Memekia Gashaw

Signature: 

Place: Addis Ababa University, Ethiopia

Intimate partner sexual violence and associated problems among women living with HIV/AIDS:

The case of Zewuditu Memorial Hospital Anti-Retroviral Treatment (ART) center

Abstract

Intimate partner sexual violence is one of the most prevalent types of violence that affects the mental health and economic stability of women, their families and communities. Globally, as per the World Health Organizations (WHO) multi-country studies done in 2002 and 2005 between 6 to 47 % of adult women report being sexually assaulted by intimate partners in their lifetime. Even if, a number of studies showed partner violence is high in Ethiopia; Study on sexual violence is very limited. The purpose of this qualitative case study is to explore the nature of intimate partner sexual violence among women living with HIV and associated psychosocial factors that influenced help seeking and treatment retention. Primary data were collected through in depth interview by using the unstructured interview guide. Purposely selected nine study participants took part in the study. Thematic analysis was used to show the findings. The study highlighted the nature of intimate partner sexual violence experienced, the risk factors predisposing women to sexual violence, women's reaction and the psychosocial problems after IPSV, factors affecting formal help seeking after sexual violence, effect of IPSV on HIV care and treatment Adherences. In this research, I have seen that these women tend to accept unwillingly the sexual demand from their partner just for the sake of avoiding associated traumatic episode of physical and emotional violence. All suffers from psychosocial problems after sexual violence (mostly accompanied with other types of violence: physical and emotional violence). The risk factors and factors affecting formal help seeking were interrelated with each level of ecological model.

Key words: IPSV, women living with HIV/AIDS, Psychosocial problems, Help seeking

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Abbreviations and Acronyms

AACAHB	Addis Ababa City Administration Health Bureau
AIDS	Acquired Immune-Deficiency Syndrome
ART/ARV	Antiretroviral therapy Antiretroviral drug
CD4 count	Count of a subset of T-lymphocytes with CD4 receptor per micro liter of blood
CDC	Center for Disease Control and prevention
CDC-E	Center for Disease Control and prevention- Ethiopia
EDHS	Ethiopian Demographic and Health Survey
EMOH	Ethiopian Ministry of Health
ETB	Ethiopian Birr
EWLA	Ethiopian Woman Lawyers Association
FDRE	Federal Democratic Republic of Ethiopia
FMOH	Federal Ministry of Health of Ethiopia
HIV	Human immune-deficiency Virus
IFSW	International Federation of Social Work
IPV	Intimate Partner Violence
IPSV	Intimate Partner Sexual Violence
MDG	Millennium Development Goal

MTCT	Mother-to-child Transmission of HIV
NGO	Non-Governmental Organization
PLWHA	People Living With HIV/AIDS
PMTCT	Prevention of mother-to- child transmission of HIV
RHB	Regional Health Bureau
UN	United Nations
UNGA	United Nations General Assembly
USA	United States of America
VCT	Voluntary Counseling and Testing
WHO	World Health Organization
ZMH	Zewuditu Memorial Hospital

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CHAPTER ONE: INTRODUCTION

Background of the Study

Sexual violence is one of the common types of domestic violence against a woman globally (Bergen, 1996; Russell, 1990). It includes any unwanted, forced penetration of vaginal, oral or anal orifices or any attempt to complete without the willingness or consent of the woman. It also includes any unwanted or forced touch of private parts of the woman (Deyessa, Kassaye, Demeke, & Taffa, 1998). Sexual violence can occur to any woman including between man and woman in intimate relationships. Intimate partner sexual violence occurs to one out of four women globally (Krug, Mercy, Dahlberg, & Zwi, 2002) or as these women are abused by their own intimate partners to whom they share their happiness and sadness many researchers, this act has been associated with the most severe type of psychosocial trauma.(Bergen, 1999; García-Moreno, Jansen, Ellsberg, Heise, & Watts, 2005; Pagelow, 1992).

Available studies indicate that between 20-50% of women in various populations around the world have experienced spouse (partner) abuse at least at some point in their lives. Globally, between 6 and 47 % of adult women worldwide report being sexually assaulted by intimate partners in their lifetime (García-Moreno, Jansen, Ellsberg, Heise & Watts., 2005; Krug, Mercy, Dahlberg & Zwi., 2002). As per the studies partner (marital) rape accounts for approximately 25% of all rapes and rape in marriage is the most prevalent type of sexual violence. Moreover, studies, which used clinical samples of battered women also, revealed partners rape to one third-one half of the battered women at least once in their life.(Ammerman & Hersen, 1991; Bergen, 1996; Campbell, Wasco, Ahrens, Sefl, & Barnes, 2001; Randall & Haskell, 1995)

The prevalence rate of wife abuse is high in Africa. Studies show that patriarchal societies are more violent towards women moreover male dominance and the force used by a man to

control his wife is seen as legitimate (Abeya, Afework, & Yalew, 2012; Haj-Yahia, 2000).

Intimate partner violence in Ethiopia is also pervasive with physical and sexual violence being the very common types. In previous study based on the data collected in Adigrat zone hospital from 2000- 2003 from 181 rape victims seeking help, 37% of them identified the perpetrator as intimate partner (Guruge, Bender, Aga, Hyman, Tamiru, Hailemariam, & Rafeie-Shirpak., 2012). The WHO's 2002, report to show that in Meskanna Woreda region of Ethiopia; 45% of women were estimated to have been victimized by their own intimate partner and 10% had been victimized in the 12 months preceding the study (Krug et al., 2002).

Ethiopia is one of the sub-Saharan African countries dominated by patriarchal types of systems. Men in this system think that they are entitled to the fulfillment of their sexual need whenever and however they want it from their partner. On the other hand, women are supposed to be submissive to their partners and do not have the privilege to say No or negotiate their sexual feelings. Moreover, the societal, cultural and religious beliefs teaches woman to fulfill their man's sexual desire and if they fail to do so, they are blamed for the failure of the relationship. Thus, these women will be forced to accept violence as their fate and tend not to report it or seek help from formal and informal sectors. This reluctance is due to fear of social stigma and discrimination associated with divorce or being blamed for the violence.

Studies show IPSV and HIV have two ways of interactions and one as a risk factor for the other. Gender-based violence plays significant roles in increasing women's vulnerability to HIV by making it difficult or impossible to abstain from sex or get their partners to be faithful (Osinde, Kaye, & Kakaire, 2011). Moreover, if a woman is forced into sexual intercourse her ability to negotiate the use condom will be eradicated. In addition, the husband may view the request as an accusation of unfaithfulness and could engage in to further physical/emotional

violence; which increase the suffering and trauma of the sexually abused women. On the other end, HIV positive women suffers from IPSV(Maman et al., 2002) and in fear of violence woman tends not to seek HIV testing or related service or choose not to disclose their HIV status to their partners even if disclosure of HIV status to the spouse is considered to being important to HIV care provision. As a result, the incidence of partner violence is a serious and prevalent form of violence that women tend to face. The incidence puts women living with HIV at double risk of facing domestic violence because of their gender and health status. They also are at double risk of associated psychosocial problems from violence and HIV/AIDS (Jewkes et al., 2006; Maman et al., 2002). Therefore, in this study we will assess the experience of intimate partner sexual violence (IPSV) among HIV Positive women in the context of HIV positive woman receiving care at the Zewuditu Memorial Hospital ART center, Addis Ababa.

Statement of the problem

Intimate Partner Violence in Ethiopia is pervasive. The most common are being physical and sexual violence (Deyessa, Berhane, Alem, Ellsberg, Emmelin, Hogberg & Kullgren, 2009; Guruge et al., 2012). Most of the researches done on issue of violence focused on the general domestic violence or specific intimate partner physical violence. Sexual violence against woman becomes a topic of scholar discussion and research in Ethiopia recently. A research done by Ethiopian Women's Lawyers Association (EWLA) in 2008 indicated the lifetime prevalence of sexual violence among woman in Ethiopia is 35% to 59% in the country (Guruge et al., 2012; WHO, 2005b).

On the other hand, studies show Intimate Partner Violence (IPV) increases risk of HIV infection and positive HIV status can also lead woman to victimization by intimate partner (Campbell et al., 2008; Gielen et al., 2007; Maman, Campbell, Sweat, & Gielen, 2000). These studies explore factors associated with the onset of IPV among HIV infected individuals; which indicate violence often occurs following HIV status disclosure (Galvan et al., 2004; A. Gielen, McDonnell, Burke, & O'Campo, 2000; Koenig & Moore, 2000; Zierler et al., 2000). However, studies of Intimate partner sexual violence among woman living with HIV/AIDS are very limited in sub Saharan Africa and nonexistent in Ethiopia. Thus, its prevalence and effect among this group is the very least investigated in Ethiopia and found to be a researchable topic. Thus, this research intends to study intimate partner sexual violence among HIV positive woman with the objective of identifying the common types of sexual violence these woman faces, the psychosocial problems this woman suffers as the result of the violence, their perception and help seeking attitude from their lived experience.

This research could be another step forward to studies on intimate partner violence and a stepping-stone to further studies on relationships between chronic illness and intimate partner sexual violence. It could also provide insight to social worker and health care professionals working with such clients to assess for violence during initial or follow up visits that would help in identifying the problem priory before causing multiple or intensified psychosocial problem. In addition, to look for individual client's perception and incorporate whenever planning an intervention such as awareness creation, referral to other services like: police, court, health care, religious advisors, and other formal or informal help. It also can be an input for the policy makers, feminist activists and advocacy groups to team up to make an effort in eliminating gender based violence from Ethiopia.

Objectives of the Study

General objective

- To explore and identify the types of intimate partner sexual violence which women living with HIV suffers and what psychosocial problems they experience from it. Moreover, to exploring risk factors and factors affecting these women's action to seek help from health care providers in Addis Ababa.

Specific objectives

- To identify the types of intimate partner sexual violence among women living with HIV/AIDS
- To identify what psychosocial problems they suffer from IPSV.
- To explore factors associated with help seeking from formal and informal sectors
- To explore the common risk factors predisposing women living with HIV/AIDS to IPSV

Research Questions

- What types of intimate partner sexual violence are common among women living with HIV/AIDS?
- What psychosocial problems HIV positive women experiences after the action of IPSV?
- What risk factors predispose women living with HIV to IPSV?
- What factors affect women not to seek help from health care workers at the ZMH ART center?

Significance of the Study to Social Work

According to International Federation of Social Work (IFSW) (2012), health chances which are "a person's chance of being ill or staying well, of living a long life or having their life cut short, are a product of economic, social, political and environmental factors; addressing these factors is social work's core health role" (para. 2). The statistics behind gender based violence and HIV/ AIDS are a call for action for the social work profession to address the existing gender inequality and provision of appropriate health services by playing an effective health role in various areas such as research and practice.

As a result, this study provides information regarding the prevalence, psychosocial problems, the common perception of abused woman that affect the help seeking intention of HIV positive mothers in the formal police and health care facilities or informal, families, friends and families. The findings can be used to help design and implement programs to improve the mental and psychosocial health care of the woman and to empower woman and end gender based violence from its core. Moreover, it will provide information for further studies.

Moreover, this paper revealed how healthcare workers at Zewuditu Memorial Hospital are trying to address the psychosocial issues of HIV positive woman regarding the issue of sexual violence and alleviating its effect on the health and treatment adherences of the women who came forward with having the problem.

Limitations of the Study

The findings of this study is specific to women living with HIV attending at ZMH, ART center in Addis Ababa, the capital city of Ethiopia. On the other hand, major advantage of the use of the qualitative approach allowed for an in-depth exploration of the lived experiences of these women, which is not possible with quantitative method, achieved the purpose of the study and answered the research questions, however it is not free from limitations.

Violence against women is a sensitive issue that needs a lot of consideration and negotiation to gather and analyze information particularly in relation to primary data. Efforts were made to interview more women who are victims of sexual abuse. Unfortunately, only a few individuals were ready to be interviewed because they were busy or/ and also they thought it was a private matter. The research also focus in one study setting and conducted in a governmental health facility. Thus, it ignored the woman receiving care at the private hospitals (who may have a better economic status and experiences). Furthermore, the scope of the study is limited to woman receiving HIV care at ART center of Zewuditu Memorial hospital which ignores HIV positive woman receiving care at the other departments of the hospital. Most notably, the results relied on self-reports of participants and key informant information. However, it was likely that the reports of the women represented actual experiences of sexual violence and problems associated with their HIV positive status. It is also important to note that the perspectives of men were not considered since men were not included. There is no justification for men to perpetrate

violence against their female partners. However, perspectives of the men regarding the motivation for their behaviors would be important to place the reported incidents in gender-specific context. Unfortunately, this study did not include male respondents. In addition, because of the limitation of qualitative research design the findings of this study will not be generalized to the larger population of HIV positive women.

Operational definition

Sexual violence: (WHO's Violence Against Women instrument (VAWI)) (Nybergh, Taft, & Krantz, 2013)

Demanded to have sex with me even though I did not want to (but did not use physical force) ,Forced me to have sex against my will by using his physical strength (by hitting, holding me firmly, or threatening me with a weapon) Forced me to perform sexual acts that I experienced as degrading and/or humiliating

Psychological violence (WHO's Violence Against Women instrument (VAWI)) (Nybergh et al., 2013)

Insulted me in a way that made me feel bad about myself , Belittled and humiliated me in front of other people, Tried to scare and intimidate me on purpose (e.g., by the way he/she looked at you, by yelling, or smashing things), Threatened to hurt me or someone I care about

Physical violence (WHO's Violence Against Women instrument (VAWI)) (Nybergh et al., 2013)

Pushed or shoved me, Threw something at me that could have hurt me, Hit me with his/her fist or with some other object that could have hurt me Kicked and dragged me and beat me up, Choked me or burnt me on purpose, Hurt me with a knife, a gun or some other weapon.

CHAPTER TWO: LITERATURE REVIEW

As Creswell states that the review of literature shares the findings of other studies, used as a framework for establishing the significance of the study, and also serves as a point of reference for comparing the results with other findings which is closely related to the one being undertaken (Creswell, 2013).

Intimate partner Violence overview

According to the UN declaration on Elimination of violence against woman (1993), gender based violence can be physical, sexual, emotional or psychological. (Watts & Zimmerman, 2002)

Physical violence includes slaps, object thrown at, being pushed or shoved, punches, kicks, beaten, drugged, being choked, burned intentionally, threatened or assaults with a weapon/knife, homicide. Psychological violence includes belittling or humiliated in front of others, the woman, preventing her from seeing family and friends, intimidation, withholding resources, preventing her from working or confiscating her earnings. Sexual violence includes rape, coercion and abuse includes use of physical force, presence of degrading sex, verbal threats, and harassment to have sex, unwanted touching or physical advances, forced participation in pornography or other degrading acts that often persist over time and are accompanied by threats on part of the perpetrator.

Stranger or individuals known to the victim (such as the intimate partner, male family members, and acquaintances) and individuals in position of authority commit sexual violence (Deyessa et al., 1998)

Intimate partner violence (IPV), which is commonly referred as domestic abuse, domestic violence, wife beating or battering, relationship violence, and spousal abuse refers to any abuse

INTIMATE PARTNER SEXUAL VIOLENCE...

mainly physical and sexual by husband on his wife is common in Ethiopia (Deyessa et al., 1998). Globally it is also noted that IPV frequently occurs in the context of marriage or cohabitation, pre-domestic relationships such as dating relationships, and post-domestic relationships, as in the case of ex-partners who are no longer living together (Guruge et al., 2012). Various forms of IPV reported. For example, a national study by Ethiopian Women's Lawyers Associations (EWLA) described wife battering, sexual abuse or rape, intimidation, insult and disrespect, denial of food and rest, forced displacement from home, beating and bodily injury, fire burns, forced abortion, abduction, underage marriages, forced labor, and exploitation (Guruge et al., 2012). Other forms of IPV included slapping, beating, and pushing (Dibaba, 2008). According to the CDC fact sheet of understanding intimate partner violence, intimate partner violence (IPV) (Black et al., 2011), occurs between two people in a close relationship. The term "intimate partner" includes current and former spouses and dating partners. IPV exists along a continuum from a single episode of violence to ongoing battering.

In most of the studies on this area, intimate partner violence includes four types of behavior: 1) Physical violence is when a person hurts or tries to hurt a partner by hitting, kicking, or other type of physical force. 2) Sexual violence is forcing a partner to take part in a sex act when the partner does not consent. 3) Threats of physical or sexual violence include the use of words, gestures, weapons, or other means to communicate the intent to cause harm and 4) Emotional abuse is threatening a partner or his or her possessions or loved ones, or harming a partner's sense of self-worth. Examples are stalking, name-calling, intimidation, or not letting a partner see friends and family (Bergen, 1999; Black et al., 2011; Deyessa et al., 2009; Guruge et al., 2012).

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Partner Violence starts with emotional abuse most of the time. This behavior can progress to physical or sexual assault. Usually, most women experience several types of violence together (Black et al., 2011). During the literature review we mostly found scholars articles and researches mostly focus on all types of gender based violence thus, I used them as reference for this specific research as not enough readings found on IPSV specifically.

Intimate partner sexual violence: Public health issue

Partner rape or intimate partner sexual abuse can be defined as any unwanted intercourse or penetration (vaginal, anal, or oral) obtained by force, threat of force, or when the wife (women partner) is unable to consent or need to participate (Bergen, 1996; Bergen, Barnhill, & Violence, 2006; Deyessa et al., 2009; Pagelow, 1992).

Most of these definitions about the intimate partner sexual abuse focus on the victim, in whom she is unable to consent or freely participate in the sexual engagement. In other words she is not willing to accept the sexual request of the male partner unless with any kind of force or threat from the partner to make her submissive. Intimate Partner Sexual Violence occurs between couples who are legally married, separated, divorced, or cohabiting and between couples in romantic relationship or ex- romantic relationship (Basile & Saltzman, 2002; Gupta, Parkhurst, Ogden, Aggleton, & Mahal, 2008; Guruge et al., 2012; Mahoney & Williams, 1998; Osinde et al., 2011; Tjaden & Thoennes, 2000). Sexual abuse is categorized into four: sexual offense, sexual coercion, sexual assault and sexual aggression ranging. Their definition range based on the nature of abuse from verbal to physical contact (attempted or no sex) to actual sexual intercourse (completed rape) and based on the tactics used to acquire the fulfillment of sexual desire from verbal, psychological and/or physical coercion (DeGue & DiLillo, 2005).

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Violence against women is a global epidemic that affects the health and economic stability of women, their families and communities. Intimate partner (marital or date) rape or sexual violence is one of the most prevalent types of violence occurs between intimates globally (Bergen et al., 2006; Guruge et al., 2012). Studies indicate that between 20-50% of women in various populations around the world have experienced spouse (partner) abuse at least at some point in their lives. According to WHO multi country violence report (2002), between 6%- 47 % of adult women worldwide report sexually abuse by intimate partners in their lifetime. (Bergen, 1996; WHO, 2005a)

Partner (marital) rape accounts for approximately 25% of all rapes and it is the most prevalent type of sexual violence. Moreover, studies which used clinical samples of battered women also showed partners rape of one third- one half of battered women at least once in their life (Bergen et al., 2006; Randall & Haskell, 1995).

In USA, the national violence against woman survey conducted in 1993 reported that from the reported cases of sexual abuse 9% of the victims were raped by husband or ex-husband and 10% by boyfriends or ex-boyfriends. Furthermore, the survey indicated that with respect the types of perpetrator relationships and reported the most prevalent in the rape cases occurring after the age of 18 indicated 76% of the perpetrators were intimate partners that is current and former spouses, cohabiting partners, dates and boyfriends. More than 1 in 3 women (35.6%) and more than 1 in 4 men (28.5%) in the United States have experienced rape, physical violence, and/or stalking by an intimate partner in their lifetime (Black et al., 2011).

The prevalence rate of wife abuse is indicated as high in Africa. Studies show that patriarchal societies are more violent towards woman. Moreover, male dominance and the force used by a man to control his wife are seen as legitimate in this type of society (Abeya et al.,

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2012; Haj-Yahia, 2000). As one of the countries dominated by a patriarchal type of society, intimate partner violence in Ethiopia is pervasive with physical and sexual violence as being indicated the very common types. WHO's (2002), report shows that in Meskanna Woreda region of Ethiopia; 45% of women were estimated to have been victimized by their own intimate partner and 10% had been victimized in the 12 months preceding the study (WHO, 2002 cited on(García-Moreno et al., 2005) . Comparatively, rates for the proportion of women reporting either sexual or physical IPV or both were about 71% and 54% (for lifetime and in the year preceding the WHO 2002 study, respectively). Ethiopia had the highest prevalence of gender based violence among the 10 countries included in the WHO multi country study 2002, and based on the prevalence of lifetime physical violence alone, Ethiopia ranked second (García-Moreno et al., 2005; Guruge et al., 2012).

This figure shows increase in the 2005s WHO report. Among 15 world countries under this study 13 countries, including Ethiopia, indicated that, between one-third and three-quarters (35 to 76%) of women had been physically or sexually assaulted by someone since the age of 15 (García-Moreno et al., 2005; Organization, 2005b) and the majority of this violence was perpetrated by a current or previous partner. Overall, 15% to 71% of the women who ever had a partner had been physically or sexually assaulted by an intimate. In most settings, about a half of these respondents reported that the violence was currently ongoing during the interview. In Butajira, the Ethiopian site for WHO's multi-country study 2005, from ever-partnered women 59% and 44.4% of participants reported having experienced violence by a current/ex-partner in their lifetime and currently, respectively (for lifetime and in the last year) (Deyessa et al., 2009; García-Moreno et al., 2005; WHO, 2005b).

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A study conducted in the Amhara region's Bahir dar/Adet sites found prevalence of 55% of any types of rape (sexual violence on women) (Muleta & Willams, 1999). Ethiopian Women's Lawyers Associations (EWLA) conducted a national survey on violence against women in 2008. The study shows the prevalence rates of sexual violence in Ethiopia ranged from 35% to 59% over a lifetime and from 30 to 50% during the last 12 months preceding the study (Guruge et al., 2012). Another study conducted on 673 ever-partnered women, who are ≥ 15 years 10% in the previous 3 months 45% reported to experienced partner sexual violence. (Deyessa et al., 2009)

Except EWLA (2008) cited by Guruge and colleagues (2012) most of the other studies in Ethiopia report the prevalence for collective physical and sexual violence between intimates or focuses on the general issue of gender based violence among woman. These studies do not specifically indicate the prevalence of IPSV separately. However, even the one study by EWLA reports shows highest prevalence in Ethiopia. And will make it an important public health issue. Thus, the knowledge on intimate partner sexual violence among different segments of the population should be investigated and needs to be addressed before it becomes a national crisis. (EWLA,2008 as cited on Guruge et al., 2012)

The effects of intimate partner sexual violence

Despite the myth that rape by one's partner is a relatively insignificant event causing little trauma, research indicates that marital rape often has severe and long-lasting consequences on women. Women who are raped by their husbands are likely to be raped 20 times or more before they are able to end the violence (Bergen, 1996; Finkelhor & Yllö, 1987; Russell, 1990)

Women who experienced IPSV face problems that affects their physical, mental and emotional health than women experiencing only physical violence (Bennice, Resick, Mechanic, & Astin, 2003; Guggisberg et al., 2010). Victims of intimate partner sexual violence not only

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experience a higher number of assaults, but also are more likely to experience psychosocial problems than women raped by other acquaintances and those who experienced unwanted oral and anal intercourse. (Basile, Arias, Desai, & Thompson, 2004; Diamantopoulou & Moumtsakis, 2011)

Husbands often sexually violate their wives when they are asleep and when denied sexual gratification by their wife. Thus men use coercion, verbal threats, physical violence, or weapons to force their wives to have sex when the women partner is unwilling. Importantly, some researchers have found that compared to batterers only, men who batter and rape are very dangerous and are more likely to severely injure their wives and even murder. In addition, women who are forced to have sex by their partners may be at a greater risk of being killed by them (Campbell & Soeken, 1999).

Intimate partner sexual violence has effect on all sides of the victim's life, which includes the physical effects: may ranges from minimal to sever injuries different parts of the body such as to the vaginal and anal areas, lacerations, soreness, bruising, torn muscles, fatigue and vomiting (Bergen et al., 2006), broken bones, black eyes, bloody noses, and knife wounds. Campbell and his colleagues (2002) report that one-half of the marital rape survivors in their sample were kicked, hit or burned during sex. Other effects of gynecological consequences include vaginal stretching, miscarriages, stillbirths, bladder infections, infertility and the potential contraction of sexually transmitted diseases including HIV (Campbell, 2002).

According to CDC fact sheet (2014), some of the Physical effects of intimate partner sexual violence includes unwanted or unintended pregnancies are also resulted result from rape every year (Holmes et al., 1996 cited on CDC, 2014). Some long-term consequences include (Jewkes, Sen, Garcia-Moreno, 2002 cited on CDC, 2014): are chronic pelvic pain, premenstrual

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syndrome, gastrointestinal disorders, gynecological and pregnancy complications, migraines and other frequent headaches, back pain, Facial pain, Disability that prevents work.

The other effect is the psychological effects, which is categorized into short-term effects, which include anxiety, shock, intense fear, depression, suicidal ideation, and post-traumatic stress disorder (Bennice et al., 2003; Bergen et al., 2006; Guggisberg et al., 2010; Kilpatrick, Best, Saunders, & Veronen, 1988; Russell, 1990). Studies have compared the short term psychological effects among women raped by strangers and marital rape survivors. The report shows higher rates of anger and depression among the victims of IPSV (Koss, Dinero, Seibel, & Cox, 1988). The Long-term effects often include disordered eating, sleep problems, depression, problems establishing trusting relationships, and increased negative feelings about themselves (Bergen, 1996; Frieze, 1983; Kilpatrick et al., 1988; Whatley, 1992). These researches have also indicated that the psychological effects are likely to be long lasting. Some victims of intimate partner sexual abuse also reported flashbacks, sexual dysfunction, and emotional pain for years after the violence end.

Information from CDC fact sheet reported the psychosocial effects of intimate partner sexual violence also indicated that Sexual violence could have harmful and lasting consequences for victims, families, and communities. As the information sheet Victims of sexual violence, face both immediate and chronic psychological consequences (Felitti et. al., 1998; Yuan, Koss, Stone, 2006 cited on CDC fact sheet, 2014). Immediate psychological consequences include: Shock, Denial, Fear, Confusion, Anxiety, Withdrawal, Guilt, Nervousness, Distrust of others, Symptoms of post-traumatic stress disorder ,Emotional detachment, Sleep disturbances, Flashbacks, Mental replay of assault. Chronic psychological consequences include Depression, Attempted or completed suicide, Alienation, Post-traumatic stress disorder symptoms (CDC, 2014).

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It also bring social problems on victims (Clements, Speck, Crane, & Faulkner, 2004; Golding, Wilsnack, & Cooper, 2002): including tense relationships with the victim's family, friends, and intimate partners, Less emotional support from friends and family, Less frequent contact with friends and relatives, Lower likelihood of re-marriage. Some researchers view the following health behaviors as both social consequences of IPSV and factor that increase women's vulnerability to future re-victimization (Brener, McMahon, Warren, & Douglas, 1999; Lang et al., 2003). The factors are victims found to be engagement in high-risk sexual behavior (i.e. unprotected sex, early sexual initiation, choosing unhealthy sexual partners, having multiple sex partners, trading sex for food, money, or other items), using harmful substances (i.e. smoking cigarettes, drinking alcohol and taking drugs), and unhealthy diet-related behaviors (i.e. fasting, vomiting, abusing diet pills and overeating) (Basile et al., 2006; Champion et al., 2004; Jewkes, Sen, & Garcia-Moreno, 2002; Raj, Silverman, & Amaro, 2000; CDC fact sheet, 2014).

Woman living with HIV and Intimate partner violence

In a country where women have lower educational attainment and most of women's work is unpaid or exists in the informal sector, women will have fewer economic opportunities than men do (Guruge et al., 2012). This situation leads women to be economically dependent on a husband, which makes it difficult to leave an unsafe marriage or refuse unprotected sex (Gupta et al., 2008).

Women account more than half of all people living with HIV worldwide, and nearly 60 percent of HIV infections are in sub-Saharan Africa. Studies indicated that, Gender-based violence plays significant role in increasing women's vulnerability to HIV by making it difficult or impossible to abstain from sex or get their partners to be faithful (Gupta et al., 2008; Osinde et al., 2011). Moreover, if a woman is forced into sex her ability to negotiate the use of condom will

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be eradicated. In addition, the husband may view the request as an accusation of unfaithfulness and could engage in further physical/emotional violence, which increases the suffering and trauma of the sexually abused women (Gupta et al., 2008).

On the other end, in fear of violence woman tends not to seek HIV testing or related service or choose not to disclose their HIV status to their partners (Lamphey, Johnson, & Khan, 2006) whereas the disclosure of HIV status to spouse is considered important in HIV care provision. As a result, the incidence of partner violence is a serious and prevalent form of violence that women tend to face (ICW, 2005).

HIV/AIDS, as one of the chronic illnesses, results in a complex psychological and emotional problem on women (Campbell et al., 2008; Greenwood et al., 2002; Shelton et al., 2005). Sexual violence and threats of violence to engage in sex are the major factors fueling the rapidly increasing of HIV epidemic among women. There are different ways in which the epidemics of HIV and violence overlap in the context of women's lives. Violence may increase a woman's risk for HIV infection through forced or coercive sexual intercourse by limiting her ability to negotiate HIV-preventive behaviors like condom use (Gupta et al., 2008; Osinde et al., 2011).

In addition to sharing all the associated risk factors for all women; HIV positive women's negotiation to condom use, the HIV status and CD4 count over 350 are positively associated with these women's risk for violence (Coker et al., 2002; Woods, Hall, Campbell, & Angott, 2008). Partner sexual violence is also associated with numerous physical and mental health effects on these women. Such studies suggest these effects are intensified among individuals suffering from both problems of HIV and Intimate Partner sexual Violence (Coker et al., 2002; McDonnell, Gielen, O'Campo, & Burke, 2005; Woods et al., 2008).

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Intimate Partner Sexual Violence affects every aspect of the HIV infected women's lives; from their personal health and safety, to the safety of their families, to their ability to earn a living (Bergen, 1996; Campbell et al., 2008). Further, the incident of unwanted sexual intercourse causes unwanted pregnancy which contributes to maternal mortality, child's survival and the boost of the harmful, long-lasting physical, psychological and emotional and social psychosocial problems (Lamprey et al., 2006). This is mainly because as someone whom they once presumably loved and trusted abuses these women, they tend to suffer severe and long-term psychological consequences (Campbell, 2002; Campbell et al., 2008; Eby, Campbell, Sullivan, & Davidson, 1995).

The Psychological effects of being raped by one's partner, when compared to other forms of sexual violence, shows that women who are sexually abused by their partners are more likely to experience multiple assaults, completed sexual attacks (Frieze, 1983; Kilpatrick et al., 1988). Moreover, negative social reaction, minimizing an incident of sexual assault and violence, blaming the victim for the rape incident and excusing the rapist and his actions were significantly associated with increased psychosocial distress, delayed recovery, and poor perceptions about physical health (Ullman, 1996; Ullman & Siegel, 1993). Thus, these victims suffer not only from the actual assault but also from negative reactions of the people around them. The societies' especially the woman's own belief and perception on the issue may also matters during social work intervention, law formulation or implementation. Self and others perception towards these victims and the perpetrators indicated as an important component in helping the victim.

Generally, individual living with HIV/AIDS despite their illness and complication associated with their health status and associated societal stigma and discrimination if they also

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suffer from intimate partner sexual abuse by their own intimate partner the psychosocial effect doubles (J. C. Campbell et al., 2008; Greenwood et al., 2002).

Help seeking of IPSV victims from Formal services

Survivors of intimate partner sexual violence are less likely to report their assaults to formal service providers than other survivors of violence, but to friends, or family members (Koss et al., 1988; Mahoney & Williams, 1998).

Among the 55% rape victims reported in the study in Amhara region of Ethiopia from which the research listed 36% for rape and abduction have been reported to police which seems high formal sector service indicator among the victims. This is may be because the study included under aged rape cases and stranger assailants (Guruge et al., 2012).

On the other hand, in the WHO study, 61% of abused women in Ethiopia disclosed abuse to informal sources, typically family or friends, and only 45% sought formal help (WHO, 2005a). Intimate partner sexual violence may be more difficult for women to talk about than other types of abuse (Howard, Riger, Campbell, & Wasco, 2003). It cannot be assumed that sexual violence will be disclosed. Often, even when the physical violence is revealed, the sexual aspect of the partner's offending is not. It is therefore not sufficient to ask only about physical violence, as this may not elicit information regarding sexual assault (Pence & Paymar, 1986). Moreover, in Ethiopia, most of the abused woman might not seek help formal services like police as the legal reforms which criminalizes IPSV is nonexistent and the even other service providers like EWLA or the court has limited availability of services or the abused woman has to suffer from other type of violence like physical with evidence. Abused women tend not to seek help from formal sectors (Abeya et al., 2012; Deyessa et al., 2009; Guruge et al., 2012) because of:

1. their perception of violence by intimate partner as "normal",

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2. fear of the partner's further violence, fear of losing children, fear of divorce or separation, fear of continuous conflict with the partner,
3. bringing shame to the family or self,
4. lack of knowledge of protective laws,
5. feelings of inferiority, loss of self-worth, dependency on financial support on the husband
6. the stigma of divorce and
7. disability, HIV/AIDS, labor problems and pregnancy

Other Researches abroad, supports such reasons and indicates the inadequate response of the police or formal sectors to the problem of wife abuse(PAGELOW, 1992; Saunders, 1986; Stanko, 1985). They also indicated that majority of women reporting their assaults to the police found the police unresponsive to the violence. Furthermore, researchers indicated that women feel discomfort when they discuss the sexual violence they experienced by their intimate partners (Bergen, 1996; Bergen et al., 2006; Russell, 1990).

A final compelling reason for women's under-reporting is that many do not define their experiences of forced sex in marriage as rape. Some believe that only stranger rape is "real rape;" and other women see sex in marriage as an obligation and define forced sex as a "wifely duty," not rape (Bergen, 1996). If they do not define their experiences as rape, women are unlikely to seek outside assistance to stop the violence.

On the other hand, when women seek assistance for partner sexual abuse, there is also a failure on behalf of others including police officers, religious advisers to provide adequate assistance. Interviews with marital rape survivors reveal that when police officers learn that the assailant is the woman's husband, they may fail to respond to a call from a victim of marital rape,

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refuse to allow a woman to file a complaint, and/or refuse to accompany her to the hospital to collect medical evidence. The police officers are even less responsive to survivors of partner sexual violence than they are to battered women. Most women do not feel comfortable contacting the police, and alternatively choose to speak with their religious advisers. Researchers have found that support for women in violent relationships is not always helpful from religious advisers (Bergen, 1996; Bergen et al., 2006; Frieze, 1983; Russell, 1990).

Reporting sexual abuse in marriage may become even more complicated in Ethiopia as no legal reforms criminalizing IPSV and difficulty to collect evidence if associated abuses are absent. Further, other associated issues like her relationship with the assailant, a woman raped by her husband may hesitate to report. These factors include family loyalty, fear of her abuser's anger and revenge, inability to leave the relationship as economically dependent or for children's sake, and the role assignment of being woman partner in martial relationship (submissiveness, sex as obligation in marriage). Moreover the emphasis of religious institutions on wives' responsibility "to obey their husbands" and the sinfulness of women's refusal to have sexual intercourse with their husbands, may make reporting the abuse or even talking about it difficult for the victims.

Health care providers can offer one of few opportunities to intervene in intimate partner violence, particularly where perpetrators are excessively controlling about their partner's movements and contacts (Coker, Smith, McKeown, & King, 2000). The health care setting may provide a private and safe place to seek help. The patient/client must feel safe and should be seen alone. Research on the impact of intimate partner sexual violence on women have revealed some concerning statistics on its effects, such as the increase in stress levels and depression, physical injury, and gynecological problems (Campbell, 2002).

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The benefits of universal screening are still inconclusive. Some studies suggest there are no clear benefits, and at worst that it may cause trauma to some women, particularly if the health care provider is unable to respond appropriately (Spangaro, Zwi, & Poulos, 2011). An alternative approach may be to ask about sexual violence in cases where intimate partner violence of any kind is acknowledged or suspected. Either way, asking directly about sexual violence may be a form of intervention in itself by giving women an opportunity to talk (Spangaro et al., 2011).

Risk factors/ causes of intimate partner sexual abuse

Most researchers of intimate partner sexual abuse agree that rape in marriage is an act of violence - an abuse of power by which a husband attempts to establish dominance and control over his wife. While the research reveals no composite picture of a husband-abuser, these men are often portrayed as jealous, domineering individuals who feel a sense of entitlement to have sex with their "property" (Bergen et al., 2006; Campbell & Soeken, 1999).

Having this in mind, according to some researchers, women appear to be particularly at risk for being raped by their partners under some circumstances. Thus, being female is a risk factors for intimate partner sexual violence as it is associated with biological, no physical fitness factors, low status due to subjugation, marginalization, and disempowerment of women (Bergen, 1996, 1999; Russell, 1990). Specially, women who are battered or physically abused are at greater likelihood of being raped by their partners (Bergen, 1996; Frieze, 1983; Mahoney & Williams, 1998).

There is also evidence that pregnancy may increase the likelihood of experiencing intimate partner violence (Burch & Gallup, 2004) including sexual violence (Martin et al., 2004) which makes addressing intimate partner sexual violence an important aspect of pregnancy care. Abuse during pregnancy have significant health issues for the unborn child and the women

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(Campbell, Garcia-Moreno, & Sharps, 2004; Jasinski, 2004). Thus, pregnancy places women at higher risk for both physical and sexual abuse (Browne, 1993; Campbell, 2002; Campbell & Soeken, 1999). This will be another area to focus in Ethiopian context in future studies. The other risk factor is, women who are chronically ill and/ or recently discharged from the hospital are at risk of sexual abuse by intimate partner (Mahoney & Williams, 1998). Even if the woman at this time is out of danger and recovers from her illness she still is weak and needs to rest to fully recover. Adding on this, low sexual function of woman (such as menopause, period, pregnancy, tiredness and being angry on the man (Guruge et al., 2012; Haj-Yahia, 2000), chronic illness or sickness of woman (cancer and HIV/AIDS) (Gielen et al., 2007), the male partner may demand for sexual gratification as the couples did not made love for so long or his desire to produce child (Haj-Yahia, 2000) contributes to the women's vulnerability to sexual violence. Thus, as women with HIV/AIDS are vulnerable to sickness and frequent hospital admission and discharge this can be seen as a risk factor to IPSV among this group.

Researches with battered women has also revealed, women are at particularly high risk of experiencing physical and sexual violence if they attempt to leave their abusers for this represents a challenge to their abusers' control. (Finkelhor & Yllö, 1987) this research shows that two thirds of the women in their sample were sexually assaulted at the end of the relationship. Other researchers have found that women separated or divorced from their partners appear to be at high risk for sexual abuse (Dobash & Dobash, 2003).

Drug and alcohol use: Some researchers have noted other risk factors including drug and alcohol use by the abuser, and previous experiences of sexual abuse among the victims. However, these factors are perceived as more controversial and the research is far from conclusive (Frieze, 1983; Russell, 1990; Whatley, 1992).

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Women's Age: Marital rape occurs in all types of marriages regardless of age, social class, race or ethnicity. Male partners raped women at a variety of ages; however, two-thirds of the wives were sexually abused by intimate partner when they were under the age of 25. Thus women's ageless than 25 is also considered a risk factor for violence (Russell, 1990).

Social class: is a more difficult variable to measure and the literature is less conclusive. women in the upper and middle class were slightly over-represented among marital rape survivors (Russell, 1990). While other researchers found about those from lower social class backgrounds were more likely to report experiencing marital rape (Finkelhor & Yllö, 1987).

With regard to race, marital rape was slightly higher for African-American women than white women, Latinos, and Asian women respectively (Russell, 1990). In Ethiopia, this is a difficult variable to measure as we have more of ethnicity difference than race. However, from my experience I have seen there are some differences on wife/partner treatment among different male and women couples from different ethnic backgrounds. This indeed needs further investigation and study. The other factors associated with IPSV are low educational level of husband and wife (Campbell et al., 2001; Guruge et al., 2012).

Theoretical explanation on the Cause of IPSV

There is no specific cause for only how men sexually abused their wife. Scholars have come up with different theoretical viewpoints on explaining the probable cause of intimate partner violence focusing on the personal threat and social learning of the behavior (Valladares, Pena, Persson, & Högberg, 2005). The other explanation according to Lenore Walker, (1977) is conflict between the intimates is one of the earliest justifications for why gender violence is occurring. Walker (1977) identified the "Cycle of Violence." among battered woman; she suggested that couples that had experienced violence moved through a predictable sequence of

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stages or phases. As a result to the tension building phase, there is a brief episode of anger lead violence. As soon as the violent attack concludes, the cycle begins again with the Honeymoon Phase (Walker, 1977, 1989)

This justification was helpful to abused women by bringing attention to the problem, however did not fully explain intimate partner abuse to those who worked in the field. It assumed that the violence occurred repeatedly, because of the actions of both the man and the woman that it was the conflict between the two that served as a catalyst for the violence. In social work terms, it was a micro-focused interactional model.

In 1986, Ellen Pence and Michael Paymar published *Power and Control: Tactics of Men Who Batter* (Duluth: Minnesota Program Development), a curriculum for working with batterers. (Pence & Paymar, 1986). Their approach to partner abuse intervention was developed based on the stories of battered women, many of whom shared that their stories did not mirror the cycle of violence described by Lenore Walker. Rather than describing a "honeymoon phase," battered women may see the nice gestures on the part of the abuser as an attempt to control her through manipulation. Instead of a "tension building phase," there is an escalation in controlling behaviors, from manipulation to intimidation. The violence itself may then be seen as an attempt to control the victim with the use of force.

The controlling behavior of man: The other reason indicated constantly from the lives of all abused women is control. That is, their male partners are attempting to control them using a variety of tactics, including the occasional use of violence. The Pence and Paymar model also takes a more "social work" view of the problem, by examining partner violence as a macro issue. They recognized that the issue of male control over women is a theme that runs throughout our society. One aspect of their model is the development of a "Community Based Response" to

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partner violence, which includes policy changes with law enforcement, prosecution, protective orders, the business community, churches and others, as well as strategies to change public attitudes about gender violence and the oppression of women.(Pence & Paymar, 1986)

Cunningham and his friends (1998) organized six theoretical models to explain spouse abuse and neglect: Social learning theory: - proposes that individuals who experienced violence are more likely to use violence in the home than those who have experienced little or no violence. Children either who experience violence themselves or who witness violence between their parents are more likely to use violence when they grow up. Family is a social group where people learn the roles of husband and wife, parent and child. The home is the primary place in which people learn how to deal with various stresses, crises, and frustrations. In many instances, the home is also where a person first experiences violence. Not only do people learn violent behavior, but also they learn how to justify being violent.

Social situation/stress and coping theory: - explains why violence is used in some situations and not others. The theory proposes that abuse and violence occur because of two main factors. The first is structural stress and the lack of coping resources in a family. For instance, the association between low income and family violence indicates that an important factor in violence is inadequate financial resources. The second factor is the cultural norm concerning the use of force and violence. Thus, individuals learn to use violence both expressively and instrumentally as a way to cope with a pileup of stressor events.

General systems theory: - a social system approach, was developed and applied by (Giles-Sims, Straus, & Sugarman, 1995; Straus, 1974) to explain family violence. Here, violence is viewed as a system product rather than the result of individual pathology. The family system operations can maintain, escalate, or reduce levels of violence in families. General systems

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theory describes the processes that characterize the use of violence in family interactions and explains the way in which violence is managed and stabilized. Straus (1973) argues that a general systems theory of family violence must include at least three basic elements: (1) alternative courses of action or causal flow, (2) the feedback mechanisms that enable the system to make adjustments, and (3) system goals.

The resource theory: - of family violence assumes that all social systems (including the family) rest to some degree on force or the threat of force. The more resources social, personal, and economic a person can command, the more force that individual can muster. However, according to William Goode (1971), the more resources a person actually has, the less that person will actually use force in an open manner. Thus, a husband who wants to be the dominant person in the family, but has little education, has a job low in prestige and income, and lacks interpersonal skills may choose to use violence to maintain the dominant position (Goode, 1971)

Exchange/social control theory: - was developed by (Gelles, 1985) on the basic propositions of an exchange theory of aggression. The exchange/social control model of family violence proposes that wife abuse is governed by the principle of costs and rewards. Drawing from exchange theory, Gelles (1983) notes that violence and abuse are used when the rewards are higher than the costs. Drawing from social control theories of delinquency, he proposes that the private nature of the family, the reluctance of social institutions and agencies to intervene, and the low risk of other interventions reduce the costs of abuse and violence. The cultural approval of violence as both expressive and instrumental behavior raises the potential rewards for violence. (Gelles, 1985)

The patriarchy theory: - the central thesis is that economic and social processes operate directly and indirectly to support a patriarchal (male dominated) social order and family

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structure. The central theoretical argument is that patriarchy leads to the subordination and oppression of women and causes the historical pattern of systematic violence directed against wives (Dobash & Dobash, 2003; Pagelow, 1992). The patriarchy theory finds the source of family violence in society and how it is organized, as opposed to within individual families or communities.

As far as the literatures indicated, in Ethiopia domestic violence is prevalent because the country patriarchal system where male dominance is visible in all aspects of woman's life, most of women are illiterate or low educational status which interns with economical dependency and the society value marriage and perceive women's submissiveness in marriage as an obligation. Thus, the societal perception of women's role as a wife to be submissive, favoring male dominance, minimizing violence and the value given to marriage, lack of social and legal support, women's hope for situation improvement, lack of alternative for employment and financial assistance (Bergen et al., 2006; Deyessa et al., 2009; Dibaba, 2008) are the main reasons found to have a connection with women's submissiveness for their violent partners. Additionally male partners' having high-risk behavior (such as jealousy and drunkenness), economical dependency and fear of physical violence prevents women from leaving the abusive relationship and become submissive (Bergen, 1996; Bergen et al., 2006).

Theoretical framework

This research is a social work thesis focusing on a gender and public health related topics; thus, it includes epidemiological principles, qualitative methodology and gender aspect. The study identifies the nature of intimate partner sexual violence, the psychosocial consequences, perception of issue and suggested intervention and preventative measures by integrating social work skills with public health and gender issue.

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The framework on this research of intimate partner sexual violence aims to estimate the magnitude of the problem among the population of women living with HIV/AIDS, identifying perception, socio- demographic and psychosocial problems for possible suggestion of intervention and preventative measures. Thus, the study laid its ground mainly on the ecological model of factors associated with partner abuse developed by (Heise, 1998) The ecological model shows the continuous transaction between the individual and the environment at individual, interpersonal, organization, community and policy levels. By using this model, we can understand the relationship between societal, community, relationship and individual situations and multiple of cause creates opportunities to intervene before violent act occur and provide policy makers with concrete options to prevent violence (Heise, 1998; Yllö, 1983).As indicated below, problem with intimate partner sexual violence as personal, interpersonal, organizational, community and society level. All these factors at all levels have varying degree of influence in helping victims of IPSV among women living with HIV , however each level factors have a strong linked relationship to each other and other factors in the rest of the levels. The outcomes of the factors minimize the effort of the women to seek formal help during abuse. These women will then be vulnerable for repeated sexual abuse and suffer from intensified psychosocial problems while dealing with HIV under the care of the health facility. This leads to increased repeated wife abuse, hopelessness with other psychosocial problems such as stress, failure for treatment adherence & HIV related death, maternal morbidity, mortality, and failure to meet MDGs.

To illustrate how this thesis is planned, Heise's ecological model (1998) is adapted and used into this research's framework. The different societal organizations carry different risk factors of which examples are given below. Some of the factors were investigated in this thesis

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leading to intimate partner sexual violence and its psychosocial problems and factors prohibiting women to seek help such as societal and self-perception of the violence.

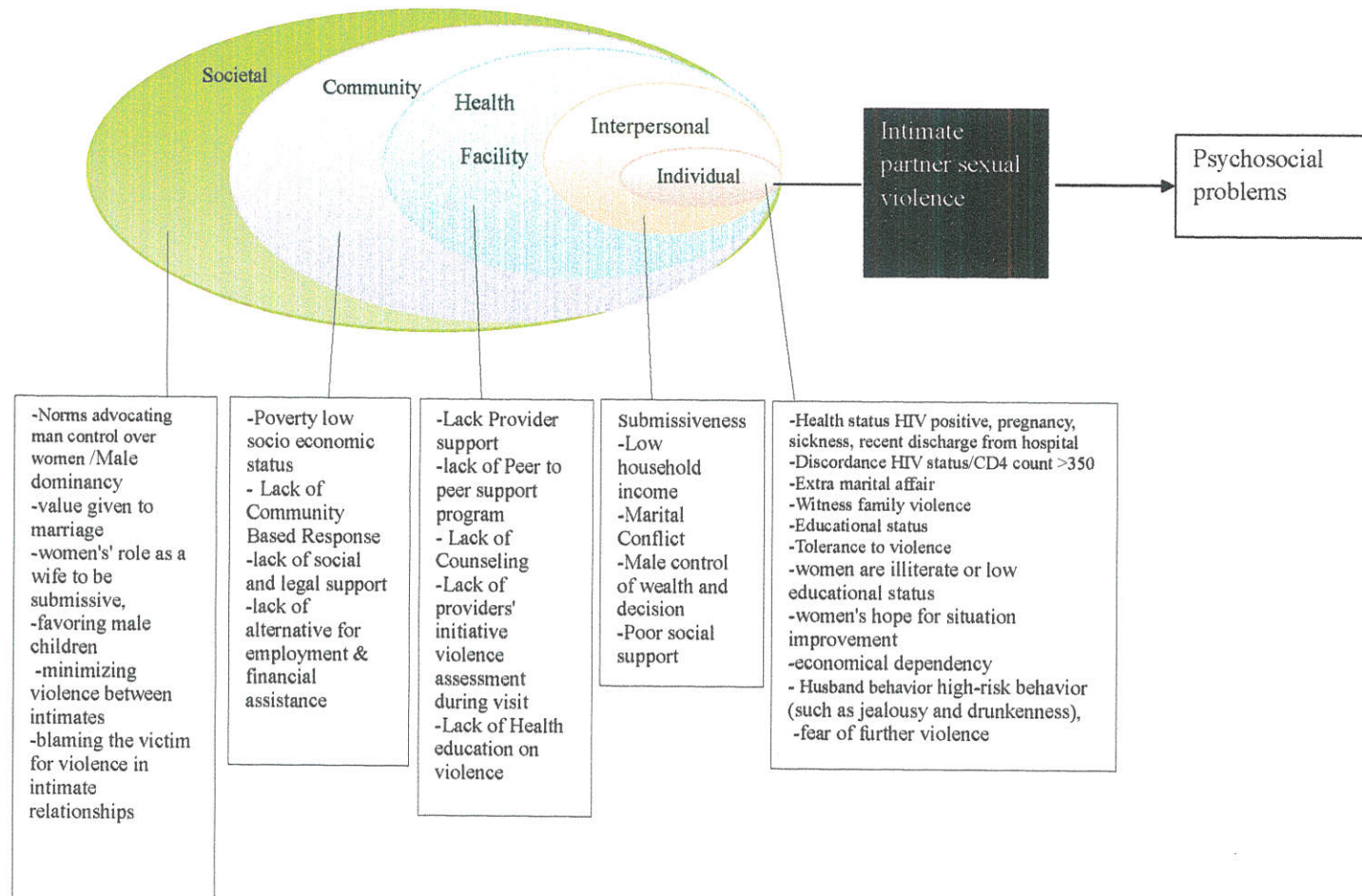


Figure 1: Theoretical framework of the study with examples of risk factors at different levels of organizations

CHAPTER THREE: RESEARCH METHOD

This chapter describes the method employed in this research to elicit the findings and the different justifications for the selection of methods. It discusses the study design, the study area, sampling frame, research instrument, data collection and analysis techniques along with the measures taken to ensure trustworthiness and ethical considerations.

Study Design

Qualitative research design with a case study approach was used to conduct the study. This design was preferred because it provides an insider perspective towards the issue of concern. The basic assumption of qualitative research is to explore about an issue from key participants who are articulate and introspective enough in providing a rich picture of their experiences (Creswell, 2013; Padgett, 2008). In addition, it empowers study participants and considers them as the writers of their accounts rather than objects of research (Tuli, 2011). Qualitative research advocates flexible design and provides unlimited freedom to the researcher to move between the steps of research. As a result, by using this design I tried to gain deeper insight about the experience of HIV positive women of intimate partner sexual violence and the psychosocial problems they face and their effect in the health care setting.

Case study is one of the qualitative research strategies of inquiry that is used to obtain rich, elaborate and in-depth understanding about the matter under study from research participants (Creswell, 2013). Case study is a preferred method to answer the "how" and "Why" research questions qualitatively with a small number of participants at a single point in time intensively (Gerring, 2007) According to Gerring, case study is holistic and thick in a way to comprehensively examine the relatively bounded phenomenon. It utilizes textual evidence that is gathered in a real life context in which individuals are the preferred units of analysis.

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As a result, in this study instrumental case study was used to explore the types of sexual violence woman living with HIV face and its psychosocial problem with their perception. It describes the participants' subjective explanations, personal meanings and feelings that attach to themselves and to what they do with a form of words (Monette, Sullivan, & DeJong, 2013) because psychological and social problems may not be quantifiable thus need to rely on their expressed feeling (Cournoyer & Klein, 2000).

Study Setting

According to the U.S. President's Emergency Fund for AIDS Relief (PEPFAR) Ethiopia operational plan report for year 2013 (January, 2014 p.2-3), in the country about 734,000 people are living with HIV/AIDS in 2013. The prevalence rate for women is 1.9% that is higher than the men's are. (CSA, 2013) This study was conducted at Zewditu Memorial Hospital ART center, Addis Ababa, Ethiopia. Addis Ababa is the capital city of Ethiopia with HIV/AIDS prevalence rate 5.2% (EDHS, 2011) and estimated population of 2,739, 551. According to CSA (2007), women comprised 52.4% and 66% of the total are in the age range of 15-49. (Central Statistics Agency [CSA], 2007). There are about six hospitals and 52 health centers, which are administered by the Ministry of Health excluding police and armed forces (FMOH & RHB's, 2012).

Zewditu Memorial Hospital is one of the governmental hospitals, which is situated at Kirkos sub city of Addis Ababa city administration. Emperor Hailesilassie founded the hospital in the year 1933 in collaboration with the seventh day Adventist missionaries. During the Derg regime, the hospital was nationalized in to public property. Since its establishment, the hospital renders services in areas such as medical, surgical, obstetrics and gynecology. Currently the hospital has broadened its services to areas like neurology, psychiatry, maternal and child health

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care, HIV voluntary counseling and testing (VCT) and ART for all groups of people. The hospital runs under control of Addis Ababa city Health Bureau. (US Embassy Ethiopia, 2009; Cromwelt for Wikipedia, 2014).

Zewditu Memorial Hospital (ZMH) is one of the institutions selected by ministry of Health in order to provide ART treatment to people living with HIV/AIDS. The Hospital ART center is the pioneer in the ART service in Ethiopia. It is found in the premise of the hospital adjacent to Pediatric ART, Regional lab, ART pharmacy, Mother's Support Group station (MSG), and Voluntary Counseling & Testing (VCT) clinic. The government of Ethiopia with help from CDC-E has launched its ART initiative in 2003 with nominal fee. Since March 2005, free ART service is launched to PLWHA and PEP service for other clients in potential danger to acquire the disease. The clinic served to more than 14,000 patients in its care with 9,287 patients started ART in 2005. In 2009 broke a ground on the construction of new outpatient department facility for the expansion of ART center in the Hospital compound. Moreover, as other ART clinics were also established around the country, the ZMH ART center gets to minimize its patient load to 5685 patients who use the ART service. (US Embassy Ethiopia, 2009)

The clinic provides comprehensive HIV services such as palliative care, HIV counseling and testing, and services to prevent HIV transmission from mother to child. TB/HIV collaborative activities are also conducted. Moreover, STI services, free client ART service and treatment for opportunistic infection, providing opportunistic infection prophylaxis, PEP (post exposure prophylaxis), providing provider initiative testing and counseling (PITC), diagnosing and treating complicated TB cases and transfer clients to health care for DOTS, initiating and following antiretroviral treatment, providing Prevention of Mother to Child Transmission

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(PMTCT) and condom provision. All activities are supported by CDC-E. (US Embassy Ethiopia, 2009; Cromwelt for Wikipedia, 2014).

Witnessing the current patient load, while conduction of this research 2013/14, the clinic's health care providers provide services for 300-400 clients per day, most of them are stable patients who came for medication refill, still makes this facility providing service to many patients. Moreover, as mentioned earlier, it is the largest and the first of its types in the country serving 15,598 people requiring HIV care. Thus, this ART center at ZMH is selected because it is the pioneer with HIV/AIDS care service provision to clients from various socioeconomic backgrounds.

Inclusion/ Exclusion Criteria

The inclusion and exclusion criteria of this study are stated as follows:

Inclusion criteria

- Women living with HIV aged greater than 18 years old and receiving service at ZMH, ART center
- Women living with HIV who are currently dating, married, divorced or widowed and have been in any kind of intimate relationship
- The participant who is willing to participate on the study

Exclusion criteria

- HIV positive women who are not willing to take part in the study
- HIV positive women who is under 18 years old
- HIV positive woman who have never been in intimate relationship now or before

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Sampling Method

Qualitative research mainly focuses on how the small number of cases (in this case individual) describes social life. Case studies often involve qualitative data about one, two or a limited set of cases and deeply investigate by focusing on several factors. Moreover, it uses analytic logic to study cases in detail because; few key cases may be enough to illustrate the issue (Creswell, 2013; Padgett, 2008).

As a result, I used purposive sampling for in depth investigation and deeper understanding of the issue by selecting research participants deliberately for the important information they can provide (Maxwell, 2012; Padgett, 2008; Patton, 2005). As Maxwell pointed out, the small sample size that has been purposely selected for typicality and relative homogeneity provides a good deal of data and conclusion to represent the average members of the population (Maxwell, 2012). As a result, based on the inclusion criteria those women living with HIV, who had been receiving HIV/AIDS care at ZMH, who reported experience of life time IPSV during the preliminary cross sectional survey were approached for re participation of this qualitative study and those who were willing to participate on the research were selected.

Sample Size

In a qualitative study, it is suggested to use a small sample size to collect information intensely and deeply. According to Ritchie, Lewis, Nicholls and Ormston (2013) "there is a point of diminishing return to a qualitative sample-as the study goes on more data does not necessarily lead to more information". Moreover, once a piece of data/code is occurred that is the necessary and sufficient condition to be part of the analysis framework. As a result, by basing the systematic analysis of research of Guest, Bunce and Johnson (2006) among sex workers in West Africa, nine in depth interviews with purposefully selected research

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homogeneous participants may suffice information saturation (p. 76). Similarly, Guest and his colleagues (2006) also suggested six to eight interviews for a homogeneous sample. However as Padgett (2008) advised the proposed sample size might end up with larger or smaller sample size than anticipated due to the flexible nature of qualitative sampling and saturation of information, where data collection no longer produces additional insights to the research question.

As I have conducted a pilot study with 487 participants in April 30 - June 4, 2013 at the clinic and found out that 102 HIV positive women have reported life time IPSV. As I have asked their phone number of study participants who were willing to participate in this study. From the 102 study participants the 86 participants' phone number is retrieved. From 86 women, 49 women denied participation due to different reasons and the phone was unreachable or wrong number for 28. Only nine study participants responded positively. Thus nine were contacted based on their willingness for re-participation and inclusion criteria.

Finally, in depth interview conducted with nine study participants to gain an in depth understanding about the topic under study. In addition, key informant interviews were conducted with three hospital staffs to get supportive information about the issue and to triangulate the findings. The key informants were purposely selected based on their HIV related patient care and counseling work experience (greater than two years) as they provide rich information on the issue.

Data Collection Tools and Procedures

The data collection procedure and the data generated are determined by "the theoretical orientation, by the problem, purpose of the study and by the sample selected"(Merriam, 2009). Since this is a qualitative research, it utilizes data in multiple forms such as in depth interviews, observations and documents rather than depending on a single source (Creswell, 2013; Gillham,

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2000, 2005) Hence, in-depth interviews were conducted with nine study participants by using the unstructured open ended interview guide developed by the researcher. The tool piloted at the Black lion Hospital with three HIV positive women for language clarity and cultural sensitivity. The Hospital is selected to minimize the potential effect of testing as a threat to validity and reliability of the findings. By using the modified tool after pilot test, primary data gathered starting from July - October 2014. During a face to face interview, six participants consented to be audio recorded and three denied so I used note taking. The interview took place in private to maintain confidentiality. Secondary sources of data from the facility logbook and clients' medical charts also utilized.

Data Analysis

Data analysis according to Gillham, (2000) is realistically present the findings in a summarized and organized manner. In qualitative research, data analysis takes place at the same time of collection (Creswell, 2013). In the case study "analysis begins with the first interview (Merriam, 2009).

This study used thematic analysis in each identified sub-categories. It is a commonly used qualitative data analysis method which focuses on identifying patterned meaning across a dataset that could provide an answer to the research question. "Patterns are identified through a rigorous process of data familiarization, data coding, and theme development and revision" (The University of Auckland, n.d. para. 2-3).

Creswell's linear hierarchical approach is used to analyze the data. (Creswell, 2013) First, the data were organized and prepared for analysis; the audio taped raw data transcribed to Amharic then translated to English. Identification numbers given and name changed to identify each individual cases and to maintain confidentiality. During transcribing the data, due emphasis

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was also given for non-verbal expressions (sighs, sobs, laughter...) and foreign language words and expressions were put in parenthesis. Secondly, after intense and repeated reading of the transcribed written records the general sense of the information was obtained. The third step was coding the data by identifying "striking points" and "meaning units" by using in vivo coding - words directly emerged from participants (Creswell, 2013; Padgett, 2008). As Padgett suggested, the right margin of the transcript was used to write relevant sections and code was assigned to label them. After three or four transcripts a preliminary list of codes were piled up and applied to additional transcripts. Over time, some codes dropped or absorbed by another code and some codes divided into sub codes. Then the relationship between codes was mapped. The research questions and the literature were referred to predetermined codes. In addition, emerging codes also included.

The fourth step was, finding the most descriptive topic from the code list. By doing this the long list of the codes downsized into five themes or categories. These themes considered as a major finding of the study and used as a heading in the finding section of the study. The themes then analyzed for each individual case.

Finally, interpretation of the findings became the last step of data analysis. The findings of the study then discussed in relation to the purpose of the study and the model used in the literature review.

Trustworthiness of the Study

Trustworthiness of qualitative study is not a "blind faith" rather it has to be proven through rigorous methods even it utilizes flexible guidelines. The study was conducted fairly and ethically. The experiences of the research participants were represented as much as possible (Padgett, 2008). To ensure trustworthiness of this study multiple strategies were used to evaluate

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the accuracy of the findings. As a result, data triangulations, member checking and negative case analysis, were used to ensure rigor and accountability to the study (Creswell, 2013; Padgett, 2008)

Data triangulation: this study used multiple data sources for validation or confirmation such as in depth interview with study participants, key informant interview with health facility workers and secondary data from the facility archive, internet, books and other researches. Because the findings of these sources converge then this study is said to be trustworthy.

Member checking: this method also used to avoid researcher bias and to demonstrate the researcher intense involvement in the study. It was demonstrated by going back to three study participants and discussed about the preliminary findings; not the raw transcript.

Negative case analysis: information that is against to the themes also discussed. Discussing such issues again added credibility to the account.

In addition, the researcher took all roles starting from designing, as the data collector, transcriber, coding and interpretation of findings to represent the findings according to the research participant's perspective.

Ethical Consideration

Qualitative researchers involve in designing a study, in collecting data from individuals by probing into their personal and social lives and interpret the findings. As a result, researchers need to safeguard the research participants in all the way and need to develop trust (Creswell, 2013). This study seriously considered the ethical conduct during the research process. The proposal submitted to the Addis Ababa University School of Social Work for approval. The official letter of approval was submitted to Zewuditu Memorial Hospital (ZMH) and ART center where the study took place.

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Since this study performed face to face interview informed consent was obtained. As Creswell suggested the consent had a brief description about, the identification of the researcher, how participants were selected, the purpose of the research, the benefits and notions of risk of participation, guarantee of confidentiality, and assurance of withdrawal at any time during the interview and provision of contact address for possible questions that might arise. (See Annex I).

Maintaining confidentiality and secrecy, freedom from deception, coercion or emotional harm was the core ethical principles of this work. Every possible effort was made to ensure secrecy, not to disclose the identities of participants and the information they provide without their permission. Moreover, participant number and name change are used to preserve anonymity (Padgett, 2008). However, the research has considered imposing some emotional harm to the participants during face to face interview. Thus, as the participants were sharing their private life experience, there were some cases where I have to stop the recording (when the participants get emotional and crying or unable to continue) until they are calm and ok to continue or postpone the interview to different time. Furthermore, all the recorded information kept in safe keeping and destroyed after data analysis.

All the nine contacted HIV positive women were given prepaid mobile cards worth of 50 ETB to thank them and to compensate their time. In addition, the three participants selected for member check also reimbursed 100ETB for transportation expenses. The health facility staffs are not given any incentive; they cooperated for this research free.

CHAPTER FOUR: FINDINGS

This chapter presents the findings obtained from the study that are related to the research questions. It has two major parts. The first section presents the socio-demographic characteristics of participants in order to introduce the reader to the participants who shared their experiences and aided this research. The second part presents themes from the case study findings. Thematic analysis is used to examine the findings.

Socio-Demographic Characteristics of Study Participants

In-depth interview participants

In this study, nine HIV positive women participated in in-depth interview. All the participants were women living with HIV, ages 18 and above on follow up at the Zewuditu Memorial Hospital (ZMH), ART center and all have been in intimate relationship. All of them speak and understand Amharic. As the table clearly stipulates, they are in the age range of 28-57. The maximum educational attainment of the participants is diploma and two of them have not been to school. Out of six participants two participants (Akal and Fate) are self-employed and doing least paying and available jobs for living (\$1-2/day). Gidey and Salima have a permanent job as a nurse and teacher in governmental health center and primary school respectively and Sosina is doing secretarial service for private company. Moreover, Liya, Mare and Boge are house wives; both of them are dependent on respective partner's support for living. However, Dawite has no job and is doing nothing for a living; she is getting support from her sister abroad. All participants knew their HIV status at least five years back, six of them are on ART, and three of them did not start anti-retroviral treatment for their own health.

Regarding their marital status, six of them are married currently, one widowed but dating someone currently, and the remaining two are separated/ divorced. All participants have one or more than one child.

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Table 1: Summary of Socio-Demographic Characteristics of women

Participant's Pseudonyms	Age	Housing: type of house, payment/ month	Educational level	Means of income	Current or former Husbands job/ income	ART use	Marital status	Number of children	Religion
Akal	57	One room mud plastered	Illiterate	Daily laborer (average \$1-2/day	Security/75\$	Not on treatment	Separated/Divorced	Two	Ox
Salima	34	Rented three roomed Mud Plastered \$20	Diploma	KG school teacher \$125/month	NGO/250\$	Not on treatment	Separated/ divorced	Three	Ox
Gidey	47	Two rooms mud plastered \$20	Diploma	Nurse at health center \$200/month	CEO/500\$	ART	Married	Four	OX
Sosina	33	One room Mud plastered \$25/month	Diploma	Secretary (\$ 150/month)	Daily laborer/not consistent but daily about 5\$	ART	Married	One	Ox
Fate	36	Illegal Plastic House	Illiterate	Daily laborer(average \$1-2/day)	Physical work in Merkato market/50\$	Not on treatment	Married	Two	Mus
Mare	56	One room mud plastered \$ 20	5 th grade	House wife (Dependent on spouse	\$102.5/month)	ART	Married	Seven	Prot.
Boge	29	Six rooms ground plus one building	12 th grade	Housewife (dependent on her husband	Merchant/ about \$1000/month,)	ART	Married	Two	Mus
Dawite	30	family house	12 th grade	No job (dependent on sisters abroad send monthly \$200/month)	Delala (liaisons)/150\$	ART	Widowed but dating currently	One	Ox
Liya	28	Private Three rooms	12 plus 2	Housewife (dependent on her husband,	NGO/\$30-35/month	ART	Married	One	Mus

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Key informants

In this study, three key informants, one female doctor, two female nurses (ART nurse and PMTCT and MSG coordinator nurse respectively) were purposively selected and interviewed. They all are known and recognized by the health facility to assist clients with psychosocial need related or unrelated to their health status. They are aged 47, 30 and 43 years respectively and all are married. They are working in the ZMH HIV care and support unit at the time of interview and all served more than two years in patient counseling related areas. All have taken trainings and refresher trainings on ART services and VCT. They all have updated knowledge on HIV related counseling in 2013.

Table 2: Summary of Socio-Demographic Characteristics of Key Informants

Participant key informant #	Profession	Sex	Age	Marital status	Total year of service	Year of service related to counseling	Training counseling	Last time of training/ refresher training
1	Medical doctor	F	47	Married	29	11	Training of trainers	April, 2013
2	ART Nurse	F	30	Married	10	7	Training of trainers	April, 2013
3	PMTCT nurse/and MSG coordinator	F	43	Married	11	7	PMTCT	April, 2013

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Thematic Analysis of Findings

The findings obtained from in-depth interview participants were presented under the themes, which emerged during transcribing and translating the audiotaped interview and notes taken during interview. All nine are HIV positive women. Eight have intimate relationships with their married husband, dating or cohabiting partner but one (Askalu) is not currently having sexual relationship after her 17-year-old relationship end in separation before 6 years.

All participants narrated how their current or former spouse/partner used physical force and verbal threats, slapping, kicking, shouting/yelling and hands being held down to force sexual intercourse from them against their willingness. Only two (Liya and Salima) but the rest admitted that they have been in a violence relationship before they have known their HIV status. However, all verbalized the increased in frequency after they have known their positive status. Four participants (Salima Gidey, Liya & Boge) told someone about the incident to seek solution (Salima concluded marriage by filing court application for divorce and Liya told Medical providers as partner does not want to use condom.

All four told someone from family friends, religious fathers, 'shimagles' and seek for informal help) the rest did not tell anybody. None of the participants seeks formal help from Medical centers or police for partner sexual violence due to different reasons.

Finally, after repeated reading of the transcription of the narration from the participants, the experience of intimate partner sexual violence on women living with HIV/AIDS categorized into five sub-categories. They are (1) The nature of intimate partner sexual violence experienced (2) The risk factors predisposing women to sexual violence (3) Women's reaction and the psychosocial problems after IPSV (4) Factors affecting formal help seeking after sexual violence

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(5) Effect of IPSV on HIV care and treatment Adherences. The experiences of the participants are presented below in accordance with the common themes or categories.

Theme 1: The nature of intimate partner sexual violence experienced

All of the participants reported experience of all three types of repeated sexual violence, completed rape with or without force, attempted rape and forced touching of the private parts of the woman in different circumstances. In addition, from key informants' interview we have identified spouse-forcing wife to perform oral and anal sex.

Eight of the participants had experienced physical and verbal violence except one (Mare) who reported only completed sexual violence without physical or violence. The rest eight participants narrated how their current or former spouse/partner used physical force and verbal threats, slapping, kicking, shouting/yelling and hands being held down to force sexual intercourse against their willingness. Sosina reported her experience sobbing during the interview as

"... When I say No....he does want to listen. I usually come tiered from work, but he gets drunk and forces me to sex in whatever condition... He does not respect me...He thinks that I went to work to sleep with another man... he humiliated me, bit and kick me... and force me to sex...I want to live to my child... he does not want to stop but he bit and slap me, even in front of my child, then he would push me to bed and remove my cloth to perform sexual intercourse... sometimes...even after I sleep saying No to his offer he will force himself for sexual intercourse when I was sleeping... 'አኔ ሰርጅ ልጄን ሳሳደግ ወይስ የሱን ድብድብና አመል ልቻል" ene serche lijen lasadig wois yesun dibidbna amel lichal' " (Sosina, 33 years old)

One participant (Mare, 56 years old) experienced repeated completed sexual violence without physical violence.

"..... my husband wants to have sexual intercourse when ever he feels like it. Although I told him that I am in pain and sick (treated for cervical cancer stage I and did surgery to remove total uterus),, and not to engage in sexual intercourse he does not listen and insist and force himself on top of me.... He does not hit or bit me 'ይለማመኛል እንደውም'... 'yilemametegnall endewm' but he just wants to do this thing repeatedly which increases my suffering and pain." (Mare, 56years old)

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The key informant (2) who is an ART nurse has stated that one women client has reported that her spouse has forced her into abnormal way of sexual intercourse with all orifices (anal, oral) some other associated problems.

"...I remember a young Muslim women client told me crying about how she is suffering from intimate partner sexual violence.... The husband wants to perform sex daily and as many times as he can. He wants to do it in every orifice and does not want to use condom at all..... She told me crying that he force her to perform sexual intercourse abnormally oral and anal sex '....when she told me crying and saying ..oh sister hulum kedadaye eko aykerewum... (ሲሰተርዬ ሁሉም ቀዳዳዬ እኮ አይቀረውም)' ..which was unbearable for me to see her suffering.... "(Key informant 2)

Moreover, Key informant 1 a doctor and 2 ART nurse stated that they have witnessed some women clients of theirs reported issues of partner violence including 1) Lack of knowledge of their partners' HIV status when they ask before sexual intercourse he will get angry and become violent 2) Husbands' avoiding or a little communication on sexual relationship including condom use 3) Husbands do not want to use condom during sexual intercourse and 4) Husbands have no understanding on the sexual feeling of the women partner before, during or after sexual intercourse.

Most of the male partners are portrayed for using force for requesting sexual intercourse. In addition to sexual violence, eight of the women have reported to suffer from lifetime intimate partner physical and emotional violence. Sosia remembers one situation that her and her partner get in conflict and she end up having her shoulder joint displaced from his physical abuse.

"... We fight... we are in conflict whenever he gets drunk... Yes he always bit and kick me... even one time as he has bitted me and my left shoulder has been injured and I went to traditional healer for massage. ' በወጊሻ ታሸኛኛ ነው የተሻለኝ ' (Sosina, 33 years old)

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Theme 2: Risk factors predisposing women to sexual violence

I have identified some individual and interpersonal risk factors predisposing the participants to intimate sexual violence. Most of the reported risk factors have based their ideologies from the larger societal system of male dominance.

Economic dependency/ excellence (Individual level risk factors)

Except Sosina, who reported earning high income for the household, all of the other women either earn low income than the husband or depend on the husband for financial need and support. (See the demographic data. Table 1)

"Because he is the major bread winner and head of the family, you are eating on his bread how can you say no. "Yemannen dabu eyebelash tikelekiyalesh" (Mare, 56 years old)

Opposite to economic dependency, economic excellence has also been reported as a risk factor for women's violence. Based on Sosina's (33 years old) report I also identified, women who are earning more than the spouse, as a risk factor for partner violence. Sosina said that to work out and earning consistent monthly income for running the household has contributed for her sexual and psychological abuse.

"...even he will call at work...many times disturbing me... he usually check on me ...stalking me and asking annoying questions while I was at work. ' ስራ ሁሉ እየደወለ የትነሽ፣ የትወጣሽ፣ የትገባሽ ይለኛል... በጣም ያሳቅቀኛል (sira hulu eyedewele yetnesh, yetwetash, yetgebash yilegnal...betam yasakikegnal) ... even if, I am not that kind of person who does not even think about going out with another man... as I am the bringing more consistent income to the home' ያዉ እኔ ስለሆንኩ ስራ የምወለወ ሌቱን የማስተዳደርወ... ሌላ ወንድ ጋር ትቸው የምሄድ ይመስለዋል... " (Sosina 33, year)

High risk Behaviors (Individual level risk factors)

Husband's life style and behavior was identified as one of the risk factor predisposing women to partner sexual violence. From this research, we have seen that the assailant is portrayed as unable to control his feeling (Sosina, Akal, Liya, Fate, Mare & Gidey), drunk,

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(Salima, Gidey, Akal, Fate, Boge, Sosina, & Dawite), jealousy (Akal, Gidey, Liya, Sosina & Salima) and having extra marital affaire (Gidey, Dawite, Fate & Liya) and resistant to the request of testing for HIV or request to the use of condom (Salima, Liya, Sosina, Fate, key informants 1 & key informant 2).

"When I came from work and he came drunk and force me to sex... he does not want to use condom when I ask him to do so he gets angry, moreover, ... He thinks that I went to work to sleep with another man... he humiliated me, bit and kick me ... I want to live for my child's sake...he is jealous ...very jealous..." (Sosina, 33 years old)

HIV positive status (Individual level risk factors)

Only two (Liya & Salima) but the rest admitted that they have been in a violence relationship before they have known their HIV status. However, all verbalized the increased in frequency after they have known their HIV positive status. Boge regrets when she told me that she regrets listening to family and friends advice for getting married to her husband knowing he is an abuser from the start.

"He is the same person even before we got married he used to be very jealous if he saw me with friends specially boys he humiliates and abuses me a lot. I thought he do this because he loved me and my family and friends used to say he will be better after marriage." በጁ ሲያስገባሽ ቅናቱ ይበርዳል አሁን ስለሚወድሽ ሰግቶ ነው ይለኛል... 'But no change HIV 'ከተመረመርን በኋላማ እንዳውም ጭቅጭቅ ድብድብ ጨመረ እንጂ አልቀነሰም 'rather he got worse after we know the HIV status during PMTCT'" (Boge, 29 years old)

Dawite and Sosina also have similar view with Boge's view of the severity of violence increased after knowing their test for HIV Positive. As Dawite stated that her previous husband was more violent after he knows his HIV positive status and get sick

"...He used to be violent even before however he got violent more after he become ill from HIV" " ድርም ያው ነበር ከበሽታው በኋላ ባለበት" (Dawite : 30 years old)

Tolerance to violence (Individual level risk factors)

In this research, the tolerance to partner violence is identified as risk factor, which predisposes women to sexual violence by their own intimate partner. Participants have reported

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that they have tolerated the abuse because of **fear of further violence, protecting their children and hoping the situation might change.**

Mare, Gidey, Sosina, Liya, Fate and Boge reported that they just fulfill the husband's desire by just lying on the bed flat until he finishes his sexual desire in order to avoid his verbal or physical insult. They report they tolerated his violence that predisposes them for repeated sexual violence by their intimate partner for fear of further violence.

"If I say no and resist his feeling he says many woeful things which psychologically irritates me so even if I don't want, I just let him to have my body. I also didnot get satisfaction but I dont want to engage in fight with him..... so that my children will not be disturbed." (Gidey 40 years old)

Mare also hopes that the situation might change

".... after all he is my husband the problem might change if I be patient so I hope he changes' (Mare, 56 years old)

Boge she does not agree with Mares Idea of that the violence and the husband's behavior could change:

"I thought he do this because he loved me and my family and friends used to say he will be better after marriage. ' በጁ ሲያስገባሽ ቅናቱ ይበርዳል አሁን ስለሚወድሽ ሰግቶ ነው ይሉኛል... But I see no change... " (Boge, 29 years old)

The other reason women in this research reported for tolerating the abuse is to protect their children from hearing their parents' conflict.

Gidey, 40 years old, also reported that she has tolerated her husband's sexual violence to protect her children from hearing their argument and watching the violence. For this reason, she reported fulfilling his sexual need unwillingly,

Submissiveness (Interpersonal level)

Women submissiveness to sexual violence as a wife and accept sexual violence as normal has been identified as one of the interpersonal factor predisposing women to IPSV. Seven of the

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participants agree that wife should be submissive to satisfy the husband's sexual feeling in normal situations. However, all participants stressed the need to have mutual understanding between partners and for male partner to consider her situations when she said no.

Dawite accepts that wife should be submissive for her husband because he requests sex because he loves her and wants to be happy with her.

"...Sometimes what can you do if your husband/boyfriend requests sex...it is because he loved you and make love to you so as his wife even if you do not like it you have to do it or he will go to look for it with another women" (Dawite, 30 years old)

Mare also agree with Dawite that a woman should be submissive and reported her husband as an exemplary father and good husband however do not know what the cause of his unhealthy sexual behavior. She just fulfills his desire even if she does not feel like to, as he is the head of the family.

'These days I don't want to even resist him I just sleep still until he is satisfied and leave me. Because he is the major bread winner and head of the family, የግንኙነት ላይ ስለሆነኝ ትክለክያለሽ "yemannen dabo eyebelash tikelekiyalesh" after all he is my husband I have an obligation if I pushed him away he will see other woman which I don't want. (Mare, 56 years old)

Sosina disagree with the idea of sexual submissiveness.

.. "የለባትም!! 'Yejabatem' ... 'Women should not always be submissive... you know he also should understand my situations when I am sick and tiered I do not want to have sex. It should be with mutual understanding" (Sosina, 33 years old)

Poor social support (Interpersonal level)

In this research, five of (Liya, Mare, Sosina, Fate & Akal) our participants reported, as they do not have a reliable social support to discuss issues, asking advice or get help about their abusive relationship or anything else except their spouse. From this research, we have seen that having poor social support make life difficult to women to leave unhealthy relationship and is a risk factor to predispose women to intimate partner sexual violence.

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Liya, 28 years old, has two sisters and a mother. However, she stated that she does not want to tell her problems to them. One time she tried to tell her mother and she did not get her the proper support as desired. Rather she was sent back to her husband who betrayed and abuses her more.

"... I have family but they do not support me. 'በኛሩም ምንም አይጠቅሙም... በሀይማኖትም ያው ሲጠይቅሽ... ለባልሽ ሁሉ እኛ ማለት ስላለብሽ..' In my religion (Muslim) they believe a husband is entitled for sexual intercourse with his wife....one time all of my family blamed me for complaining on him...After... one time, when I left home after he hit me for resisting sexual intercourse as I saw him with other women... I said I do not have anybody to rely on even my own family believes a women has to be submissive to her husband in whatever case. Now he knows that my family does not support me, his abuse humiliation increased. "ማንም እንደማይገዛልኝ ሲያውቅማ... ይኸው እንደረለገ ያሰቃየኛል..." (Liya, 28 years old)

Mare also have similar idea as Liya that she also has poor social support and reported that she thought to leave the relationship for better but as she does not have any body to care for she stayed with the husband.

"However I even think of running away or go to monasteries and live alone but I have no one ...I think with my sickness and all about who takes care of me; let him do what he want and what will be my fate, who is going to be there for me when i am sick. so i don't want to go to the police or any where. 'እርሱ እንደረለገ ያደርገኝ እንጂ ምን አደርጋለሁ' " (Mare, 56 years old)

Akal shares Mare's idea that having no social support predisposes her to frequent violence until it ends when the husband left her to another woman.

" I do not have anybody to rely on... he betrayed me a lot and left me for other women after 16years of life in misery.... as I could not afford to live in the previous home anymore some people gave me one room out of courtesy. "ምን ሰው አለኝ... ሰው እንደሌለኝ አይቶማ ተጫወተብኝ... አሁንም ለነፍሳቸው ያሉ አስጠግተውኝ እኖራለሁ... ሁለት ልጆች አሉኝ እነሱንም አማሮ ከቤት ከወጡ ቆይተዋል... ለራሳቸውም አልሆኑም እርሱማ ሊጎዳኝ ነበር. እኔንም እግዚር ገላገለኝ እንጂ... I have two children from him but they left home at early age to avoid his abuse they do not have nothing to help me at last God saved my misery" (Akal 57 years old)

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Theme 3: Associated problem after sexual violence

Woman in this research are victims of IPSV living with HIV suffered from different kinds of associated problems. The associated problem victims have are divided into health related problems and psychosocial problems.

Health related problems: participants. Physical problems such as Gynecological problems abrasions, infection increase of viral load and decrease CD4 count, and unwanted pregnancy (Mare & Salima).

Key informant one, who is a Doctor, also witnessed that some women clients has reported that they have suffered from gynecological infections and repeated Sexually Transmitted Infections and gynecological area trauma and laceration as the partner is not using condom and forced sexual intercourse. She also mentioned that these women were concerned and in stress situation thinking what could happen if their CD4 decreases and gets worried a lot that they will get infected with different kind of virus (ART resistant) from him. Key informant 2, who is an ART nurse, also shares similar problems regarding stress of clients who is suffering from IPSV when her CD4 count drops while she is on treatment.

"I remember one time a women experiencing IPSV ... when she notices that her CD4 count dropped one time and she cried a lot as she is doing whatever she can as we suggested and told me that it dropped because of her suffering from IPSV by associating the two. May be it needs further investigation however it seems like the truth for the time being". (Key informant 2)

Psychosocial problems: In this research, we have seen that victims of IPSV have suffered from depression, anxiety and somatic problems.

Symptoms of depression including self-blaming, crying, feeling helplessness, sadness, anger , severe anger and rage, hatred, felling of being unloved, feel betrayed, worthlessness

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loneliness or nobody to care, stress and thought of ending life. (Gidey, sosina, Dawite, Key informant 2, Mare and Liya)

Gidey, 40 years old reported that she has suffered from some of the depression symptoms hatred, hopelessness, worthlessness and flash back of the rape incidence. She told me her suffering with emotion while she talks, moving her hands .

"....And I swallowed my hatred but after this kind of action always I just remembered the first day he raped me. When he insist to do sex when I said I am tiered and sick...So I (መጎዳቱማ.. ያው መጠቀሚያ የሆንኩ እነደ ሚሰት ሳይሆን እንደተራ ሴት የሚገትተኝ የሚያከብረኝ.. ብዬ አዝናለሁ... የው መባላጩት ማዘን እንጂ ምን ማደረግ አቸላለሁ... እንዴ ልጄ ወልጄለታለሁ) feel betrayed, unloved, worthlessness, no body to care for but because of my children I accept the situation with my husband "ባልማ ባዳ ነው ሲመችሽ፣ ሲደላሽ ነው... እንጂ ሲያምሽ ስትወደቁ ምንም አይረዳሽም" (Gidey, 40 years old)

Similarly, Akal (56 years old) and Salima (34 years old) also do not want to be in a relationship with another man even after divorcing their abusive husband.

Salima (34 years old) thinks of her suffering whenever her boyfriend suggests sexual intercourse and she do not feel happy as she wishes. On the other hand, Akal prefers to stay alone.

The other symptom identified as psychosocial problem is suicidal ideation of the women. Only Sosina (33, years old) stated that she has thought of worthlessness and killing herself. The rest of the participants answered never thought of taking their life as a result of their violence. She cried when speaking about how she wishes to end her life and stopped for a while as she was very emotional. And she continued after taking deep breath.

"I always cried... stressed.... I have no peace...I thought about killing myself to end my misery ... and when you think about my daughter ..." (Sosina, 33 years old)

The other psychosocial symptom these women experience includes: being angry easily, blaming them self for the tension and conflict created between them and their spouse. Fate, Gidey, Sosina, Salima, Akal and Liya stated for example that they gets angry easily, restless and

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does not want to talk to anybody. Dawite, Gidey, and Mare has blamed themselves for her resistance in the first place. Dawite (30 years old) stated that sometimes she regrets of the conflict and abuse (with her late husband), as it would have been better if she has done the sexual intercourse and get over it even if it hurts so much.

"Sometimes it should have been better if I say Ok when he asks because even if I resist he will be doing it anyways. (አንዳንድ ስሜዬ ቃሬታ አድርጌ በተገላገልኩ አላለሁ)" Dawite, 30 years old

Symptoms of anxiety: Salima suffers from shock and did not know what to do when her husband came drunk and kicked her to death and force her to sex after she ask him to be tested for HIV. Sosina and Fate also reported that they fear the night's time when they go home or expect partner to come home and wishes their partner not to come home, also reported nervousness, shakiness, having no peace or chaotic thoughts and trembling when they think about their partner.

"I have no peace I wish for him not to come home. Always I am nervous" (Sosina, 33 years old)

Fate also shares her experience of feeling of unsafe and she becomes restless and expects fight and abuse whenever he comes home.

"When I think of the time that he is coming I become restless and think my misery" (Fate, 36 years old)

Key informant 3, PMTCT Nurse, also agree that her client who is in sexual conflict with her husband tells her that she always argue with her husband on using condoms and does not have mutual sexual understanding in her relationship so when she comes to the clinic she always want to come in fast and leave the place as soon as possible, she does not even hear what the nurses are saying when giving her advice for her kid's medication. She comes to the clinic because she is told to bring her child for PMTCT care for child to be free of HIV/ AIDS. Her

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husband does not know his status and he is abusive so she fears him and she is always nervous do not want her spouse know her coming to the clinic.

Somatic symptoms: some of the symptoms we have seen from in-depth interview participants are pain, felling of tense loss of sleep and apatite.

Mare (56 years old) suffers from pain, especially back pain, she stated that she has pain and does not have any sexual feeling and felling of tense and do not relax at all which increases her suffering and pain. Key informant 2, who is ART nurse, also stated that one of her client suffers from stress, and loss of appetite and loss of sleep. Dawite (30 years old) and Mare (56 years old) stated that they lost hope and energy to function properly and feels tired usually.

Theme 4: IPSV Effect on HIV care and Adherences

This issue was raised for both the women participants and key informants to identify the effect of IPSV and associated psychosocial problems on the health status and medication adherence of HIV positive women. All agree that being victimized by their own partner and having conflict and abusive relationships has affected their health. Sosina stated that

"yes...HIV/AIDS need care and support, however I am always stressed, I am not thinking of myself I feel hopeless and sick...but my spouse does not understand" (Sosina 33 years old)

Gidey (40 years old not on ART) and Sosina (33 years old not on ART) also agreed that not using condom and forcing them to sex may affect their health status.

"...It is true as the health providers told us I am not taking ART medication but he is when I ask him to use condom he doesn't say ok... I might get his virus which is medication resistant" (Gidey, 40 years old)

Two of the health providers also agreed with the participants on the effect of IPSV on the health of the HIV positive women. Key informant one, who is a medical doctor, also witnessed that some women who has reported they have suffered from gynecological infections, repeated

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Sexually Transmitted Infections, gynecological area trauma and laceration as the partner is not using condom and uses force for sexual intercourse. She also mentioned that these women was concerned and in stress about if their CD4 decreases and they will be infected with different kind of virus (ART resistant) from him. She said it does not have an effect on the women's adherence to treatment.

" ... what you have to do is just take your medication on time for adherence as directed so in My opinion I do not think IPSV has such effect for the client's medication adherence" (Key informant 1)

Key informant 2 and 3, who are both nurses, contradicts this idea and believed it has tremendous effect on the women's ART treatment adherence. They both stated that mostly the psychosocial problems such as being stressed and feeling lonely associated with IPSV can affect the patients' health status and they might neglect to take their medication.

"If you have a problem which bothers you daily, you really need to discuss with other people and vent yourself. Otherwise, you will be stressed which might make you forget the time to take your medication. Moreover you might lose your appetite to eat well and will not get the necessary food staff and sleep to care for your health which indirectly affects your immunity." (Key informant 3)

"I remember one time a women experiencing IPSV her CD4 count dropped and she cried and told me that she did whatever she can to eat well, and taking the medication on time however she was blaming it on her stress as she lost her sleep over suffering from IPSV by associating the two.... May be this needs further investigation however it seems like the truth for me at the time being". (Key informant 2)

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Theme 5: Factors contributing poor help seeking

Individual/ Interpersonal level factors

All the participants have reported repeated sexual violence by intimate partner. Some of the individual factors which affect the women's initiation to leave the abusive relationship or for not reporting the abuse to police and suffers from repeated sexual violence. There are various reasons why women in a violent relationship may find it difficult to seek help when their partners are sexually abusing them. Some of the Individual/ Interpersonal level factors identified include: Perception of sexual violence by intimate partner as "normal", Fear, Lack or lack of knowledge of protective laws, Economic dependency, Sickness (Health status) and Poor social support.

Perception of sexual violence by intimate partner as "normal",

Some women accept the violating relationship with the belief that it is normal for her husband to hit, kick their wife as it is culturally assumed that it is a sign of love. Or on the other hand it is an obligation for a woman to accept his sexual offer and to provide sexual gratification for the man. Otherwise the husbands may see other women to fulfill their sexual need. Mare also argues that she has an obligation to her husband when he needs sexual intercourse even if she does not like it.

"....after all he is my husband if I pushed him away he will see other woman which I don't want. ..." (Mare, 56 years old)

Fear

The other reasons are fear of the partner's further violence, fear of losing children, fear of continuous conflict with the partner, to continue relationship and family children's sake and to avoid fight and confrontations with the partner.

"If I say no and resist his feeling he said many woeful things which psychologically irritates me so even if I don't want I just let him to have my body. I also did not get

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satisfaction but I don't want to engage in fight with him so that my children will not be disturbed. "(Gidey, 40 years old)

Fear of bringing shame to the family is the other factor mentioned by women as a reason to clearly tell about their experience of sexual violence to anybody even to informal families and friends in fear of shame. Gidey and Sosina reported their experience of help seeking as worthless with facial and hand gestures of hopelessness

".....but I tried to tell him through his uncle but I didn't talk about the sex part you know it is private matter. And shame" (Sosina, 33 years old)

"...Even if I told them... what could they do? It is my fate except that they will talk to others and you will be ashamed. I usually talks with friends and they also shares similar experience and we ventilate ourselves, laugh on the incidents and let it pass" (Gidey, 40 years old)

Lack or lack of knowledge of protective laws

Most of the women participant and key informant 2 stated that they do not know if the law could protect violence between intimates. I have also tried to see if a law is formulated on this issue to punish the IPSV assailants as far as my search I could not find any record.

"I didn't go to police you and I don't know if any regulation exists...." (Gidey, 40 years old)

Economic dependency:

Most of the women participants are dependent on their husband for HH expenses or gets less income than their husbands. The women also have children who depend on them. Children care in these days is also very expensive which further make it difficult to leave the abusive relationship. They did not leave the relationship because of economic dependency and frustration

"....Now a days I don't want to resist him I just lie still until he is satisfied and leave me. Because he is the major bread winner and head of the family, "yemannen dabo eyebelash tikelekiyalesh" (Mare, 56 years old)

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Sickness (Health status) and Poor social support

Some of the women who are sick need every support they get to recover from their illness. Thus, as Mare reported if you do not have social support and economic power to take care of your health it will be difficult to leave the established family which you depend on when getting sick. Thus we have seen that having frequent health problems and diseases affect the women's decision to leave abusive relationship.

".... I even think of running away or go to monasteries and live alone but I think with my sickness and all about who takes care of me; and what will be my fate ...when I am sick. So I don't want to go to the police or anywhere. "(Mare, 56 years old)

".....who is going to be there for me when I am sick? So I don't want to go to the police or anywhere. "(Mare 56 years old)

Institutional Health facility level factors

Lack /Poor violence assessment tool

In this research, not all the victims of IPSV reported the abuse to their health providers. Only Salima seeks medical help after the abuse. Even Salima denied the cause of her problem for the providers due to fear of shame of talking on private matter.

"....I was bruised andOh... no... we didn't tell them how can you say such thing? ...I was afraid to tell such thing? ...it is a shame so I said I fall off stairs...." (Salima, 34 years old)

As per key informant, all the three health providers agreed that they do not have any standard form that is designed to assess violence among each women client during time of their follow up. They witnessed that there is lack of any ways of assessing and treating any kind of sexual violence between intimates during their appointment unless victims report their problem.

"...And about the 'provider initiative assessment', as far as I know there is no standard sexual violence assessment tool...." (Key informant 1)

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Lack of Knowledge to deal with IPSV

In the key informant interview, the health care professionals all verbalizes of not having or little knowledge on the magnitude of intimate partner sexual violence in the ART center. They witnessed that there is lack of ways of assessing and treating any kind of sexual violence between intimates during their appointment unless victims report their problem. All of them did not have proper training on social problems assessment and intervention skills

"...if it is visible body trauma on which case we might get involved in medical care. However, if the victim does not state her problem of being sexually abused by her partner it is very difficult to find out the abuse."(Key informant 1)

Lack of proper referral system

All participants reported that they wish there was a separate office, which helps this victims and health providers to refer women reporting such issues. The health care workers were also in the same page with the women regarding having separate but integrated center which address the issue of violence. Key informant 1 and 3, who is a medical doctor and PMTCT Nurse respectively, mentioned that the Rape Center at Ghandi Memorial Hospital as a role model of addressing such issues inside health facility.

They also suggested that mostly the police and court system has an obligation and responsibility and doubt the health care professional's involvement except helping the victim and reporting the incidence to police whenever it happens if requested by the legal authorities or the client.

".... As the health care provider everything had to be kept confidential and I do not think you can go ahead and report the incidence to police. Reporting without the consent of the client ኢትካል አይደለም 'is not ethical'However, sometimes if the abuse was already reported to the police there will be legal paper to request for any medical evidence and doctors write a report to police.... as we do for all types of rape cases we send the evidence but for intimates sexual abuse I have no experience or the information...."(key informant 3)

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Clinic Workload

All the informants states that the clinic has tremendous workload. Thus, they hesitate to talk during the limited contact time (monthly or three months appointment time). Hence, clients might not discuss the issue with the medical provider at all. One of the key informants also agrees on the challenge of the facility to discuss non-medical issues during busy clinic hours.

"....previously before we moved into the new building, we used to share examination rooms. Most of the time we have two clients, sometimes even more, with additional relatives too. Thus, during medical evaluations it is difficult for women to discuss their personal violence related issue. However, now the rooms are much better for confidential discussion. I think the problem now is the case load on the providers. This makes it difficult to give more time to discuss this issue and counsel the individuals. As other clients will be waiting for their turn the contact hour is very short to deal with this type matter..... However, when I say this it does not mean that we haven't given time for some who needs to talk to us. we sometimes stay even after hours to discuss and counsel people who need our help...." (Key informant 2)

Key informant 1, who is a medical doctor, suggested that the women support group (peer-to-peer support) is a good idea-sharing environment so that they can discuss their relationship problems with each other and get the courage to deal with the problem and come forward to seek help from police or health care providers.

Key informant 3, PMTCT nurse and former MSG coordinator, also witnessed the MSG group members at ZMH discuss many issues and creates solution for colleagues. However, her biggest fear is that most of the woman who are in problematic relationship with their husband, do not even want to join the group.

Community/Societal level factors

Perception of women's submissiveness in marriage (cultural Norms advocating male dominance)

Most of the informants state that the male dominancy ideologies and cultural norms make them to accept their violence as their fate.

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Boge and Mare believed that they have to fulfill their partners' sexual desire in order to protect their spouse from having an extra marital affair.

"He is my husband how can I say No to him even if I am sick I have to perform sexual intercourse otherwise he will see other women." (Boge 30 Years old)

However, Sosina and the rest of the participants believe that women should be submissive for spouse's request not always but only during normal times. If she said no to the spouse's sexual request whenever she is unwilling he should understand as well.

Minimizing violence between intimates and blaming the victim (Society level)

Some women participants have told suffering from intimate partner violence (physical & emotional) to at least to one individual however none of them told about the sexual violence.

Three (Sosena, Boge & Gidey) of the participants said they got appropriate help from the people they told who also were touched by their problem and did not blame them but the victim.

On the contrary, one participant Salima reported the incidence of IPV to family members and they ignored her abuse and made her ask excuse for humiliating her husband in front of his colleagues. Even if she told them that she was the victim of violence during discussion to resolve the conflict between her and her husband most of them told her it is normal for a husband to hit his wife.

"Family of his and mine get involved and we got reconciled.... they made me ask excuse for humiliating him at work. He was angry because I humiliated him at his work. As I was stating he abused me physically... they said it is ok the husband to hit his wife which doesn't make sense at all... sometimes because he is a man he is always correct and they minimizes your problem... he did not stop after even so It does not help for me to stay in the relationship or collect go between 'Shimagle' any more that thus I filed divorce to get separated"(Salima, 34years old)

Thus, from this we have identified that there are different ideologies among the society on minimizing violence between intimate as normal and blame the women victim.

CHAPTER FIVE: DISCUSSIONS

In this study, the experience of intimate partner sexual violence among woman living with HIV/AIDS was assessed qualitatively using in-depth interview guide with nine women respondents and three key informants at ZMH ART center. The study focuses to explorer the nature of intimate partner sexual violence among women living with HIV AIDS with associated psychosocial problems, risk factors and help seeking tendency.

This research found that HIV positive women experience all the three types of sexual violence which include completed rape, attempted rape and forced touching of the private parts of the woman. This finding is comparable to other studies on women around the world (Bergen et al., 2006; Campbell et al., 2008; WHO, 2005b; Osinde et al., 2011). More over most of the women, who are victims of sexual violence, reported that they have suffered from intimate partner physical and emotional violence. The male partner uses force, hit, beat and verbal threat when participants say no to sexual offer was reported by most of the participants. This finding shows high response of male partners' using of force during sexual assault. Other researches indicated that abusers do not always use force and sometimes tends to be polite, charming, and manipulative (Pence & Paymar, 1986). This research has different findings with these researches (Frieze, 1983; Russell, 1990; Whatley, 1992). Only one participant from this research reported that her spouse ask her politely and use no force.

Participants also believed that they are sexually abused due to different reasons. They have portrayed their partner cannot control his sexual feeling, drunk and jealous. The risk factors associated with predisposing women living with HIV/AIDS to intimate partner sexual violence can be seen using Heise's ecological model as individual, interpersonal community and societal level risk behavior of abuser (drug and alcohol use by the abuser), and the sex role definition of

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male female relationship were reported as a risk factors. We have identified in this research that their intimate partner, because of their HIV status, has victimized women. Moreover, we have seen the violence has been increase after they have known their HIV sero-status. Even if we have no previous data to compare it with in Ethiopia, this finding shows that, women could be abused by intimate partner because their HIV status. Thus, this finding is supportive of other research which finds out that HIV positive status could lead to victimization (Campbell et al., 2008; Gielen et al., 2007; Maman et al., 2002). However, how and when the incident occurs could be another area of future research.

Among the sexually abused woman, all of them responded as experiencing at list one of the symptoms of psychosocial problem or experience post-traumatic stress disorder.' This finding supports the other studies that found anxiety, shock, intense fear, depression; suicidal ideation as common types of psychosocial problems among IPSV victims (Bergen et al., 2006; Eby et al., 1995; Jewkes et al., 2006; Lang et al., 2003; Woods et al., 2008)

The women's IPSV help seeking from both formal and informal sectors were extremely low in this research and identified different factors affecting help seeking initiation to formal and informal help. These factors range from societal level factors to individual level factors influence. This finding is in consensus with Heise's ecological model that violence is affected by interrelated multilevel influences starting from the individual level to the external environment in which people make their choices and live such as the family, friends, neighbors, organizations, physical environment and policy. All the factors were interrelated to one another. For instance, viewing sexual violence as normal (perceived-individual or actual-interpersonal/community) leads to fear of disclosure of IPSV (interpersonal), this in turn affects seeking for help and leads to repeated violence. In addition, the model provides a framework to understand the interaction

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of the determining factors of gender based across different levels and indicated the importance of targeting change at each level (Heise, 1998)

This research has shown low help seeking from the medical provides' at ZMH, ART center. These women have been coming to the clinic at least every three month for follow up. However, as there is lack of routine violence assessment tool in place, clinic's busy schedule and lack of appropriate referral and support for these women at the health facility level, the women are not motivated to speak out to seek help. This finding contradicts to other researches on intimate partner sexual violence which, indicates that health care settings provide an opportunity for support and intervention if patients/clients are asked about it (Bennice et al., 2003; Campbell, 2002).

In short, the clinic workload, lack of adequate knowledge to deal with such clients and lack of proper referral system for victims of sexual violence makes ZMH ART center inconvenient for clients to seek help or receive support. As per key informants report even for those who has reported sexual or other type of violence other than taking care of the health related problem the common practice identified as way of giving a solution by the providers is calling in each participant for a discussion and counseling. If one of the parties fail to come to the clinic for the discussion there is no other way to tackle the problem in hand and the providers are frustrated to deal with the issue.

As one of the gender based violence research, we have used the ecological model of understanding intimate partner violence. This model conceptualizes IPSV as a multi factored phenomena grounded in interplay of individual, family, community and societal factors. The frame work takes into account the different level of societal organizations and their role in influencing women's attitude to seek help towards IPSV. Each level of a societal hierarchy has

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potential influence on the individual's attitude towards IPSV. This model has been used by many researchers to understand the interplay of personal, situational or cultural factors that combine as risk factors predisposing women to IPSV and influence their help seeking attitude.

This model postulate that IPSV results from the interaction of factors at different level of social environment. It allows for the inclusion of risk factors from multiple domain of influence (individual, relationship, community and society level). Building such model offers a frame work for understanding the complex interplay of all the factors that influence IPSV and can therefore provide key points for prevention and intervention.

The ecological model also supports a comprehensive public health approach that not only addresses an individual's risk of becoming a victim, but also the norms, beliefs and social and economic systems that create the condition for IPSV to occur and affects the attitudes of women to speak out and seek help from formal and informal services. In this research we have identified Inadequacy of psychosocial help from the health service, poor help seeking attitude and unable to verbalize their violence in fear of shame and lack of policy to protect women have effected women living with HIV, who reported sexual abuse by their own partner. These women reported they are usually in conflict and abusive relationships that also affects their health and made them vulnerable to illness. In this research, we have also seen HIV positive women whom spouse is resistant to use condom and forcing them to sex has reported an effect their health status. Health providers also reported they have seen the effect IPSV on the health of the HIV positive women. They have seen women suffered from gynecological infections and repeated Sexually Transmitted Infections and gynecological area trauma and laceration. These women were highly concerned and become stressed about their CD4 count. Whenever, it decreases their stress increases, as it will affect their immunity and increased risk of being infected by different kind of

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virus (ART resistant). Moreover, the psychosocial problems such as being stressed and feeling lonely, loss of sleep and appetite were reported to have association with IPSV can affect the patients' health status and treatment adherence. This result is similar with the finding by Campbell, 2008 possible link between violence-related post-traumatic stress disorder and comorbid depression on immunity to HIV acquisition and HIV disease progression warrants further investigation. Sexual risk related to IPV works through both male and female behavior, physiological consequences of violence and affects women across the lifespan. As a result, of the incidence of partner violence is a serious and prevalent form of violence that women living with HIV tend to face. Furthermore, IPSV puts women living with HIV at double risk of facing violence and are at double risk of associated psychosocial problems from violence and HIV/AIDS because of their gender and health status.

In general, we can see the findings of this research interrelated with one another as of Heise's ecological model. The below shows this study findings of IPSV risk factors and factors affecting help seeking at different levels of organizations (ecological model) which predisposes women living with HIV to IPSV and psychological problem which also affect their health and treatment adherence.

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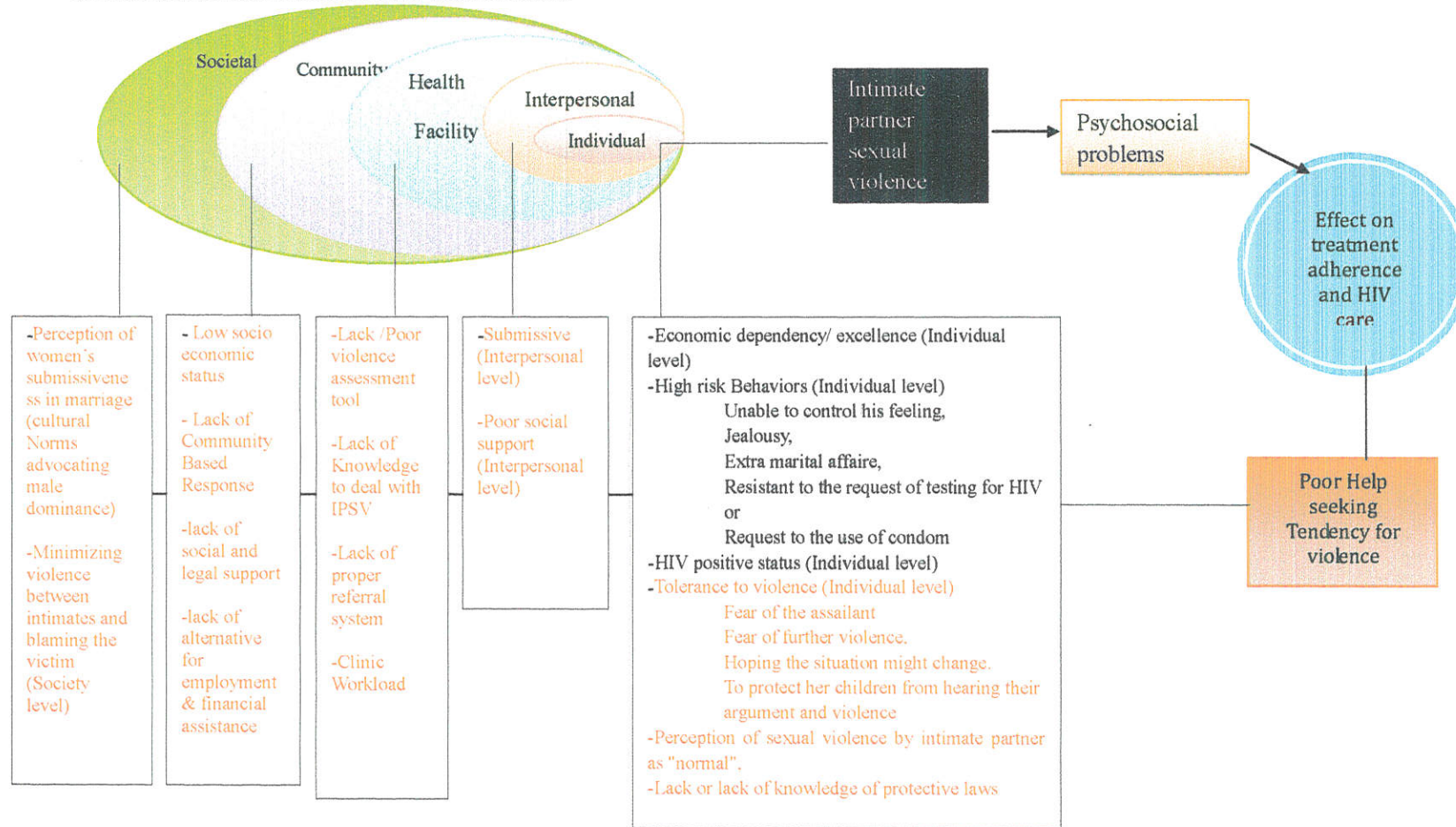


Figure 2: Study findings of IPSV risk factors and factors affecting help seeking at different levels of organizations (ecological model) which predisposes women living with HIV to IPSV and psychological problem which also affect their health and treatment adherence

CHAPTER SIX: CONCLUSIONS, SOCIAL WORK IMPLICATIONS AND RECOMMENDATIONS

Conclusions

From this qualitative study and observations, we concluded as reported by women participants IPSV with attempted, forced, and fondling or forced touch is common. Sexual violence may or may not be associated with physical violence however, most of the participants witnessed physical and verbal violence with sexual violence. Women tend to accept the sexual demand from their partner just for the sake of avoiding this traumatic episode of emotional violence. However, all women, who are victims of IPSV, experienced psycho-socials problems from the sexual and verbal or emotional violence. The common psychosocial problems are depression, anxiety and somatic problems. Two the participants suffer from flashbacks of the sexual violence, which is considered as post-traumatic stress disorder the incident. Participants reflected that Victims of IPSV suffered from emotional Disturbances, shock, intense fear, hatred, anger and suicidal ideation are the common psychosocial problems. The risk factors are interrelated in each level of Heise's ecological model. However, most of the participants in this study did not leave the abusive relationship because of economic dependence and submissiveness to marriage. Some of the individual risk factor predisposing these women to sexual violence is unable to control sexual feeling; drunkenness and jealousy of the assailant. The Help seeking attitude of all women form both formal and informal sectors was low. The main reasons are fear of further violence, shame and keeping the incident as private. However, each level of social hierarchy (from individual- interpersonal- health facility-community and societal level) has its own contribution to the poor help seeking tendency of these victims of IPSV. At the health facility level, there are factors that makes the facility non-conducive for reporting such issues. The health facility does not have more help from other stakeholders such

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as legal authorities and dedicated trained social workers that participate on the care of victims of sexual violence. They do not have violence assessment tool or mechanism in place to assess women during visit. They depend on the women's' own initiation to report any kind of violence or misunderstanding at home, which rarely happens. They also have a heavy workload to care for the health issue of their clients. Thus, the clinic has very tight schedule to an individual client, which makes the clinic unfavorable environment for the woman to report her violence and seek help.

For those who has reported sexual or other type of violence other than taking care of the health related problem the common practice identified as way of giving a solution by the providers is calling in each participant for a discussion and counseling. If one of the parties fail to come to the clinic for the discussion there is no other way to tackle the problem in hand and the providers are frustrated to deal with the issue.

Social work Implications and Recommendations

In Ethiopia, little empirical knowledge existed about intimate partner sexual violence. Similarly, most Social workers and other providers in the health care settings are not trained for dealing with this kind problem. Intimate partner sexual violence is private and seen as a family problem and personal issue. However, its effect is extended to family and societal level. Thus, having a research on this area will benefit students and social workers during practice experience on this area.

The implications of intimate partner sexual violence are significant for social workers providing care in all micro, mezzo and macro levels. Such as many of the individuals we work with might be or have been affected as primary and secondary victims of IPSV. Many of our male clients have abused or battered their partners. Many of us have felt the impact of violence

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in our own families. Social workers must have deep insight into the problem of partner sexual violence to effectively work toward ending violence and incorporate other stakeholders. Thus, interventions for intimate partner violence victims should be planned at all levels: individual (micro), family (mezzo), and societal (macro). In doing so, social workers should be aware of the following facts about the problem from this study and other literature on the area.

The high prevalence of Violence (both physical and sexual violence) in women with HIV infection has critical implications for policy and practice in programs and interventions for HIV or fight against gender based violence. These interventions should incorporate strategies to address the problem on several levels of social hierarchy. Such as to change the underlying societal perception of male dominancy and gender power imbalances, which is risk factor favoring IPSV. The experience of violence also creates gender inequalities that predisposes women to HIV risk, such that women who have less negotiation power in their sexual relationship are at higher risk of having HIV (J. C. Campbell, 2002) and women with less power have a lower likelihood of condom use. In addition, health education should be provided to women receiving care for HIV and IPSV regarding the nature of the associated risk, as well as reduction of risk factors. Secondly, policy guidelines should incorporate routine screening for partner violence when women come to the HIV care in healthcare settings. Thirdly, health providers should incorporate inquiries about IPV to women accessing care for STIs or have frequent doctor's visit. Lastly, our findings have implications for future research: A larger study comprised of both HIV positive and HIV negative participants would confirm whether a true association exists between HIV infection and IPV.

Social workers need to be involved in providing services to those directly involved in violent families, but we also must be working at the community level and on policies that will

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create a society that is less tolerant of gender based violence specially gender based violence

Given the undeniable prevalence of IPSV in the country, this study focused on IPSV victimization among HIV positive woman, and the associated psychosocial problems. Based on the learning experience of doing this research the following recommendations are suggested.

Primary care physicians and social workers are in an ideal position to diagnose victims of IPSV and provide them and their families with appropriate care or provide information on the available resources. When social worker or health care providers meet patients present with signs and symptoms consistent with IPSV emphasis needs to be given to provide help for these women in primary care settings, and associated medical and societal problems. As Partner Violence affects not only the victim but also all members of the family such as children and the larger community, intervention should be planned in all levels and need to incorporate all stakeholders.

It is equally important to be proactive and put prevention measures in place to keep any type of partner Violence from occurring in the first place. Violence assessment and screening during initial visit and follow up sessions are essential components providers -delivered gender base violence screening strategy for identifying and preventing abuse among chronically ill patients like HIV positive women. Moreover, strategies for preventing partner violence and to promote respectful, nonviolent relationships through individual, relationship, community, and societal change. It would be good strategy to incorporate in Ethiopia. Partner violence prevention and intervention can substantially decrease the public health burden and substantially improve the quality of life for many women.

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ANNEX

Annex I, English subject information, consent, in-depth interview guide participants

Subject information sheet for women study participants

My name is Memekia Gashaw, I am a student at Addis Ababa university. I am here to interview women living with HIV/Aids on their sexual relationship with their partner. The study is conducted for the requirement of masters' degree in social work. The general purpose of the study is to identify the prevalence and associated psychological and social problems of intimate partner sexual violence among HIV positive woman and their perception about the issue. Your contribution is very important for the success of the study. The study will generate information from woman living with HIV/AIDS who are/was married or currently dating and health professionals from ZMH clinic by conducting interview using in-depth interview guiding questions. The interview for the case study we use unstructured interview guide using both open and closed ended type of questions with you and will take 30-60min depending on your willingness and health condition. The data collection process fully considers your right of asking questions and you have the right to withdraw from the interview at any time for any reason. You have the right not to respond to questions that seems uncomfortable to you. The confidentiality, risk and benefits of the research will be handled in the following way. The information you provide is fully confidential will never cause any harm on you or your partner. All shared information is free from any personal identifier and it will be used only for research purpose. To insure confidentiality personal identifier (name) of the participant will not be mentioned when writing the report. Based on your willingness, tape recording and note taking will be carried out while conducting the interview. The tape recording is important to facilitate transcription and keep the quality of data. The tape-recorded information only heard by the interviewer. You are not also directly beneficial from this study in any ways however; we will give you a 50-birr mobile card for appreciation of you giving us the time to interview you and cooperate in this study.

Informed consent form for women participating in the study

I have understood and agreed to the participation on the study that focuses on prevalence perceptions and identifying the psychosocial problems of intimate partner sexual violence among HIV positive woman.

Date----- if yes signature-----

Signature of the interviewer-----

INTIMATE PARTNER SEXUAL VIOLENCE...

Annex II: In depth interview guide for study participants

(Women living with HIV at Zewditu Memorial Hospital)

Part I

Age _____

Primary language _____

Marital Status _____

Educational Level yours _____

Spouse's _____

Spiritual beliefs/background: _____

Occupation/financial situation _____ / _____

Spouse occupation/Financial situation: _____ / _____

Number of Children _____

Housing situation: _____

HIV diagnosis date/year: _____

Are you on ART? _____

Client Support system _____

Who is aware of the client's diagnosis? _____

Who are important people in the client's support system? _____

Discussion of disclosure issues/partner notification: _____

Part II - Knowledge about IPSV and experience

2.1. Can you tell me your relationship with your partner how it starts and your life shortly?

2.2. What is the nature of sexual violence from your husband you mentioned on the previous study? (Completed, attempted or forced touch?) Can you explain by remembering one of the incidents?

Probe: forced sexual intercourse, use of force, bit, hit, hand twist?

Probe: attempted sexual intercourse

Probe: forced touch of private parts, forced removal of your clothing

Probe: forced oral and anal intercourse

Probe: unwanted or force recording of the sexual intercourse

2.2.2. When do you think your partner commit sexual violence?

2.2.3. What do you think about the cause?

2.3. When you resist sexual violence what other type of violence did he commit to force you into sexual intercourse?

Probe: physical abuse

Probe: psychological/ violence abuse

2.4. How frequent the incident of sexual violence occurs?

If frequently: probe for individual, relationship, community and societal factors

2.5. When did it start before or after knowledge of your HIV status?

2.5.1. Did the sexual violence increased in frequency or decrease after the knowledge of your HIV status?

Probe for perceived reason?

2.6. What do you think the reasons predisposing you to sexual violence by your intimate partner?

Probe: individual factors, relationship factors, community, and societal factors

2.7. Associated Problems

2.7.1. What problems you have from experiencing IPSV?

INTIMATE PARTNER SEXUAL VIOLENCE...

- 2.7.1.1. Physical injuries? Gynecological problems? Pain? Unwanted pregnancy....
- 2.7.1.2. Psychological problems? Depression? Feeling of worthlessness? Fear? Anger....
- 2.7.1.3. Social problems? Isolation from family

2.7.2. What was the effect of these problems on your health?

Probe: Effect on medication adherence and frequency illness, CD4 count...

2.8. Perception

2.8.1. Who do you think is responsible for the sexual violence on dating/married women?

2.8.2. Do you think women should accept and fulfill their intimate partner's sexual desire?

Probe: If yes. why?

Probe: If No. why?

2.8.3. What do you think yours and your partners' role in preventing sexual abuse?

2.9. Help seeking

2.9.1. Have you reported your problem to health care providers?

Probe why for No and

Probe: what help do you get if Yes answers

2.9.2. Have you reported your problem to legal authorities?

Probe why for No

Probe: what help do you get if Yes answers

2.9.3 Have you reported your problem to anybody?

Probe why for No and

Probe: to whom what help do you get if Yes answers

Part III- General Questions

3.1. What are the services you expect from this health facility pertaining to psychosocial support for women facing violence?

3.2. Are you satisfied with the service provided?

3.3. What was your reason for not perusing formal help from the medical help or police)?

Why do not you tell anyone about your problem?

Probe: Individual, Individual related (fear, transport money, lack of support system, stigma discrimination, lack of disclosure, forgot, lack of knowledge...)

Interpersonal,

Institutional (health care/legal authorities) Institutional factors (nobody listens, rooms are not comfortable...)

Social factors (unable to go out to the clinic, lack of support system, presence of in-laws, stigma & discrimination...) Community and societal factors

3.4. How do the mentioned reasons made you to compromise accessing the service regardless of knowing the risk of sexual violence and HIV? (Do you believe that the barriers outweigh the benefit of seeking help?)

3.5. In your opinion, what are the situations needs to be improved in order to a woman to seek the formal health care or police services to fight IPSV? (Probe institutional and socio-cultural factors that need to be improved)

INTIMATE PARTNER SEXUAL VIOLENCE...

Annex III: Key informant in depth interview guide

(Three health care providers with more than two years work experience in ART center)

Part I

Age _____

Profession _____

Work experience in year _____

Have you ever taken PSYCHOSOCIAL COUNSELING or social work related training? ____.

When? ____.

1. How many HIV positive are you serving every day?
2. How many HIV positive women came for counseling on domestic violence especially sexual violence daily?
3. Do you assess each women client for partner abuse or violence? Is there a provider initiated violence assessment tool in place?
4. What are the services the facility provides for HIV positive women reporting sexual violence from their intimate partner?
5. If they come, do you have all the support needed for helping these women victims?
Yes, what help? _____
No, what do you think should help? _____
6. In this facility, is there a problem related to assisting women with intimate partner sexual violence?
If yes, in your opinion what are these problems hindering you from assisting these women?
If No, what is the strength of the facility? And what kind of mechanism do you have in place?
7. From your experience, what are the prominent psychosocial problems these women tend to face from experiencing intimate partner sexual violence?
Could you please compare the victims with non-victims and rate?
8. In your opinion or experience, how does being not able to assist these women reporting IPSV with psychosocial interventions affect the HIV care/ AIDS prevention related work goal and quality for your female clients?
9. Do you believe that addressing or providing proper psychosocial support for victims of IPSV could help in increasing women's adherence to HIV treatment and care provided by the clinic?
10. How do you think is the factor that affect HIV positive women's decision towards fighting domestic violence by intimate partner and accessing formal help and solution for the problem?
11. How are you trying to address the problem both at the institutional and individual level?
12. What do you suggest to improve the situation in order to a woman to seek the formal health care or police services to fight IPSV? (Probe institutional and socio-cultural factors that need to be improved)

INTIMATE PARTNER SEXUAL VIOLENCE...

Annex IV. Amharic Subject information, consent in-depth interview guide questions

በሰላም ጥናት ለተሳታፊዎች አጭር ገለጻ በአማርኛ

ስሜ መመኪያ ጋሻው አባላለው። የመጣሁት ከአዲስ አበባ ዩኒቨርሲቲ የሶሻል ወርክ ድህረ ምረቃ ትምህርት ከፍል ሲሆን ተመራቂ ተማሪ ነኝ። ጥናቱም የሚካሄደው የድህረ ምረቃ ወይም የማስተርስ ዲግሪዬን ማሟያ። መረጃውን የምሰበስበው ኤች አይ ቪ ቫይረስ በደማቸው ያለባቸውና ያገቡ፣ አግብተው የነበሩ፣ ወይም የፍቅር ጓደኛ ካላቸው ሴቶች እና ከክሊኒክ ነርሶችና ሀኪሞች ጋር ይሆናል። ይህ ጥናት እኒህ ሴቶች በትዳር አጋራቸው ወይም በፍቅር ጓደኛቸው አማካኝነት በሚደርስባቸውን የታዊ/ወሲባዊ ጥቃት መኖርና በሱ ምክንያት መሟያጋጥማቸው ስነልቦናዊ ተፅእኖ እና ስለሁኔታው ያላቸው አመለካከት ላይ የሚያተኩር የመመረቂያ ጥናት ነው። የእርስዎ ቀና ትብብር ለዚህ ጥናት መሳካት ከፍተኛ አስተዋፅኦ አለው። ጥናቱ የሚያተኩረው ያገቡ ወይም የፍቅር ጓደኛ ያላቸው እና ከኤች አይ ቪ ቫይረስ በደማቸው ውስጥ ያለባቸው ሴቶች ላይ በትዳር ወይም በፍቅር አጋራቸው በሚደርስባቸውን የታዊ ጥቃት መኖርና በሱ ምክንያት የሚያጋጥማቸውን ማህበራዊና ስነልቦናዊ ተፅእኖ ማጥናት ላይ ነው። ይህም ጥናት ከላይ የተገለፁትን ሴቶች ጠለቅ ያለ መጠይቅ በመጠየቅ ሲሆን ቃለ መጠይቁም ሁለት አይነት ነው። ቃለ መጠይቁ ከ30 ደቂቃ እስከ 1 ሰዓት የወስዳል። ቃለ መጠይቅ የሚያከራው ስለጥናቱ በቂ መረጃ ለመሰብሰብ እና በማብራራት ላይ እንዲሁም በተጠያቂውና በጠያቂው መካከል መግባባት በመፍጠረና በአጠቃላይ ጉደይ ላይ መረጃ መሰብሰብ ስለተጠያቂው ጠለቅ ያለ መረጃ የሚጠየቅበት ነው። ይህ የሚወሰነው በርስዎ ፈቃደኝነት ላይ ነው። ቃለ መጠይቁ በቴፕ ሪከርደር ይቀዳል ወይም በፅሁፍ ይፃፋል። ቃለመጠይቁ በቴፕ ሪከርደር የሚቀዳው የሚገኘውን ማብራሪያ ተጨማሪ ትንተና ለመስጠት ስለሚረዳ እና ጥራት ያለው መረጃ ለመሰብሰብ ነው። የተጠያቂውን ማንነትና ቃለመጠይቁ በሚሰጥ የተጠበቀ ሲሆን በሰጡት መረጃ ምክንያት በእርስዎም ሆነ በባለቤትዎ ላይ ምንም አይነት ችግርም ሆነ ጉዳት አይኖርም። የሚሰጡት መረጃም ከጠያቂው፣ ከዋና አጥኝዋና ከአስተማሪው ውጪ ለማንም አይገለፅም። በቴፕ ሪከርደር ወይም በመቅረፅ ድምፅ ለመቀረፅ ወይም በጽሁፍ ለማፃፍ ፈቃደኛ ካልሆኑ በጥናቱ ላይ ተፅእኖ ስለሚኖረው በጥናቱ አይካተቱም። የማይሳማማዎት ወይም ለመመለስ የማይፈልጉት ጥያቄ ካለ የአለመመለስ መብትዎ የተጠበቀ ነው። በቃለመጠይቁ ጊዜ ግልፅ ያልሆነልዎት እና እንዲብራሩልዎት የሚፈልጉት ነገር ካለ በማንኛውም ጊዜ መጠየቅ ይችላሉ። በዚህ ጥናት ሲሳተፉ ቀጥተኛ ተጠቃሚነት አይኖርዎትም ነገር ግን ለሰጡን ጊዜ ለማመስገን ያህል ከመጠይቁ በኋላ የ 50 ብር የሞገደል ካርድ በስጦታ መልክ ይሰጥዎታል። ይህ ጥናት የሚካሄደው በተሳታፊው ሙሉ ፈቃደኝነት ላይ የተመሰረተ ሲሆን መሳተፍ ካልፈለጉ በማንኛውም ጊዜ ከጥናቱ ውጪ መሆን ይችላሉ። ለማንኛውም ጥያቄዎ ወይም ለበለጠ ማብራሪያ ካስፈለገዎ 0911106050 ደውለው መጠየቅ ይችላሉ።

አመሰግናለሁ!!

በጥናቱ ላይ ለመሳተፍ ፈቃደኛ የሆኑ የስምምነት ቅጽ

ያገቡ፣ አግብተው የነበሩ ወይም የፍቅር ጓደኛ ያላቸው እና ኤች አይ ቪ ቫይረስ በደማቸው ውስጥ ያለባቸው ሴቶች ላይ በትዳር ወይም በፍቅር አጋራቸው በሚደርስባቸውን የታዊ ጥቃት ምክንያት የሚያጋጥማቸውን ማህበራዊና ስነልቦናዊ ተፅእኖና በአላቸው አመለካከት ላይ በማተኩር በሚጠናው ጥናት ላይ ለመሳተፍ ተረድኜ መስማማቴን በፈርማዬ አረጋግጣለሁ።

ቀን፡-----

ተስማምቻለሁ፡ የተሳታፊ ስምና ፊርማ----- የኮድ ቁጥር-----

የጠያቂው ስምና ፊርማ፡-----

Annex V: interview guide with participant women living with HIV in amharic

ለተሳታፊ ሴቶች የቀረቡ መሪ ጥያቄዎች

ክፍል I

እድሜ:

የጋብቻ ሁኔታ:

የትምህርት ደረጃ:

የባለቤትነት:

ሀይማኖት:

ስራ ወርሃዊ ገቢ:

የባለቤትነት ስራ ወርሃዊ ገቢ:

ስንት ልጆች አሉ:

ምን ዓይነት ቤት ውስጥ ትኖራለህ?

ኤች አይቪ በደምሽ ውስጥ እንደሚገኝ ያውቀሽው መቼ ነው?

የጸረ ኤች አይቪ መድሀኒት ትወስጃለህ?

ስለ አንቺ የሚያውቅ የሚረዳሽ እየዞሽ የሚልሽ ሰው ረዳት አለሽ

ኤች አይቪ በደምሽ ውስጥ እንደሚገኝ የሚያውቅ ሌላ ሰው አለ?

በሀይወትሽ ትልቅ ቦታያለው ብትችገሪ የሚደርስልሽ ሰው አለ?

ባለቤትሽ ኤች አይቪ በደሙ ውስጥ ይገኛል?

ከባለቤትሽ ጋር ስለህመምሽ ትወያያለሽ :

ክፍል II – ስለሚደርስብሽ ጥቃት

2.1. ከባለቤትሽ ጋር መቼ ተገናኛችሁ ከዚያም ስለአሁኑ ሁኔታሽ በአጭሩ ንገሪኝ?

2.2. አሁን ስለሚያደርስብሽ ወሲባዊ ጥቃት ዓይነት ንገሪኝ? ሁኔታውን አስታውሰሽ ንገሪኝ

Probe: አስገድዶ መድፈር?

ሙከራ ብቻ ወይም

አስገድዶ መነካካት

ባልተገባ መንገድ በአፍ፣ በሰገራ መውጫ ወሲባዊ ግንኙነት መፈጸም፣

ያለፍላጎትሽ ወሲባዊ ቪዲዮ መቅረጽ ነው

2.3. ወሲብ አልፈጽምም ስትይ በምን ዓይነት ሁኔታ ነው ለመፈጸም የሚፈልገው ወይም ምን ያደርጋል?

Probe: አካላዊ ጥቃት

Probe: አዕምሮአዊ ጥቃት

2.4. ይህ ጉዳይ በተደጋጋሚ ነው የሚከሰተው ወይስ አንድ ጊዜ ብቻ ነው?

2.4.1. በተደጋጋሚ ለመጠቃትሽ ምክንያቱ ምንድን ነው?

Probe: የግል ችግር፣

የጋራ ችግር፣

የህብረተሰብ ወይም

የማህበረሰቡ ችግሮች

2.5. ወሲባዊ ጥቃቱ በፊትም ያለ ነው ወይስ ኤች አይቪ በደምሽ ውስጥ እንደሚገኝ ካውቀሽ በኋላ የተጀመረ ነው?

2.5.1. ኤች አይቪ በደምሽ ውስጥ እንደሚገኝ ካውቀሽ በኋላ ድግግማሹ ቀነሰ ወይስ

ጨመረ?

Probe: ምክንያቱ ኤችአይቪ በደምሽ ውስጥ ስለሚገኝ ይመስልሻል?

2.6. ወሲባዊ ጥቃቱ የሚደርስብሽ በምን ምክንያት ነው?

Probe: የግል ችግር፣ የጋራ ችግር፣ የህብረተሰብ ወይም የማህበረሰቡ ችግሮች

2.7. ተያያዥ የሚከሰቱ ችግሮች

INTIMATE PARTNER SEXUAL VIOLENCE...

2.7.1. የፍቅር ገደኛ ስህተት ወሲብ ከፈጸመ በኋላ የገጠመኝ ችግር ምንድን ነው?

Probe: አካላዊ ጉዳት? Gynecological problems? Pain? Unwanted pregnancy....

አእምሮአዊ ጉዳት? Depression? Feeling of worthlessness? Fear? Anger....

ማህበረሰባዊ ጉዳት? Isolation from family

2.7.2. ኤችአይቪ በደምሽ ውስጥ እንደመኖሩ ይህ ጥቃት በጤናሽ ላይ ምን ተጽዕኖ አለው?

Probe: መድሀኒት አወሳሰደሽ ላይ የበለጠ ለህመም መጋለጥ ሲዲ4 መጠን ...

2.8. በትዳር ግንኙነት መሃል ስላለ ወሲባዊ ጥቃት አመለካከትሽ

2.8.1. በትዳር ግንኙነት መሃል ለሚከሰት ወሲባዊ ጥቃት ተጠያቂው ማን ነው ትያለሽ?

2.8.2. በትዳር ግንኙነት መሃል ባለ ወሲባዊ ጥያቄ ሲጠይቅ ሚስት መስማማትና መፈጸም አለባት ትያለሽ?

Probe: አዎ፣ ለምን?

አይ፣ ለምን?

2.8.3. በትዳር ግንኙነት መሃል ለሚከሰት ወሲባዊ ጥቃትን ለማስቀረት ባልሸና አንቺ ምን ማድረግ አለብን ትያለሽ??

2.9. ከጥቃቱ በኋላ የተደረገ እርዳታ መፈለግን አስመልክቶ

2.9.1. የደረሰብሽን ወሲባዊ ጥቃት ለህክምና ባለሞያዎች አማካሪሻል?

Probe: አዎ፣ ምን እርዳታ አገኘሽ?

አይ፣ ለምን?

2.9.2. የደረሰብሽን ወሲባዊ ጥቃት ለህግ ባለሞያዎች አማካሪሻል?

Probe: አዎ፣ ምን እርዳታ አገኘሽ?

አይ፣ ለምን?

2.9.3 የደረሰብሽን ወሲባዊ ጥቃት ለሰው አማካሪሻል?

Probe: አዎ፣ ለማንኛውም እርዳታ አገኘሽ?

አይ፣ ለምን?

ክፍል III- ማጠቃለያ

3.1. በዘውዲቱ ሆስፒታል ኤደስቲክ ክልኒክ ውስጥ ባለቤታቸው ወሲባዊ ጥቃት ለሚደርስባቸው ሴቶች ምን አይነት እርዳታ ቢደረግ ትያለሽ?

3.2. ከክሊኒኩ በሚደረግልሽ እንክብካቤ ደስተኛ ነሽ?

3.3. የደረሰብሽን ጥቃት ለማንም ለመናገር ያልፈለግሽው ምክንያትሽ ምንድን ነው?

Probe: የግል ችግር፣ Individual related (fear, transport money, lack of support system, stigma discrimination, lack of disclosure, forgot, lack of knowledge...)

የድርጅቶች ችግር፣ (የክሊኒኩ፣ ፖሊስ ጣቢያ) Institutional factors (nobody listens, rooms are not comfortable....)

የህብረተሰብ ወይም የማህበረሰቡ ችግሮች Social factors (unable to go out to the clinic, lack of support system, presence of in-laws, stigma & discrimination...)

3.4. የጠቀስሻቸው ምክንያቶች በአንቺ ላይ ችግርሽን እንዳተረናገሪ ያሳደሩት ተጽዕኖ ብትናገሪ ከምታገኝዉ እርዳታ ጋር ሲወዳድር ላንቺ የቱ የበልጣል

3.5. ምን አይነት ችግሮች ቢቀረፉ በትዳር አጋራቸው ወሲባዊ ጥቃት የሚደርስባቸው ሴቶች ችግራቸውን አውጥተው በመናገር መፍትሄ ሊፈልጉ ይችላሉ ትያለሽ?

Probe: በተቀምም ሆነ በማህበረሰብ ደረጃ ምን ቢሻሻል ይሻላል (institutional and sociocultural factors that need to be improved)

Annex VI : Amharic Key informant in depth interview guide

(ከተመረጡ ሶስት የህክምና ባለሞያዎች ጋር ለሚደረግ ጠለቅ ያለ ቃለመጠይቅ መሪ ጥያቄዎች)

ክፍል I

1. እድሜ _____
2. ሙያ _____
3. የስራ ልምድ _____
4. የሳይክሶሻል ምክር አገልግሎት ለመስጠት የሚያስችል ስልጠና ወስደዋል? ____ መቼ? ____
5. በቀን ምን ያህል ህመምተኛች ያስተናግዳሉ?
13. ምን ያህል ሴቶች በትዳር አጋራቸው ወሲባዊ ትንኮሳ ደርሶባቸው ለምክር አገልግሎት ወደርሰዎ ይመጣሉ?
14. ሴት ህመምተኛች በቀጠሮ ሲመጡ ለቤትዉስጥ በተለይም ወሲባዊ ጥቃት መገላጣቸውን ለማወቅ መጠይቅ አላችሁ?
15. ሴቶች በትዳር አጋራቸው ወሲባዊ ትንኮሳ ደርሶባቸው ለአገልግሎት ወደክሊኒኩ ሲመጡ ምን አይነት እርዳታ ይደረግላቸዋል?
16. ሴቶቹ ሲመጡ አስፈላጊውን እርዳታ የሚሰጣችሁ ክፍል እና እገዛ የምታገኙበት መንገድ አለ? አዎ ካሉ ምን አይነት እርዳታ ጠቀማችሁ? አይ ካሉ ምን ብታገኙ ይጠቅማል?
17. በዚህ ክፍል በትዳር አጋራቸው ወሲባዊ ጥቃት የተጋለጡ ሴት ህመምተኞችን ለመርዳት እነዳትችሉ የሚያደርጉ ችግሮች አሉ?
 Probe: አዎ ካሉ በምን አይነት ችግር ነው የሚገጥማችሁ?
 አይ ካሉ ድርጅቱ የሚያደርግላችሁ መልካም አስተዋጽኦ ምንድን ነው?
 ምን ዓይነት መርጃ መንገዶች ተቀምጠዋል?
18. ከስራ ልምድሽ በአብዛኛው በትዳር አጋራቸው ወሲባዊ ትንኮሳ ደርሶባቸው ለአገልግሎት ወደክሊኒኩ የሚመጡ ሴቶች ጥቃቱ ካደረሰባቸው ሴቶች አንፃር ምን አይነት ስነልቦናዊ ችግር ያጋጥማቸዋል?
19. ከስራ ልምድሽ በመነሳት በአብዛኛው በትዳር አጋራቸው ወሲባዊ ትንኮሳ ደርሶባቸው ለአገልግሎት ወደክሊኒኩ የሚመጡ አችላይቪ በደማቸው ዉስጥ ያለባቸው ሴቶች ተገቢውን አይነት የስነልቦናዊ ምክርና እርዳታ አለማግኘታቸው በጤናቸው ላይ ተጽዕኖ ይኖረዋል?
20. ከስራ ልምድሽ በመነሳት እኒህ በትዳር አጋራቸው ወሲባዊ ትንኮሳ ደርሶባቸው ለአገልግሎት ወደክሊኒኩ የሚመጡ አችላይቪ በደማቸው ዉስጥ ያለባቸው ሴቶች ተገቢውን አይነት የስነልቦናዊ ምክርና እርዳታ ሲያገኙ በመድሀኒት በትክክል ለመውሰድ በሚኖራቸው ተነሳሽነት ላይ እና በአጠቃላይ ጤናቸው ላይ ጥሩ ተጽዕኖ ይኖረዋል?
21. በትዳር አጋራቸው ወሲባዊ ትንኮሳ የደረሰባቸው ኤችአይቪ በደማቸው ዉስጥ ያለባቸው ሴቶች ለችግራቸው ምክርና እርዳታ ለማግኘት ጥረት እንዳያደርጉ ተጽዕኖ የሚያሳድሩ ሁኔታዎች ምን ይመስልዎታል?
22. በእናንተ በኩል ይህንን ሁኔታ ለማስተካከልና ሴቶቹ ችግራቸውን አንዲያወሩና እርዳታ እንዲያገኙ የምታደርጉት ጥረት ካለ?
23. በአጠቃላይ ሁኔታውን ለማስተካከልና ሴቶቹ ችግራቸውን አንዲያወሩና እርዳታ እንዲያገኙ ምን ዓይነት ነግሮች ቢስተካከሉ ወይም ቢሻሻሉ የሚሉት ሁኔታዎች ካሉ?
 Probe: በህክምናና ፖሊስ ድርጅቶችም ሆነ በማህበረሰብ ደረጃ ምን ቢደረግ ጥሩ ነው